

Update

mhsoac
newsletter

April 2010



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MHSOAC Welcomes New Executive Director

On March 30, 2010, MHSOAC Chair Andrew Poat and Vice-Chair Larry Poaster announced Ms. Sherri L. Gauger as the new MHSOAC Executive Director. Ms. Gauger previously worked as the Deputy Director of the Division of Addiction and Recovery Services for the California Department of Corrections and Rehabilitation. She also served as a Career Executive (CEA) for the Governor's Strike Force on Prison Reform; Deputy Director for the Office of Legislative and External Affairs at the Department of Alcohol and Drug Programs; and has experience as the Assistant Deputy Director, Administrative Division for the Victim Compensation and Government Claims Board.

The Commission is very excited to have her on board. Chair Andrew Poat said, "Sherri Gauger is exceptionally well qualified to assume the duties of Executive Director of the MHSOAC. She brings a wealth of executive level state work experience to the Commission and we are very fortunate to have her join us." Vice-Chair Poaster seconded the Chair's comments in saying, "Sherri Gauger has the knowledge, skills, and abilities to lead the Commission staff to serve mental health clients, families, and stakeholders."

Ms. Gauger officially began work for the MHSOAC on April 19, 2010.



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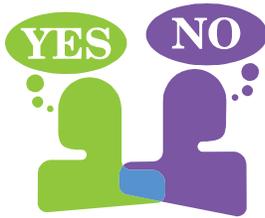
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Californians Opposed to Mental Health Program Cuts



By Amy Shearer

A majority of California voters are against cutting mental health services to fill the budget gap, according to a recent Field Poll by the Field Research Corporation.

The independent and non-partisan survey looked at voter opinion with regard to making spending cutbacks in several categories, including environmental regulation, child care programs, and state road and highway building repairs. 503 randomly se-

lected registered voters were asked whether they opposed or favored cuts in each of the fourteen categories.

In seven of the fourteen categories, more voters supported cuts than in the previous year; two of the remaining categories (one of which was mental health programs) had no change in support level; two of the categories were new and had not appeared in the previous year's Field Poll; the remaining three categories showed a decrease in support of spending cuts for those areas. This trend shows that, while more Californians acknowledge the need for spending cuts compared with last year, there are certain areas where voters are unwilling to see cuts, regardless of the economic climate. These areas included education (both public schools and higher education), health care programs for low-income

Californians and the disabled – and mental health programs.

A 65% majority of voters were against cutting mental health spending. In fact, mental health programs tied for 9th place (with law enforcement and police) in order of those favoring cuts, with only 31% of voters unopposed to cuts. This effect was visible across parties; only 24% of Democrats, 41% of Republicans, and 31% of non-partisan voters supported funding cuts to mental health programs.

There was majority support for cuts in only two areas: state prisons and correctional facilities (56%), and state parks and recreational facilities (52%).

Data from: The Field Poll, Release #2335 (March 24, 2010). The Field Research Corporation.

New Health Care Bill Protects Mental Health Parity

By Amy Shearer

On March 23rd, 2010, the long-awaited Patient Protection and Affordable Care Act (the national healthcare reform bill) was signed into law by President Obama. Among other provisions, the law makes it illegal for insurance companies to deny coverage for pre-existing conditions or to drop policy holders when they become sick, and allows children to be included in their parents' health insurance plans until age 26. It also extends Medicare coverage, lowers the cost of prescription drugs, and disallows spending caps on healthcare coverage.

Importantly, mental health care is included in the list of essential health benefits that all health insurance plans are required to provide under the new law. This includes mental health and substance use disorder services, as well as behavioral health treatment.

The "comprehensive primary health services" that insurance plans are required to provide include, "Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs." Preventative and wellness services and chronic disease management are also emphasized; in the Act, mental health conditions and substance use disorders are included in the definition of "chronic conditions."

Throughout the Act, prevention and intervention, screening, and research for medical and mental health issues are emphasized. The Act also specifically calls for more research on postpartum depression, and support for those suffering from it. This includes

enhancing home-based health and support services, and providing community education.

The Act requires the creation of teams of health care professionals within each State who will advise the legislature on current health concerns. These teams will include medical professionals, as well as, "social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers)."

True to the Mental Health Parity and Addiction Act, which took effect on January 1st, 2010, mental health care is treated as synonymous with traditional health care in the Patient Protection and Affordable Care Act.

*All information comes from the Patient Protection and Affordable Care Act, which can be found online at: http://dpc.senate.gov/dpcdocsen_health_care_bill.cfm

A Warm Welcome to Our New Commissioner Sheriff-Coroner Curtis J. Hill



By Christina Call

This is Sheriff-Coroner Curtis Hill's 34th year in law enforcement. Sheriff Hill says he knew he wanted to work in law enforcement as a college freshman in 1972.

"I've worked in every division," says Hill. "I started working in the department in 1976. I've experienced and seen everything you can see in law enforcement...terrible tragedies, terrible crimes, victimization issues that are shocking and people doing fantastic and heroic things...I have seen citizens at their very best."

Sheriff Hill's numerous years in law enforcement and his wide span of experience in different divisions bring a unique perspective to the Commission. He hopes his experience and perspective will help further the work Sheriff Kolender began. As the Sheriff-Coroner of San Benito County, Hill has several responsibilities including: full patrol responsibility for parts of San Benito County, running the county jail, death investigations in the county, being a bailiff to superior courts, responsibilities as the project director for a multiagency regional narcotics task force and for all search and rescues in the county, director of emergency services, and oversight of the communications center which handles all of the 911 calls in the county. However, these responsibilities are just a part of

Sheriff-Coroner Hill's "day job".

Aside from the responsibilities that come with being a Sheriff-Coroner, Hill is also the first vice president of the California State Sheriff's Association and was elected to be its president; his term will begin this month. The California State Sheriff's Association is a nonprofit organization that gives the 58 sheriffs of California one voice. Having the trust of the 58 sheriffs in the association has been a big deal for Hill. Also, having the trust of the community to be elected as sheriff-coroner for three terms means a lot to him. "The community entrusted me to be their sheriff. I'm proud of that. That is my best accomplishment," says Hill.

When asked what he is most passionate about, Sheriff-Coroner Hill had two answers. The first is being a part of an executive committee for an organization called Fight Crime, Invest in Kids California. The organization advocates for and works on legislative issues to enhance prevention and early intervention for juveniles to keep them out of trouble and to help them succeed.

