Mental Health Services Act
MHSA Steering Committee
Meeting Notes
Wednesday, September 30, 2009

Meeting Date: Wednesday, September 30, 2009
Location: 675 Texas Street, 1st Floor, Multi-Purpose Room
Note Taker(s): Lisa Singh & Kristina Feil
Facilitator: Jayleen Richards & Lynn De Lapp

DRAFT

Attendees: Laurie Andres (for Debbi Davis), Araminta Blackwelder, Kay Bosick, Karl Cook, Travis Curran, Lynn DeLapp, Kristina Feil, Norman Filley, Rachel Ford, Susie Frank, Robert Fuentes, Nadine Harris, Everette Hicks, Cecilia Jungkeit, Kelli Kekki, Susan Labrecque, Marge Litsinger, Sanjida Mazid, Martin Messina, Joyce Montgomery, Sonja New, Michael Oprendek, Jayleen Richards, Megan Richards, Donna Robinson, Candice Simonds, Lisa Singh, Robert Sullens, Tony Ubalde, Pam Watson,

Agenda Item	Notes	Public Comment/Action Steps
I. Welcome and Introductions	Jayleen opened with a welcome and introductions took place around the room.	
II. Review Purpose of Meeting & Brief Recap of Last Meeting	• The workgroups will report out to the committee about their recommendations and Lynn will facilitate a conversation about next steps. • We will cover MHSA funding projections. • Lynn reviewed the notes from the last meeting and asked that acronyms be kept to a minimum to avoid confusion. • There were no comments or questions asked about the notes.	
III. Reports from MHSA Workgroups	Each workgroup chose their top 5 recommendations (please see the MHSA Steering Committee Workgroup Recommendations handout): **Transition Age Youth (Candice Simonds of Seneca)** 1. Develop a Peer Mentoring Program – to reduce the stigma associated w/ mental illness, people need sustainable connection to others in their community. TAY attended workgroup meetings to inform the workgroup and identified this as a high priority.	• *How did you deal with the cost aspect of the analysis?* Recommendations 4 and 5 were low cost. Recommendation 3 was high cost but also high need. • *How many transition age youth were there at the workgroup?* Four

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III. Reports from MHSA Workgroups, cont'd	2. Utilize psychiatrist in a TAY Full Service Partnership – there is a window of opportunity for the age group to seek treatment. The current wait to see a psychiatrist prevents many TAY from following through with treatment. 3. Housing opportunities – continuum of housing options per the acuity of the client and have more than one tier of housing assistance. Also discussed the difficulty of TAY to sustain housing (main issue). 4. Create matrix – need to know what resources are available and as providers, be able to share with/refer TAY to services. There is an "emancipation binder" for someone who exits services to give the client a "roadmap." There is a website which serves as a "hub" with connections to other resources. 5. Increase coordination with Mobile Crisis and other providers to more effectively assist TAY – this seemed less important to TAY who participated in the workgroup than the first four recommendations.	• *How do you find the emancipation binder online?* It is on the Solano County Office of Education website: http://www.solanocoe.net/ourpages/auto/2008/10/7/1223404732260/Resource_Guide 2007-2008.pdf?rn=8543774 • *Regarding peer mentoring, were groups that already do peer mentoring identified?* Yes, and a transition age youth who participated in workgroup stated that he should be a peer counselor and help someone else.
	Older Adults (Robert Fuentes of Faith in Action) 1. Senior peer counseling/support groups outlined in the last Community Services & Supports Strategic plan should be implemented now because of need and because it was never implemented as it should have been. There is an "in-between" group that do not need intensive Full Service Partnership services, but still need more than what is offered by outpatient clinics. This allows for that group to receive services and also address the issue of homebound older adults.	

