NOTES from
Mental Health Service Planning Committee
Friday, February 25, 2005
Michael Heggarty, Chair

I. Notes from Sheet #1:

Began with Some Descriptors of Evidence Based BEST PRACTICES Model

1. Has proved itself statistically
2. Client Strengths-Based Approach
3. ACT-like small teams with
   a) Small caseload;
   b) Wraparound services;
   c) Multi-disciplinary (inter-disciplinary) teams
   d) Services are individually responsive (services geared toward individual client's needs, rather than fitting client to specific teams that may be changes as client's needs change.
   e) Shared caseload within the team (has assigned primary staff, but all team members have knowledge and can respond to client when in need).
4. Puentes program Per client cost same as for other teams

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II. Notes from Sheet #2:

BRAINSTORMING SUGGESTIONS FOR IMPROVING/EXPANDING SERVICES

1. Additional funding for local programs that work.
2. More Case Managers; and
   Additional Coordinators For smaller caseloads to provide more assistance to individual clients, when necessary.
3. More Benefit Representatives (*STRONG, consensus/committee agreement*) to help with:
   a) SSI application, etc. (for rent)
   b) Medi-Cal for medications
   c) Food Stamps
   d) Section 8 Housing
   e) Transportation
   f) Monitor ongoing requirements for each benefit
   g) Have appointments available in community, rather than all taking place with just 1 Rep. At Bldg K
4. Availability of Support for Clients, as needed, 24/7
5. Team and services located onsite (where clients are housing/located).

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III. Notes from Sheet #3-6:

MORE UNMET NEEDS

1. Services for those who don't qualify for SSI or Medi-Cal
2. Services for those who may not "appear or look needy" or severely Mentally Ill enough
   "Threshold" is Too High
3. Office of Consumer Affairs (also STRONG advocacy for this idea in Committee)
   a) This office would be staffed with consumers with expertise who could offer assistance, information, advocacy for current consumer.
   b) Focus on services would be Client Strength based
   c) Intent: to help REDUCE DISPARITY OF SERVICES among clients assigned to various teams, Meds-Only, etc.
4. Conservatorships: NEED:
   a) Better trained conservators (more attuned to mental health needs of clients)
   b) To lessen length of time individuals are conserved
   c) Have fewer people conserved
   d) Assistance with getting OFF Conservatorship (role for consumer Advocate?)
5. OUTREACH: Information:
   a) Restore MH RESOURCE CENTER (with consumer participation/county partnership
   b) More community education about mental illness and available services
   c) In various locations, including "street calls", house calls
   d) Full spectrum of outreach activities, new ways to inform those in need, wherever they may be located.
6. Outreach Services:
   a) Psych/Mental Health Vans/Mobiles for mobile services and information
   b) Increase accessibility to services through better transportation options and s
   c) Services off "County Campus at Bldg. K. to other community sites (eg. MHCAN below)
7. CLEARINGHOUSE
   Central location and/or person(s), especially for those without a Coordinator, where clients can go for information about other available community services
8. MHCAN
   Expand available services;

   Site of professional services, such as:
   a) Housing
   b) Employment
   c) Health
   d) MH Services
   e) Benefit Reps

   More employment opportunities for clients
9. Need Mentoring/Peer Support Program

10.. Need Services to reflect Recovery Model :that includes

a) Ability to get higher or lower level of care, as needed

b) Increased flexibility for clients to move to get level of care needed without losing their Coordinator/therapist, etc.

11. More Flexibility in Access Gates/Points of Entry into System, perhaps Drop-In site(s)

12. Increase Consumer Participation throughout the entire MH system, including both paid and volunteer jobs/activities

13. Additional Professional Staff, such as:

a) Nurses
b) Occupational Therapists

14. Wellness Center Model (as described by BJ North) which is a peer supported residential alternative to hospitalization, with MH crisis service available, max 3 day stay; individual referrals

15. Increase Family Support Opportunities

PROBLEMS WITH CURRENT SERVICES

1. Limitations of therapists/choices for consumers, as therapist may be too narrowly focused, eg. too behaviorally oriented

2. Need Sexual Abuse Treatment expertise within MH system

3. Need help for those with health/medical problems

4. Not enough volunteer and employment opportunities for consumers.

IV. NOTES from pages 7-8:

SUGGESTED IMPROVEMENTS from Consumer (male- ? name?)
(I don't have group list)

1. Increase MH professionals pay to industry standard

2. Emergency Drop-In sites (e.g. Bldg. K; DBHU; El Dorado)

3. Computers with Internet capabilities for MH Client Access to internet

4. Increase in client benefits/pay to help with rent and living expenses

5. Increase rent subsidies

6. Increase employment subsidies

7. Increase pay rate and services for residential housing services

8. Help clients transfer out of locked facilities to lower res. level

9. Increase individual and satellite (full range of) housing facilities

10. More housing support services

11 . Increase Medication Education

12. Increase services to Mentally Ill Homeless population
13.. Encourage more participation in MHSA Recovery Model
14. Increase Staff Training
15. Prevent as many Conservatorships, as possible
16. Expand Peer Counselor Relationship Services (expand/restore RESPITE)
17. Offer Symptom Management Training
18. Increase Employment Training and Job Opportunities

V. NOTES from pages 9-10:

COMMITTEE'S LIST OF TOP SERVICE IDEAS
(Taken from previously discussed ideas)

1. Increase Case Coordinators
2. Office of Consumer Affairs
3. Increase funding for more social integration activities
4. Increase outreach and education services/activities
5. More (and mobile) Benefit Reps
6. Clearinghouse for Information/Assistance in accessing community services
7. Increase Peer Counseling Services
8. Increase Job Training and Social Integration Opportunities
9. Increase Housing Placements
10. Implement WRAP (Wellness Recovery Action Plan) opportunities throughout the system
11. Increase funds for Evidence Based Practices (e.g. College Connection)
12. Restore funding Community/Social Integration services –e.g. Mariposa Center, Drop In
13. Implement Multi-disciplinary Teams with :
    Therapists
    Nurses
    Employment Specialists
    Housing "
    Substance Abuse "
    Occupational Therapist
    Consumer Representative
14. Utilize Wellness/Holistic Center or Approach
15. Increase the flexibility of services, so client can receive increased or decreased levels of care, depending on immediate needs without changing coordinators/therapists, etc.