Sheriff Hill's biggest passion is his involvement with educating the state's coroners on organ donations. "I work to train coroners to make sure they release each potential organ donor 100% of the time," says Hill. "What happens is the family will say yes, but the coroner says no. I work with the coroner to get them to say yes. There is a lack of knowledge sometimes. The coroners think that if they donate the organs of a victim or inmate, they'll lose evidence or jeopardize successful prosecution of the killer. In fact, I was involved in legislation in 2004 that's saving about 150 Californians a year."

Sheriff-Coroner Hill has also sat on the CA Commission for Fair Administration of Justice and served a term on the Correction Standards Authority which

was, at the time, called the Board of Corrections. In 2006, Hill was awarded the Leadership Award by the Chamber of Commerce. This honor is awarded to just one person a year for the community of San Benito. Sheriff Hill is also excited about his nomination for his high school hall of fame. The nomination means a lot to him as he is one of four generations, including his son, to attend San Benito High School. Hill is also proud of being able to look back at his life and see that he was fully committed to being a part of his department and enjoyed working with his fantastic staff. "(I am) able to look at my community and my organization from a perspective where I have been able to provide a high level of service at the least expense for taxpayers. I have a good staff with high morale. I have been able to create a leadership dynamic with my staff, [and we've] made progress with limited dollars." However, what Sheriff Hill says he is most proud of is his family, his son Kevin and wife Ellen. "My wife and I were high school sweethearts. We started dating as sophomores in high school", he says with a laugh.

Commissioner Curtis J. Hill brings experience, perspective and passion to the Mental Health Services Oversight and Accountability Commission. He hopes his experience will help bring more energy to the issue of the large population of inmates suffering from severe mental health issues who are getting stuck in a "revolving door" in the criminal justice system.

As for the future of the MHSOAC, Commissioner Hill says "I would like to see all of the different organizations that are working on mental health issues to continue the collaboration that has started in the last several years. We've really started to come together...where everybody's really started to collaborate...it's been a very enjoyable thing for me to see."

Commissioners Awarded for their Leadership



Commissioner Vega will be accepting an award for his excellence in state government leadership from the National Resource Center for Hispanic Mental Health at their 7th Annual Shining Lights, Outstanding Leaders for A Brighter Future for Hispanics Award Gala. The Gala will be taking place on May 6 in West Orange, New

Jersey.

This is the first year this award has been given to an individual outside of the state of New Jersey.

Henry Acosta, the Executive Director of the National Resource Center for Hispanic Mental Health and Deputy Director of the New Jersey Mental Health Institute, Inc. said, "Mr. Vega has consistently demonstrated commitment to creating a brighter future for all Americans and has developed programs and activities that are sensitive to Hispanics, especially those with Limited English Proficiency. He is a role model for Hispanics all across the nation and is highly respected for his personal and professional courage, contributions and leadership."

For more information, you can visit the center website at <http://nrchmh.org/index.html>.

*Congratulations
Commissioner Vega!*

This year, the National Council for Community Behavioral Healthcare presented Commissioner Richard Van Horn with a Visionary Leadership award for his years of excellent leadership and guidance of Mental Health America, Los Angeles (MHALA).



Commissioner Van Horn has led Mental Health America, Los Angeles into being one of the top nonprofit mental health associations in Southern California. He has done this through a number of innovations in service, system design, and public policy.

The National Council for Community Behavioral Healthcare said it is "his unassailable belief in the power and potential of people with mental illness" that makes him an "individual of vision and commitment".

Commissioner Van Horn was recognized at the National Council's Fabulous Forty Gala on March 16th in conjunction with the 40th National Council Conference in Disney, Florida. For more information about his award and the organization, you can go to <http://www.thenationalcouncil.org/cs/awards>.

*Congratulations
Commissioner Van Horn!*

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MHSA Papers



By Danielle Thompson

The Mental Health Services Oversight and Accountability Commission (MHSOAC), in collaboration with the Department of Mental Health and the Stigma and Discrimination Reduction Advisory Committee, recently released printed copies of the new California Strategic Plan on Reducing Stigma and Discrimination¹. The new plan was adopted by the MHSOAC on June 25, 2009². The Stigma and Discrimination Reduction Advisory Committee consists of 56 members from all over the state of California. The members come from a wide range of backgrounds including health clinicians, county mental health officers, consumers, family members, and mental health advocates.

Part of the process for creating the plan included looking at results of surveys given to the public to help get a sense of the current views of mental health and to help figure out a starting off point for the plan. The studies showed that there is a lot of work to be done: "Nearly half of the adults in a nationally representative survey said they were unwilling to socialize with, work with, or live near people with mental health issues."³ In addition the surveys found that this negative stereotype does not just affect adults, "...It is estimated that approximately 33 percent of children experiencing social, emotional, or behavioral difficulties have been the target of bullying in schools."⁴ Once the overwhelming need for public education and the need to confront stigmatizing views were identified, the plan began to take shape.

The new plan is made up of three parts: first, the plan contains a discussion on what stigma is and how it affects those with mental illness; second, the plan lists strategies, approaches, and methods for avoiding and reversing the effects of stigma; and last, the plan outlines a blueprint for readers. The blueprint is a simple guide for individuals, organizations and systems that is organized in three levels: strategic ac-

The California Strategic Plan on Reducing Stigma and Discrimination: *A Blueprint for Change*

tions, recommended actions and next steps. The blueprint identifies many ways to help make a change; it can be as simple as having a conversation or interaction with someone affected by mental illness in order to change an attitude, or it can be larger steps, such as enforcing laws and forming local coalitions to launch community action plans. The blueprint is written in a way that provides Californians with methods and strategies that they can use at a local, regional or statewide level.

The blueprint also addresses prevention and early intervention activities that confront the fundamental causes of stigmatizing attitudes. There are many highlights in this plan; however, a very strong emphasis is placed on the importance of proper and accurate education of what mental health really is and how it affects those who are challenged by it. One of the key populations that needs to be educated, and that will also have a great impact on the cause, are youth and transition aged youth:

"Given the fact that one in five children and adolescents experience the signs and symptoms of a mental health disorder during the course of a school year, schools are an ideal setting to address stigma and discrimination."⁵ A major part of the blueprint integrates mental health topics within the required health education and other school-based prevention programs, such as violence prevention and anti-bullying. A strong positive response is shown when people who are uneducated about mental illness are able to meet and hear personal stories from those affected by mental illness: "In another study, high school students showed less stigmatizing attitudes after receiving one-hour presentations by consumers."⁶ The blueprint suggests establishing training programs for teachers and counselors to help them both work more effectively with students with mental illnesses as well as to help relay the message and awareness of positive mental health attitudes to their students. By educating students at a young age, the stigma of mental health can be brought to light and defeated before children form lasting opinions.

