From the Desk of Danielle Curtiss, a Mom on a Mission

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State of California Judicial Council

State of California Dept. of Health and Human Services

County of Los Angeles, Department of Mental Health Executive Management Team

Dear Interested Parties,

I am a parent of a young adult with Schizophrenia in Los Angeles County. I have been actively engaged in advocacy on his behalf for over three (3) years, and have sought appropriate treatment for him even before we had an official diagnosis. ***In that span of time, I have met so much resistance on behalf of the service providers, the county that I reside in, the legislators whom I have gone to for help to change the laws, the superior court system, and the state of California. No parent, no young person and no mentally ill person should ever have to be subject to such bureaucracy, such lack of concern, and lack of coordination of care. I have even gone to the extraordinary effort of meeting with state and federal legislators and asking for mental health reform, only to be told that they cannot or WILL NOT help..***

Despite the fact that , residents of the state of California overwhelmingly voted to use tax dollars to assist with the provision of care for the mentally ill through the Mental Health Services Act (MHSA), there remain steadily increasing numbers of seriously mentally ill on our streets that are homeless, and patients like my son whom have cycled in between the streets, incarceration, and worse, just trying to get by. ***We desperately need reform, accountability and transparency and better patient care. I ask you to consider my requests for reform as an advocate, a person with lived experience in trying to obtain care for a loved one, and lastly as a parent on a mission, with this question in mind. If this were YOUR child/young adult with a serious mental illness, where would you stop trying to ask for help? When would you give up? What would you do in your power to try to make change?***

In regards to the Mental Health Services Act, my ideas for reform include the following:

1. ***Specific focus on care for homeless/seriously mentally ill/treatment resistant/dual diagnosis patients***

    These patients receive the least care and are the most in need of help

    These patients are often not insured, underinsured

    These patients often cannot advocate for themselves

    These patients often do not know how to seek assistance, or speak for themselves regarding needsy

    These patients cannot write to you and ask for help

    MOST chronic homeless patients have a co occurring serious mental illness, or substance addiction issue

    This is the MOST underserved population in the country

    MOST county departments do not have enough services or funding for this population. Additionally, in my specific county, I was told MHSA money cannot be used for care of these patients.

    Often, these patients need intensive treatment and or supportive housing, neither of which MHSA has support services for. The money exists, but there is a believe that MHSA funds cannot be used in this way

    Requests for funding for MHSA money for this population should be FIRST priority and streamlined to obtain services ASAP

2. ***Specific efforts to verify that MHSA funds are appropriately being used***
    a. **Many programs do NOT have statistics or measurable outcomes posted**
    b. **MHSA money is sent to programs REGARDLESS of their efficacy**
        i. **If programs don't work, we should not pay for them**
        ii. **Programs are paid MHSA money even when they don't have patients in their programs**
            1. **This lowers the programs' overhead for staff/liability/etc**

2. **This incentivized programs to NOT have patients, because they get paid for doing nothing**
3. **NO fraud prevention or oversight means its EASY to take money from taxpayers for nothing**

iii. **Fraud prevention and waste in these programs is rampant**

3. ***Specific grants and funding should go to law enforcement and first responder programs, and they are not .***
   a. ***In Ca, a law enforcement officer is often the first responder to a mental illness crisis. We do not SPECIFICALLY fund additional training for these officers, for coordinated teams with clinicians such as MET teams.***
   b. **Often, law enforcement are tasked with writing a 5150/5585 hold as first responders. These officers have training in how to write a hold but NO specific treatment in understanding mental illnesses, the system of care, or various other laws related to how care is provided/mandated(such as LPS Conservatorships)**
      i. **Providing law enforcement additional training mandates will help them provide better service**
      ii. **Providing them additional funding will help them provide better services to a greater portion of the population**
         1. **Funding MET teams with MHSA money will alleviate the burden of funding MET teams and clinicians from municipal budgets**
            a. **Funding MET teams with MHSA money will mean more officers on patrol and safer streets at less of a cost to municipal agencies.**
      iii. **Working with CA POST to write specific training related to mental illness and the intersection of law enforcement will mean a better coordinated response that MAY decrease officer involved shootings**
         1. **Making training mandatory and uniform across the state means a better coordinated and safer response**

iv. **Reinforcing our first responder response to the mentally ill, including mandated training for EMS, Fire Depts and Law Enforcement will save lives via a better coordinated response**

v. **When writing 5150/5585 holds, law enforcement is keenly able to document the reporting party, and IF the patient is already in some form of treatment or system of care, medications that were given, and IF the patient can return to that treatment system. Requiring them to do this means the patient may be easily able to return to their program once stabilized or transition safely with appropriate coordination of care.**