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III. Reports from MHSA Workgroups, cont'd	2. Retain and strengthen current Full Service Partnership by returning supervisor to full time and by additional nursing support. 3. Revisit program design. Provide services for the "in-between" group by looking at the IMPACT model (to provide treatment for depression through primary care provider, specifically for seniors), which has been explored by other counties through Prevention & Early Intervention and other MHSA programs. 4. Mobile crisis in-home case mgmt – for many older adults having case mgmt in the home is necessary to receive treatment (homebound, stigma, transportation are all issues). Provide additional training for Mobile Crisis staff on geriatric mental health. This should also include training for other staff and providers. 5. Affordable housing – it is difficult for seniors to continue in their homes. Possibly clustered in a duplex/triplex? Housing would be supported housing that would address medical and mental health needs.	• *How did we deal with cost issues?* All are high cost. We can modify recommendations to reduce cost (e.g. train mobile crisis staff rather than add them, explore IMPACT model). Many providers should receive training on geriatric MH issues. • *What is mobile crisis in-home case management?* Key part is the "in-home" part. It can be through mobile crisis or Full Service Partnership to address those who need treatment but are homebound or have transportation issues. More like the public health nurse model, not necessarily connected to mobile crisis.

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<tr><td>III. Reports from MHSA Workgroups, cont'd</td><td>Adults (Pam Watson of NAMI)
The focus was on mobile crisis and consumer operated programs. The group put together a survey with respect to mobile crisis and consumer operated recovery programs and received input from consumers, family members, and county staff.
Implement customer service training with a focus on respecting the dignity of the individual – respect and dignity are the key words (e.g. talking to loved one/family member instead of the consumer).
Increase integration and/or collaboration with community partners, particularly law enforcement and hospitals. Because there is no longer a physical crisis center, mobile crisis is becoming more and more important. Crisis intervention training for law enforcement makes them aware of the services available in the community.
Increased educational training and employment opportunities for consumers/family members – have larger scale trainings. Consumers/family members should receive the same trainings as County employees. Have volunteer or paid opportunities for consumers on mobile crisis teams. Create a program that will get people into jobs/internships through community college or business partners. Volunteer work with a goal of a job or education opportunity should be available.</td><td>How did we deal with cost issues?
Outside of the last recommendation, fairly low cost and feasible.
Comment on recommendation 2 – The quickest way to respond to that is to contact the chaplain's office; part of the law enforcement community.
Did this group work with the Area Agency on Aging?
No. This workgroup was not dealing with the population that Area Agency on Aging works with.</td></tr>
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III. Reports from MHSA Workgroups, cont'd	4. Disperse educational resource info throughout the county by resource guides/website – how to get info out to those who need services but don't know how to access. 5. Create a structured outpatient follow-up – a place people can go to "cope" with their mental illness.	
	Children (Kay Bosick of Youth Family Services) 1. Provide additional funding to staff mobile crisis to increase in-home/in-school response. Mobile crisis needs to be able to go to where the consumer is to prevent a 5150 hold being placed (hold results in child having to stay in emergency room/hospital for 72 hours). 2. Services in natural environment – there should be focus on treating children in the environment where they are the most comfortable. 3. Train Mental Health staff on evidence based practices related to children – not everyone knows how to relate to children/deal with children's mental health issues because it is very different from dealing with adult mental health illness. Training should include mobile crisis responders (there is currently only one children's responder).	• *What children's programs do these pertain to?* All programs • *Some aspects of cost already covered, but please address cost in more detail.* Much of this would be funded by leveraging funds through foundations or grants. • (comment) We know there is less funding, so maybe rather than getting more staff, which is ideal, training for current staff, families, schools, etc. can be an alternative. • (comment) Having mobile crisis treatment in the home or school is the most important. • *Mobile Crisis is mobile. When they get a crisis phone call, the staff drives to the place where the crisis is and does a 5150 (Involuntary Containment) on the client. We have plenty of cars for staff's use. Our Crisis staff goes to kids' clinics with the client's family and meets with their therapist. Since we've had the Mobile Crisis, the statistics showed over 800 calls during a month and only 49 hospitalizations. Mobile Crisis is working.*