The California Strategic Plan on Reducing Mental Health Stigma and Discrimination is simple and anyone can help make a change towards ending mental health stigma. The Strategic Plan is written as a ten year process because those who wrote the plan know that the fight against stigma is a battle that cannot be won overnight. The plan authors also stress the importance of research. Those that are helping put the plan into action want to create a method to track their progress so that they can pass their challenges and successes onto other Californians in order for a clear, effective method for fighting stigma and discrimination to be identified. Stigma and discrimination are two very powerful and overwhelming problems that many Americans face in thousands of different ways. The California Strategic Plan on Reducing Mental Health Stigma and Discrimination provides Californians with methods that they can use to help fight this battle locally and help change the state one step at a time.

¹ http://www.dmh.ca.gov/PEIStatewideProjects/docs/Reducing_Disparities/CDMH_MH_Stigma_Plan_09_V5.pdf

² Department of Mental Health (DMH), [California Strategic Plan on Reducing Stigma and Discrimination](#), p. 1

³ IBID, p. 9

⁴ IBID, p. 9

⁵ IBID, p. 23

⁶ IBID, p. 32

For more information or a copy of the California Strategic Plan on Reducing Mental Health Stigma and Discrimination, please visit www.dmh.ca.gov

A Brief History *of the* Mental Health Services Act

By Amy Shearer

Prior to the Mental Health Services Act, mental health care in California looked very different. During the 1950's, most mentally ill persons could be found in state-run institutions, where they generally remained until they died. These institutions, while they provided shelter and rudimentary mental health care, were often places of neglect and abuse that effectively eliminated individuals' freedoms¹. The Lanterman-Petris-Short Act, which came into effect on July 1st, 1972, made it illegal to commit any person with a mental illness or substance abuse disorder to a psychiatric institution without their consent. In many ways, this was a huge step forward in promoting the rights of patients. There was, however, an unforeseen consequence of the Act. Because it was no longer legal to detain people with mental illnesses in state institutions, and with the advent of effective medications to treat various mental illnesses, it became more cost effective to close state-run psychiatric hospitals and turn patients over to "community care". In fact, between 1957 and 1988 the state hospital population was reduced by 84%². Unfortunately, this placed the burden of care on unprepared and underfunded community support systems that were not sufficiently prepared to deal with the influx of individuals needing treatment and care. Consequently, thousands of mentally ill Californians were left without anywhere to turn for help. Many became homeless, others were incarcerated, and most were left without any kind of scaffolding to help

them find mental health care, homes, or jobs. This human cost also created a significant cost for state and local governments. With daily jail costs ranging from \$50 to \$60, and medical or psychiatric hospitalization for inmates ranging in cost from \$300 to \$400 a day, the lack of adequate mental health care was also creating a fiscal predicament³. Clearly, a better system was needed to cope with the rising economic and human costs associated with the lack of comprehensive and accessible mental health care.

To remedy the situation, a series of Assembly bills that addressed the problem of access to mental health services were passed; notably, AB 34 and AB 2034. These bills laid the foundation for prevention and recovery based community mental health programs, and provided evidence for their effectiveness. They subsequently led to the creation of the ground-breaking Mental Health Services Act (MHSA), which incorporates many of the same concepts of these bills, and was built upon the success of the programs that they established.

Assembly Bill 34 was created to address the growing need for effective community-based treatment programs. AB 34 allocated about \$10 million to fund three pilot programs aimed at reducing homelessness and incarceration for people with serious mental illnesses. The three counties targeted to implement the program were Stanislaus, Sacramento, and Los Angeles. The funds could be used for outreach, mental health services, vocational training, housing, medication assistance, and substance abuse rehabilitation⁴. Less than a year after the pilot programs began, participants showed improvements in three critical areas: a 74% reduction in days spent in jail; 59% reduction in days spent homeless; and a 64% reduction in the number of participants who were hospitalized. Importantly, less than 15% of eligible people declined to participate in the program, and fewer than 4% dropped out⁵. It was clear that the program worked, and judging by the low drop-out rate, the consumers thought so, too.

Assembly Bill 2034 expanded the original pilot program to create 53 programs in 34 counties⁶. Importantly, several target

populations were added to the Bill: young adults under the age of 25 who were homeless or at-risk for homelessness; women from different cultural backgrounds; older adults; and the physically disabled mentally ill. Less than 20% of the participants dropped out of the program. Importantly, the rate of hospitalization for participants dropped by almost 78%; the number of days incarcerated dropped by almost 85%; and the number of days spent homeless decreased by 69%⁷. The annualized cost for the programs totaled about \$14.1 million, which was offset by the savings of \$7.3 million from reduced incarceration and inpatient hospital days⁸. More importantly, many Californians living with mental illness were able to achieve independence and stability, and reintegrate into their communities as contributing members.

With a working model as a template, it was time to expand the programs laid out by AB 34 and AB 2034 to provide wraparound services in all 58 counties, for all specified target populations.

On November 4, 2004, the Mental Health Services Act (Proposition 63 on the ballot) was passed, and came into effect on January 1, 2005. The Act imposes a 1% tax on personal income earned over \$1 million in California, which is used to fund mental health services. The MHSA is based on the belief that recovery from mental illness is feasible for most people, and with the correct care and support, people can lead full and productive lives as members of their communities.

The MHSA funds programs designed to provide services and support for people with mental illness; prevent mental illness from occurring or worsening; train providers to be culturally competent; and support communities and providers by providing for technological and organizational needs. These programs are divided into several critical areas: Innovation; Prevention and Early Intervention; Workforce Education and Training; Capital Facilities and Technological Needs; and Community Services and Supports⁹.

The MHSA also created the Mental Health

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A Brief History of the MHSA

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Services Oversight and Accountability Commission, which oversees the distribution of MHSA funds to counties for Innovation and Prevention and Early Intervention programs. The MHSOAC is accountable to the public, the Legislature, and the Administration and ensures that the provisions of the MHSA are carried out in accordance with best practices and are cost-effective.

The MHSA marks a shift in California's mental health care system. The emphasis on prevention, early intervention, and wellness and recovery models has moved mental health care from a 'fail first' to a 'help first' system, and has provided thousands of people statewide with mental health services and support. The MHSA goes beyond traditional mental health care and emphasizes collaboration among health-care providers and cultural competency.

Unfortunately, despite its success, the MHSA is not immune to the current economic crisis. MHSA revenues are declining steadily, even as service expectations increase; in FY 2011/2012 revenues are projected to be only \$871.7 million – almost a 40% reduction compared to the current FY 2009/2010¹⁰. County mental health revenue from the State General Fund and Realignment are also decreasing¹¹. Another challenge that counties face is that of creating new and innovative mental health programs even as existing programs are facing funding shortages. Efforts are currently underway to create a more integrated system that continues to reflect MHSA values.

However, in May of 2009, recognizing the importance of continued funding of mental health programs, two-thirds of California voters rejected a proposal that would divert \$230 million away from the MHSA fund¹². A redirection of Proposition 63 funds would also cause counties to lose federal matching dollars, which would necessarily result in program and service cuts. Ultimately, redirecting MHSA funds would disproportionately damage counties' ability to serve mental health consumers and their families. Mental health care in California has come a long way since deinstitutionalization; reducing funding and cutting mental health programs would only recreate

the same problems that Californians have spent the last half of a century trying to address.

¹ Maisel, A. Q. (1946). *Bedlam 1946: Most U.S. Mental Hospitals are a Shame and a Disgrace*. The Minnesota Governor's Council on Developmental Disabilities. Accessed April 6, 2010. <http://www.mnddc.org/parallels2/prologue/6a-bedlam/bedlam-life1946.pdf>

² Proposition 63: Mental Health Services Funding. Institute of Government Funding; University of California, Berkeley. December 2004. <http://igs.berkeley.edu/library/htProp63MentalHealthServicesExpansion.htm>

³ Data adapted from Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A Report to the Legislature as Required by Assembly Bill (AB) 2034, Steinberg, Chapter 518, Statutes of 2000. http://www.dmh.ca.gov/About_DMH/docs/press/Homeless-Mentally-Ill-Leg_rpt.pdf

⁴ Assembly Bill No. 2034, Chapter 518. Steinberg, 2000. http://info.sen.ca.gov/pub/99-00/bill/asm/ab_2001-2050ab_2034_bill_20000919_chaptered.pdf

⁵ Ibid.

⁶ Drafting California's Ten-Year Chronic Homelessness Action Plan: State of California Highlight AB 2034, HomeBaseSCC, June 21 - 23, 2006. <http://www.homebaseccc.org/PDFs/CATenYearPlan/CAHighlightOutreach.pdf>

⁷ Data adapted from Effectiveness of Integrated Services... (Ibid).

⁸ Ibid.

⁹ The Mental Health Services Act. Steinberg, April 24, 2009. http://www.dmh.ca.gov/Prop_63/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf

¹⁰ FY 2010/11 Governor's Budget, DMH MHSA Expenditure Report (FY 04/05 through 10/11 amounts).

¹¹ FY 2010/2011 Governor's Budget, DMH MHSA Summary Comparison (Posted 12/31/09)

¹² MHSA Funding Fast Facts. Mental Health Services Oversight and Accountability Commission. February 2010. http://www.dmh.cahwnet.gov/MHSOAC/docs/Fast_Facts_Prop_63_funding--Revised_03-8-10.pdf

Timeline of Events

- ◆ **1950's** → Most patients with a mental illness in state-run institutions.
- ◆ **July 1, 1972** → Lanterman-Petris-Short Act: Illegal to commit person with mental illness/substance abuse to an institution without consent.
- ◆ **1957 - 1988** → State hospital pop. ↓ 84%, burden of care shifts to community support systems.
 - Communities unprepared/ underpaid. Many people left homeless.
- ◆ **1999** → AB 34. \$10 M to 3 pilot programs.
 - Days in jail ↓ 74%
 - Days homeless ↓ 59%
 - Hospitalizations ↓ 64%
- ◆ **AB 2034** expands pilot program. 53 programs in 34 counties.
 - Days in jail ↓ 85%
 - Days homeless ↓ 69%
 - Hospitalizations ↓ 78%
- ◆ **Nov. 4, 2004** → MHSA (Prop 63) passed
- ◆ **Jan. 1, 2005** → MHSA comes into effect
- ◆ **2009** → Voters reject proposal to redirect \$230 M from MHSA fund

MHSA Papers



Achieving Wellness

By Christina Call

Wellness means something different to everyone. For mental health consumer Derrick Orcutt, being well means “getting up everyday, showering and shaving which,” he says, “isn’t normal for those of us with mental health issues... It’s learning, through the assistance of Behavioral Health, that I’m OK—this isn’t the end of the world—my diagnosis can be treated and there is hope for a future...” Christa Thompson, the MHSA Coordinator for Calaveras County, defines wellness as an inner peace and sense of contentment. “We are all on a spectrum of physical and mental health,” says Thompson, “Few of us are as healthy as we would like to be, but we strive to better ourselves. Wellness, I

 * Wellness - “How being in control of *
 * how I deal with my feelings/pride can *
 * improve my life.” *
 * – Carl Ladd, Consumer *

believe, is finding contentment with who we are and working toward the well-being of ourselves, others and the communities we live in—that is where the inner peace comes in.” These definitions of wellness, among numerous others, are appropriate. How a person defines wellness depends on them; their life experiences, the obstacles they’ve faced and how they’ve overcome or dealt with those challenges.

Because everyone is different and achieves wellness differently, there are several models and tools that are being used in mental health programs and wellness centers to promote wellness. The wellness model used today looks at health and disease as being two separate dimensions. Recovery bridges those two dimensions and builds on “the strength of health to address the weakness of disease” (Manderscheid 2010). In this model, a person’s strengths

are emphasized and are used to address their weaknesses or mental health issues. In this wellness model, recovery is viewed as being a “life-long process in which a person with a mental illness strives to participate fully in community life, even in the presence of continuing symptoms and disabilities” (Manderscheid 2010).

How “well” a person is depends on two indicators, according to a commentary by Stephen Schueller of the University of Pennsylvania in the *Journal of Community Psychology*. These two wellness indicators are markers of well-being and signs of positive functioning. Markers of well-being are evaluations of how satisfied a person is in several areas of their life: for instance, work, marriage, and the community they live in. If they express high levels of satisfaction in those areas, they most likely feel well overall (Shueller 2009). Signs of positive functioning, on the other hand, are explained by Schueller to be “the repertoire of resources and the knowledge and desire to use these resources effectively” (Shueller 2009); simply stated, these markers are a person’s strengths and their desire to use them. Under this assumption, a person will actually increase their own happiness and well-being by focusing on their strengths over weaknesses and using those strengths for the purposes they were intended. To help individuals identify their top strengths, psychologist and past president of the American Psychological Association (APA) Martin E.P. Seligman and psychology professor Christopher Peterson have created a 240-item self-report questionnaire, Values in Action. Values in Action is just one example of a strength-based tool. Strength-based tools and programs are often used to promote wellness in mental health services.