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III. Reports from MHSA Workgroups, cont'd	4. Training for school administrators and teachers – they are the ones who initiate the process if child is in crisis. We want to give them effective ways to access services including what is available throughout the entire County and community. 5. Increase outreach efforts by developing a resource guide and utilizing existing networks to distribute – outreach should be commensurate with the County's capacity to serve clients.	
	Full Service Partnership (Kelli Kekki of Solano County Health & Social Services, Mental Health) Each Full Service Partnership has its own characteristics based on the population it is serving, so these recommendations are overreaching core values that address generally what a FSP should be doing. 1. Consumer/family driven – who does the client believe is their support group? 2. Focus on entire situation – specifically with older adults there are medical issues involved. May need help with work, school, etc. In regard to different levels of service, the person should receive the services they need when they need them. 3. Move clients toward Wellness & Recovery, it is the least restrictive treatment possible. We need to work with them to achieve independence.	• *Is this intended as a specific recommendation to continue all of these?* Yes, and to build on them, this is a learning process and a creative process. • *For recommendation 1, would it also include assistance to caregiver?* For an elderly client who has an in-home caregiver and identifies that as part of their family/support group, absolutely.

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III. Reports from MHSA Workgroups, cont'd	4. Culturally and linguistically appropriate services, we need to make sure to provide what is appropriate for each client. 5. Key aspects – coordinating medical and mental health, 24/7 access to services, supported housing, advocating for consumer needs and teaching consumers to be empowered – should be individualized.	
IV. Review MHSA Funding Projections for Next Three years	• We need to keep in mind that Community Services & Supports, component of MHSA, has roughly $9M for budget this year. • Future year funding is anticipated to dip about 30% next year, 50% the year after that, and even more the following year. • Internally, there are some strategies to deal with this. One is to take the next 3 years of funding and the average of those 3 years will be the budget for Community Services & Supports. Another strategy is that the Dept. of Mental Health has advised us they anticipate that counties will be able to tap into their Prudent Reserve (based on consumer price index). There are projected decreases in other pots of funds (like Prevention & Early Intervention) but it will happen later because those funds were released later. As a community, we will have to decide what our basic, core priorities are.	

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IV. Review MHSA Funding Projections for Next Three years, cont'd	• We can look at options for funding/budget next month or the month after. We want to implement as many of these ideas as possible. • The Strategic Plan is to develop a framework for us to operate. The County's responsibility is then to build a plan and budget using the framework.	
V. Next Steps: Developing a MHSA Strategic Plan	• We need to get a representative from each workgroup to work with Jayleen, Lynn, a consumer, and a family member to sort through all of the recommendations. We need to determine feasible, finite set of potentially doable recommendations to bring to the next meeting. • Volunteers from each workgroup: ➢ Childrens – Cecilia Jungkeit ➢ Transition Age Youth – Candice Simonds ➢ Adults – Pam Watson & Susie Frank ➢ Older Adults – Terri Restelli-Deits ➢ FSP – Candice Simonds ➢ Consumer – Susie Frank & Norman Filley ➢ Family Member – Pam Watson • Please review and be familiar with the Proposed Timeline for Mental Health Services Act Strategic Plan (handout).	• Should workgroups meet again to discuss outcomes? *It may take some time, but our goal is to meet with the volunteers to discuss the recommendations and then take it to the committee at the next meeting. Afterwards, the committee will set performance and outcome measures.*

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VI. Announcements	• The Innovation Plan (handout) has gone through a four month community planning process to develop the plan. It will be called the CARE project (Community Access to Resources and Education). It is now available for a 30 day public comment and is on the agenda for the next Local Mental Health Board meeting on Oct. 20th. • Due to financial difficulty many agencies are facing, Area Agency on Aging has produced a calendar available for $15.00. The calendar represents heroes and the diverse community that the organization is serving. Area Agency on Aging will also be putting on a variety show at the empress theatre on Nov. 1st from 3pm-5pm.	
VII. Adjournment	Next Steering Committee Meeting: Wednesday, October 28, 2009 3:00 pm – 5:00 pm UC Cooperative Extension 501 Texas St. Fairfield	Please notify Solano County Mental Health should you need assistance at the meeting at 707-784-8320.