The Wellness and Recovery Action Plan or WRAP is another tool used for promoting individual wellness in the form of a self-help system. Mary Ellen Copeland, Ph.D., authored WRAP with the help of individuals who have experienced mental health challenges and who have learned to use their own resources to achieve long term wellness. Copeland herself experienced years of mental health issues and was able to reach long-term wellness using the tools

addressed in the WRAP system. These wellness tools include techniques such as eating three meals a day and getting at least thirty minutes of exercise each day to maintain wellness on a day-to-day basis as well as tools that can be used when symptoms of a mental health challenge worsen. Each participant is encouraged to identify their own wellness tools and create their own “wellness toolbox”. They are also taught how to identify life events that could trigger symptoms and how to respond to those events in a more positive way.

“Wellness means not letting your mental illness control you, but instead staying in control of it. It means keeping empowered and using skills learned in groups to stay stable.”
 – Harmony Harper, Consumer

WRAP is supplemental to other forms of treatment, such as medication and group therapy. WRAP seminars and workshops are available countrywide and are also available as an e-course online and with support groups. Copeland also collaborated with the Substance Abuse and Mental Health Services Administration (SAMHSA) to create an “Action Plan for Prevention and Recovery” and a “Recovery and Wellness Lifestyle Self-Help Guide”, both available to the public at no cost at <http://mentalhealth.samhsa.gov/>.

Wellness and Recovery Centers (WRCs) apply models like the wellness model and use systems like WRAP to promote wellness at the community level while offering clients a place where they can socialize and receive mental health services and take other life skill courses. Many WRCs offer

“Wellness is when there is nothing in my head bothering me. It is when I’m in free spirit in my heart that is not aching.”
 – Lazaro Hernandez Jr., Consumer

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MHSA Papers

Achieving Wellness

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client-run services and peer-to-peer counseling. They are also a great tool for measuring the success of different models while supplying the mental health community with wellness models and suggestions of their own.

James Hurley, MFT, co-founded the Wellness and Recovery Center in Stanislaus County which opened in June 1998. It was the first of its kind, offering peer support and employing consumer staff. During the ten years Hurley worked there, the Center was visited by more than twenty counties to benchmark their work and explore how their experience could help them in creating their own wellness centers. Eight years later, Hurley wrote *Big Picture Considerations*

“Wellness is being able to function and be happy even with ups and downs. To me, it’s overriding the stress of ‘disabling thoughts (and) limiting physical problems (pain, overwhelm, fatigue, etc.)”

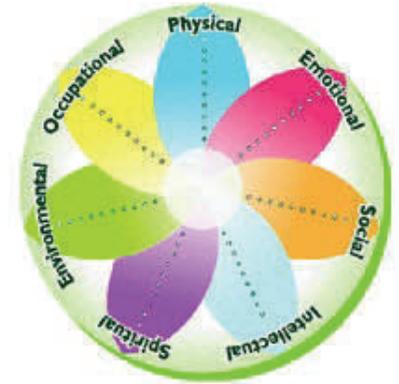
– Anonymous, Consumer

tions for an “Ideal” Wellness Recovery Center, a paper that addresses several issues the WRC encountered and includes considerations to keep in mind when establishing a wellness center. The first was the issue of whether a program should be run by consumers or be staffed by both consumers and non-consumers. Hurley suggests the more consumer-run programs, the better. He believes it is vital that consumers be a large part of the WRC, as paid staff and as volunteers. The WRC in Stanislaus County has blended staffing which has the benefit of ‘role modeling’ for clients with consumer and non-consumer staff working together (Hurley 2006). Another important part of a WRC is having a network of peer support. Hurley says “Peer volunteers are the heart of the WRC.” In Stanislaus, they have what they call a “network of recovering peers” (NRP) which provides supports independent of clinical services. Not only do peer volunteers provide support, but they also bring ideas to the WRC about how recovery works. They also allow cli-

ents/peers to participate even if they are not “open clients” and people can participate as long as they want, even after exiting the mental health system. Lastly, Hurley addresses the issue of whether a WRC should be a part of a county mental health system or a stand alone program. Hurley points out that because Stanislaus’ WRC is a part of their Adult Systems of Care, they are able to provide their clients with other services like housing and employment supports. If they were a stand alone center, it might have been easy for them to become isolated from the rest of the system (Hurley 2006).

The Sacramento Consumers Self Help Wellness and Recovery Center North (WRCN) is a great example of a well-rounded approach to wellness. The WRCN offers classes such as yoga, certified WRAP courses, and spirituality-oriented groups like “meditate and share”. They also offer numerous group art classes in writing, music and the visual arts. A full monthly calendar of the services they offer can be found at <http://sacpros.org/wellnessrecoverycenter.aspx>. Gail Erlandson, a mentor at the Center, says the WRCN also encourages wellness by using language that empowers clients with words like *mental health* instead of *mental illness*. Eric Zuniga, the Program Coordinator at the WRCN says their services provide a bridge between traditional and wellness approaches. “For many members, it takes courage to cross the ‘bridge’... many members have mentioned how WRC’s wellness based services are new and different from anything they have experienced before.” One client says “Mainly it is a positive place to go and be with people who are like me.” “It’s about the group – it’s what you can count on rain or shine,” says another.

Trinity County Behavioral Health is also seeing positive things happening at their drop-in center. Boe Anna Gorsuch works with Trinity County Behavioral Health and says their drop-in is encouraging their clients to be a community and support each other in a variety of ways. “We are seeing people blossom and change, developing self-confidence



“Dimensions of Wellness”

<http://www.definitionofwellness.com/>

and helping others do things to improve their functioning in many areas of their own lives. They often need less medicines as they grow in self-understanding. Wellness is a balance in your life that involves personal satisfaction and it is for everyone,” says Gorsuch. The drop-in center offers a variety of services such as training clients for employment opportunities and helping them apply for benefits like social security, providing an important link between the clients and resources that are available to them. They also employ consumers and family members on their staff.

Wellness is a journey; it is something that must always be worked at and is something that is unique to each individual. Different wellness “tools” work for different people and it is important to keep that in mind

(Continued on page 11)



Consumers Self Help Wellness and Recovery Center North (CSH WRCN) in Sacramento
Courtesy of Consumer Self Help

PEI & INN

Prevention & Early Intervention Progress Report

County	Date Approved	Amount Approved	County	Date Approved	Amount Approved
Alameda	11/20/2008	\$4,891,876	Placer	02/27/2009	\$1,433,374
Alpine	07/23/2009	\$278,500	Plumas	03/26/2009	\$225,000
Berkeley	04/24/2009	\$966,700	Riverside	09/24/2009	\$31,853,700
Butte	06/26/2009	\$1,823,300	San Benito	05/28/2009	\$467,900
Calaveras	04/24/2009	\$291,000	San Bernardino	09/25/2008	\$14,239,611
Colusa	02/27/2009	\$150,000	San Diego	02/03/2009	\$25,193,145
Contra Costa	03/26/2009	\$5,553,000	San Joaquin	05/28/2009	\$10,337,900
El Dorado	12/18/2009	\$635,997	San Francisco	04/24/2009	\$6,436,374
Fresno	08/27/2009	\$6,537,258	San Luis Obispo	02/27/2009	\$1,979,500
Glenn	09/25/2008	\$155,300	San Mateo	12/16/2008	\$2,071,177
Imperial	07/23/2009	\$1,835,124	Santa Barbara	03/25/2010	\$3,754,690
Humboldt	02/03/2009	\$613,853	Santa Clara	09/24/2009	\$12,429,997
Inyo	05/28/2009	\$150,000	Santa Cruz	05/25/2009	\$3,800,242
Kern	09/24/2009	\$3,859,069	Sacramento	10/22/2009	\$1,600,000
Lake	02/25/2010	\$410,000		03/25/2010	\$6,106,000
Lassen	04/24/2009	\$156,600	Shasta	05/28/2009	\$2,789,500
Los Angeles	03/26/2009	\$5,739,200	Solano	09/25/2008	\$1,890,633
	08/27/2009	\$121,661,559	Sonoma	03/26/2009	\$1,117,500
Madera	03/26/2009	\$1,247,900	Stanislaus	05/28/2009	\$7,845,800
Marin	03/26/2009	\$1,338,927	Sutter-Yuba	08/27/2009	\$1,350,300
Mariposa	03/26/2009	\$150,000	Tehama	01/28/2010	\$497,500
Mendocino	02/25/2010	\$187,409	Tri-City Area	03/25/2010	\$1,555,118
Merced	11/20/2008	\$1,903,000	Trinity	02/27/2009	\$125,000
Modoc	09/25/2008	\$125,000	Tulare	05/28/2009	\$7,682,776
Mono	07/24/2008	\$125,000	Tuolumne	02/27/2009	\$378,200
Monterey	07/24/2008	\$3,357,700	Ventura	10/22/2009	\$5,250,583
Nevada	05/28/2009	\$1,454,500			
Orange	03/26/2009	\$31,146,234			

PEI & INN

Yolo	04/24/2009	\$1,439,700
Total PEI Plans Approved:		55
Total Expenditures Approved:		\$350,595,226

Innovation Progress Report

County	Date Approved	Amount Approved
Alameda	01/28/2010	\$2,543,800
Kern	07/23/2009	\$2,254,600
Los Angeles	01/28/2010	\$20,293,924
Mono	02/25/2010	\$24,000
Monterey	12/17/2009	\$1,307,783
Riverside	09/24/2009	\$224,949
San Bernardino	02/25/2010	\$5,606,800
San Diego	12/17/2009	\$6,272,050
Santa Cruz	03/25/2010	\$776,710
Solano	01/28/2010	\$1,078,300
Trinity	12/17/2009	\$70,000
Total INN Plans Approved		11
Total Expenditures Approved		\$40,452,916

In Remembrance Of Michael Oprendeck

Michael Oprendeck, the Health and Social Services Deputy Director for Solano County Mental Health, passed away unexpectedly on Wednesday, April 7th.

The MHSOAC recognizes Mr. Oprendeck for his dedication to his work and for his outreach efforts to the mental health community of Solano County. Our condolences go out to his wife, Stephanie and family.

Achieving Wellness

(Continued from page 9)

when developing mental health programs and services. It is for this reason that it is imperative that clients are a large and vital part of any wellness and recovery center and any other mental health program. WRCs and programs throughout California are using tools like WRAP and holistic programs to help clients actualize their own wellness. The outcomes of using these tools have contributed to what we know about wellness, the recovery process, and ourselves as individuals.

Hurley James. "Big Picture Considerations for an 'Ideal' Wellness Recovery Center: A Working

Draft". (2006): 1-3. Print

Manderscheid, Ronald W., et al. "Evolving Definitions of Mental Illness". *Preventing Chronic Disease* 7.1 (2010): 1-6. *PubMed Central Open Access*. Web. 3 March 2010.

Schueller, Stephen. "Promoting Wellness: Integrating Community and Positive Psychology". *Journal of Community Psychology* 37.7 (2009): 922-937. Wiley Interscience. Web. 3 March 2010.

Seligman, M.E.P. & Peterson, C. *Character Strengths and Virtues: A Handbook and Classification*. New York: Oxford University Press, (2004), Print.

PEI and INN

MHSOAC Releases Prevention & Early Intervention Trends Report

By Amy Shearer

On December 28, 2009, the MHSOAC released the 2009 Prevention and Early Intervention Trends Report, compiled by Consulting Psychologist Deborah Lee. The report describes how California counties intend to use their PEI funds according to their first three-year Prevention and Early Intervention plans. Data was collected from the 223 programs outlined in 32 approved PEI plans. At the release of the report, the MHSOAC had approved 48 PEI plans for a total of over \$337 million. In the fiscal year 2008/2009, over 540,000 individuals were targeted to receive services from PEI programs. Included at the end of the report are several California counties' PEI program "success stories."

The report looks at the program areas specified in the Mental Health Services Act and the PEI Guidelines, including at-risk children and young adults (removal of children from homes, school failure, stressed families); suicide; first episode of serious psychiatric illness; incarceration; homelessness; co-occurring disorders; stigma; and trauma. Over 50% of all the programs surveyed were aimed at children, youth, and young adults, and all counties had at least one such program. This is not surprising, as the PEI Guidelines require that at least 51% of PEI funds be used to serve this age group (except for small counties). Nearly all sample counties (94%) addressed

school failure or dropout (termed by the PEI Guidelines as a priority population). Seventy-eight percent of counties included provisions for co-occurring disorders, which is a priority of the MHSOAC. Three-quarters of counties addressed incarceration (a PEI Guideline priority population) and stigma and discrimination in their plans. Stigma and discrimination is addressed through a separate state-wide project, so it is notable that so many counties chose to address it locally as well. Only 22% of counties included programs aimed at preventing the removal of children from homes.

The report also analyzes the distribution of programs prioritized for racial, ethnic, and language groups; 63% of counties focused specifically on the needs of Latinos; Native Americans were the least common group to be the explicit focus of PEI plans (31% of counties). It is impossible to determine from plans the total percentage of racial and ethnic groups who will be served, because these groups are also included in other program categories that do not explicitly target ethnic or racial groups. Information is available on the age groups intended to be served by counties' PEI programs. Children (from birth to age 17) were included in 97% of surveyed county plans. Older adults (ages 60 and over) were the least commonly served group, but still had high rates of inclusion in plans (72% of counties sur-

veyed).

An important aspect of PEI programs is that they must be located in sites that are easy to access by their target population. Ninety-one percent of surveyed counties plan to place at least one program in a school; primary care and community-based organizations were the second most popular choice (about 80% of counties include a program in each location). Other locations included faith-based organizations, day-care centers, homes, and family resource centers.

The data collected are based on a sample of PEI Program plans, and reflect only the intentions of the programs as outlined in the plans, not necessarily implementation data. Implementation data will not be available until counties have had time to launch their programs.

Overall, it is clear that California is making significant progress in providing access to mental health care, and preventing the human and economic costs associated with mental illness.

For the full Trends Report, and to read the inspiring PEI Success Stories, log on to www.dmh.ca.gov/mhsoac

Calling All Artists and Writers!

We're getting ready for another summer edition of the *MHSOAC Expressions* newsletter, and we need your creative submissions! For details on submitting your art and written work, and to fill out a consent form, please visit <http://www.dmh.ca.gov/MHSOAC>

Submissions are due May 31st, 2010.



Committees

Committee Reports

Cultural and Linguistic Competence Committee

The CLCC is in the process of sending a letter to the Department of Mental Health (DMH) requesting an update regarding the progress of the contracts that were assigned to the California Reducing Disparities Projects. The CLCC is responsible for monitoring and providing updates to the MHSOAC on the Department of Mental Health's Office of Multicultural Services Reducing Disparities Project. Also, the CLCC has established a workgroup to develop a selection process to help determine which ethnic or cultural communities will present at CLCC and MHSOAC meetings.

MHSA Services Committee

To ensure compliance with Welfare and Institutions Code (WIC) Sections 5846 and 5847, the MHSA Services Committee works on behalf of the Commission in making recommendations regarding the implementation and sustainability of MHSA programs and services to the MHSOAC. The Services Committee most recently completed work which resulted in the issuance of the DMH Information Notice 10-05 regarding the Assignment of MHSA Prevention and Early Intervention (PEI) Funds for PEI Statewide Projects. In 2010, the Services Committee Workplan includes: making recommendations on the PEI and Innovation (INN) draft regulations when they are published for public comment, making recommendations for coordination of training and technical assistance necessary for implementing and sustaining MHSA Services, and showcasing models of PEI or Innovation programs for adaptation or replication.

Evaluation Committee

The Evaluation Committee is currently working with Resource Development Associates (RDA) providing technical assistance and overseeing completion of Phase I of the Mental Health Services Act (MHSA) Evaluation project. RDA is a consulting firm located in Oakland, CA and dedicated to helping public and non-profit agencies continually improve their efforts to serve their clients. This contractor is assisting the Mental Health Services Oversight and Accountability Commission (MHSOAC) in developing the Scope of Work for the competitive process to select an MHSA Evaluation project contractor, called Phase II of the MHSA Evaluation. Phase II of the Evaluation project will entail the assessment of MHSA data and information to determine current status of the MHSA programs and projects. RDA is in the midst of gathering pertinent MHSA information from our mental health partner organizations and those who have been working on the MHSA initiative since its inception in 2005. Phase II of the MHSA Evaluation project is anticipated to start at the end of 2010 or in the beginning of 2011.

Client and Family Leadership Committee

The CFLC is currently working on implementing the approved public comment (PC) recommendations passed by the MHSOAC in January. The committee is working to develop a PC participation training program. A second draft of the training program will be discussed at the March meeting. Commissioner Vega will be presenting the history of the client and family advocacy movement to the Commission at the April 2010 Mental Health Services Oversight and Accountability Commission (MHSOAC) meeting. Lastly, the CFLC had its first of six Community Forums at its February meeting in Visalia. The next Community Forum will be held at the CFLC meeting in Los Angeles in April.

Mental Health Funding & Policy Committee

The Mental Health Funding and Policy Committee is currently working on completing all the components of the MHSOAC Financial Report. In April 2009 a framework for the financial report was approved by the Commission. The framework included Mental Health Services Fund (MHSF) balances, Mental Health Service Act (MHSA) reserves, forecasts of community mental health funding and critical policy issues. The Committee is continuing to develop this report which will be presented to the Commission on a semi-annual basis, or as requested. The Committee is also beginning to review policy issues related to the Prudent Reserve, declining MHSA revenues, State Administration Funding and reversion. Recommendations on these topics will be presented to the Commission throughout 2010.

Success Stories

Sunflower Gardens Grand Opening June 18



Platinum certification from the LEED for Homes program for its energy efficiency. LEED for Homes is a rating system that promotes the design and construction of high-performance “green” homes. Green homes use less energy, water and natural resources, create less waste, and are more durable and comfortable for occupants.

have applied for the 23 beds at Sunflower Gardens. Residents must be low-income and have a major psychiatric disability. Priority consideration is being given to applicants who participate in Monterey County’s full service partnerships funded under the Mental Health Services Act. Applicants are currently being screened and will be receiving notifications at the beginning

We’ve watched Sunflower Gardens grow from the ground up!
The following update was submitted by Susan Alnes, Director of Development and Communications, Interim, Inc.

The first project in California to be built from the “ground up”—concept to completion—with MHSA Housing funds is on target for a May completion! Sunflower Gardens, at 29 Sun Street in Salinas, a project of Interim Inc. of Monterey County, will house 23

Construction at Sunflower Gardens is moving along quickly. The interior has been painted, and flooring has been laid. Cabinets have been installed, and appliances will be installed in early April. Phone and power lines are in place. Outside, the concrete is being poured for the sidewalks and courtyard, and the planting beds are being prepared. The exterior watering system will be installed by the middle of April, and the site will be cleared of construction materials.



of April.

The furniture will be arriving at Sunflower Gardens at the end of April, and 23 handmade quilts—a generous donation from an Interim supporter—will help to turn this “construction project” into a home!

The Sunflower Gardens Grand Opening is scheduled for June 18, 11:00 AM, 29 Sun Street, Salinas!
The public is invited to attend. Information can be obtained from Interim’s website at www.interiminc.org. Click on the Sunflower!



One of the final touches will be the installation of six handmade mosaic tile murals with sunflower designs on the exterior walls at Sunflower Gardens. These extraordinary artworks are the result of an unusual collaboration between Interim’s Breakthrough H’Art—an art collective for homeless adults with psychiatric disabilities—and Dorothy’s Place, a day center in Salinas serving homeless men and women living on the streets in Salinas. Dorothy’s Place is operated by the Franciscan Workers. The tile artists have been meeting for approximately a year designing the mosaics, collecting materials, laying out the tiles, and grouting them for outdoor use.

low-income adults with mental illness who are homeless or at-risk of homelessness. Of the 18 units, 15 are funded with MHSA Housing Funds. The Grand Opening is scheduled for June 18, 2010.

Upon completion, Interim expects Sunflower Gardens to achieve Gold or

As of March 26, more than 80 people



Success Stories

San Bernardino County Supports Military Families

By Amy Shearer

San Bernardino County is working to serve members of the armed forces and their families using an innovative Military Services and Family Support Program (MSFSP). This Prevention and Early Intervention program is funded with MHSAs money, and supports families living on and off military bases within the county. San Bernardino County has a large population of military families, due to the county's three military bases: Ft. Irwin, an Army National Training Center; Twentynine Palms, a Marine Corps Combat Center; and a Marine Corps Logistics Base.

"Unbelievable services... love the fact that they come to the home and are able to track dynamics of family and are adaptable to our schedule."

Although there are support services for personnel and their families on the bases, these services are often underutilized because of

the stigma attached to seeking mental health services in the military. Many families feel uncomfortable using the on-base services, where they may be recognized by friends and community members. Because the Military Services and Family Support Program centers are located off base, there is more privacy for families seeking their services. However, some of these families do not have the option of driving to a neighboring city for services. A unique component that contributes to the success of the program is that the therapists provide in-home services. This is important because the bases are relatively geographically isolated; in fact, Fort Irwin is in the middle of the Mojave Desert.

The program offers services for individuals transitioning back to community life, including peer support groups, depression and post-traumatic stress disorder screenings, substance abuse referrals, and case management. They also offer short-term family interventions to help children adjust to having a parent deployed or return from deployment. There is even a support group for children age seven to twelve who are having problems in school. One parent commented that they are, "Way happy

they come to the home and [are able] to build rapport with...our child." Beginning in early March they will be starting a new parent and spouse support group that will focus on the issues specific to military families.

The current mental health services are provided by two contracted provider agencies, and they are on target to meet or even exceed the originally intended number of families, reported San Bernardino County's Prevention and Early Intervention Program Manager (I), Michelle Dusick. Helen Horn, a Clinical Supervisor at the High Desert MSFSP noted that, "Since October of last year when the program began we have had 42 referrals for services that we have responded to." Of those referrals, most were for assistance with family relationships, problems with school or work, high levels of stress, or depression. Referrals can come from contacts on the bases, but many of their consumers find the services through flyers, press releases, and word-of-mouth – something Dusick laughingly refers to as "grass roots marketing." Much of the success of the program is due to excellent communication between the providers and the county's Office of Veteran's Affairs, who, Dusick added, have been, "very supportive and instrumental in teaching us about military structure and culture."

The response to the program has been overwhelmingly positive. One consumer commented that the program has, "Unbelievable services... love the fact that they come to the home and are able to track dynamics of family and are adaptable to our schedule."

The following success stories come from the High Desert Military Services and Family Support Program. (Thank you to Helen Horn for providing these).

"This family was referred to us from Army Community Service. The family includes an active duty soldier, his wife, and three boys. The soldier and his wife were having frequent and severe fights centered around the father's interactions with the kids and his temper; Dad is a combat veteran with six overseas deployments. We met with the family and assisted with communication skills and anger replacement training interventions and also helped them to see that they cared about each other but had drifted into an adversarial relationship. At intake, they told us that they were going to get a divorce and that they "were done with each other" at that time. We continued to work with the family on dealing with adult problems when the kids were not around and also trying to see each other's viewpoint. The family has since announced to us that they have decided to try again and are going on a vacation to get reconnected with each other. The children have been acting out less with better school grades and less school behavior referrals, and have been able to see Mom and Dad resolve some problems successfully."

"Another family that was referred to the Military Services and Family Support program was in danger of having

(Continued on page 16)



MSFSP Staff in attendance at the John F. Kennedy University "Front Line to Home Front" conference, 2009.

Calendar

San Bernardino County Supports Military Families

(Continued from page 15)

one of their minor children lose the privilege of living on base because of behavior on the base, at school, and on the bus. We made contact with the family and began to cultivate a working relationship with the mother, and also the youth, who was having problems with being defiant and would communicate in an argumentative manner with his family habitually. The family had experienced loss because of an unfortunate accident that the whole family witnessed and was also dealing with ongoing stress from challenges that the mother had experienced in her past. After helping the family to work on communication as well as effectively addressing behaviors the youth has had success in staying out of trouble to a large degree and family relationships are beginning to rebuild. Most of all, it seems that the family will not have to move off post, which would have been a hardship for the family to endure."

This program is successful because it meets the needs of the targeted population; specifically, the need for privacy in accessing services, and accessibility of those services. These needs are met by having off-base centers, and therapists who can make 'house-calls'. Another important element of their success comes from the initial planning process. Dussick noted that having all the partners organized beforehand, and having an appropriate infrastructure in place before implementing the program, was pivotal in ensuring that the programs would be successful. "Just having everybody on the same page up front, and working together," was important in making sure everything ran smoothly from the beginning.



Save the Date!

Disability Capitol Action Day Resource Fair

Wednesday May 26th
10 am - 3 pm

Main Event on West steps of the Capitol
Come celebrate 20 years of the Americans with Disabilities Act

For more information, visit www.disabilityactioncoalition.org and click on Resource Fair

Mark Your Calendar!

Upcoming Commission Meetings

April 29, 2010 - Sacramento

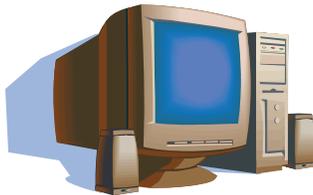
May 27, 2010 - Sacramento

June 24, 2010 - Sacramento

July 29, 2010 - Sacramento

August 26, 2010 - Sacramento

Contact Us:



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