1. **Decreases the wait time for patients to get a bed in a treatment facility**
2. **Decreases strain on Emergency Departments to board patients awaiting a treatment facility**
3. **Decreases strain on county mental health departments to find a new treatment facility**
4. **Decreases possibility that patient can suffer a medication overdose by insuring emergency department personnel have information from treatment programs**

B: Reinforcing our first responder programs/law enforcement with funding for Mental Health Evaluation and Outreach teams allows municipalities to begin providing services at the first contact

1. **Partnering a clinician/service provider or civilian patient advocate can assist law enforcement and first responders in obtaining resources and connecting with the hardest to reach clients**
2. **Allowing MHSA finding to be used for these teams means more staffing, more teams and more outreach services, better coordination of care and better outreach at the street level where the most seriously mentally ill can be found**

4. Allow MHSA funds to be used to provide comprehensive residential and community based programs where FSP is not appropriate or has failed.

This SHOULD include AOT programs with state wide standards for implementation.

Currently, patients are being placed in "community based treatment" which consists of unregulated board and care facilities that provide no assistance with medication, no assistance with activities of daily living or supportive care of any kind on a regular basis.

This level of care is not sufficient to care for the seriously mentally ill

There is no oversight to determine quality of care

IF MHSA funds were able to be used for residential treatment centers where care was provided in house with permanent support available, quality standards and evidence that patients are meeting measurable treatment goals, patients would do better at this level

Allow MHSA funds to be used for other Psychiatric Health Facilities.

The number of beds available is at a critical shortage for the seriously mentally ill. There is no incentive to provide this level of care for them, independent of federal funds. IF we used MHSA money to support these facilities, with quality standards and oversight, patients would be safer and have better treatment success.

Allow MHSA funds to be used for Assisted Outpatient Treatment.

Encourage AOT programs that are both voluntary and involuntary

Streamline ability for AOT courts and LPS Conservatorship cases so that AOT can be a step down from LPS, so that courts can easily refer clients to one or the other

Mandate that the public guardian expedite these cases

Set standards of care for treatment of the mentally ill throughout the state. Standards for AOT and for any agency obtaining MHSA funds.

Formulate a process by which a patient may have an advocate appointed to them via the court, whom can assist with the patient obtaining treatment, services and or whom can speak for the patient when they are in crisis or unable to. Formulating a specific patient advocate position will allow patients to have someone whom will help uphold their interests WITHOUT having to be under LPS Conservatorship. Currently, facilities, providers, and professionals often REFUSE to communicate or work with a patient's chosen advocate, citing HIPAA privacy laws. There is NOTHING compelling these professionals and agencies to cooperate with someone who has the patient's best interests in mind.

Require that ANY program receiving MHSA funds must assure that services are provided in a safe, equitable and patient centered manner.

Provide a hotline for concerned family members to contact state agencies when they are told there is no funding for services for a loved one.

Immediately notify all programs that receive MHSA funding that they must coordinate with other agencies, patient advocates and families or MHSA funding will cease to be provided.

Lastly, one of the BIGGEST barriers to obtaining help for my son, besides the morass of bureaucracy that exists, is that EVERY agency, program, clinician, and first responder will tell family members/advocates that they cannot speak to them due to HIPPA privacy laws. We need to amend

our state mental health laws so that patients who have serious mental illness can have an advocate who is allowed to coordinate care across the continuum that exists. The ONLY way I am able to advocate for my loved one is by keeping him under LPS Conservatorship, even if he is no longer gravely disabled, and that is NOT what the intent of EITHER the LPS Act was, NOR the various state and local privacy acts. There is NO reason that getting care for a patient, knowing what medication they are taking, asking for a particular program, or advocacy on behalf of the patient should be so incredibly difficult.

Please consider this document as my urgent request for reform and assistance. My son's life depends on your swift action. I can be reached at the above email and or phone number should you have any additional questions or need to discuss these experiences further.

Thank You,

Ms. Danielle Curtiss, RN

Public Comment from Dr. Loren Dittmar regarding
Action 3: Schools & Mental Health Report Implementation Plan

First, I'd like to thank this commission for highlighting the necessity of improving School Mental Health services throughout California, especially for underserved populations and in response to the impact of this horrific pandemic. I truly applaud the efforts of this commission for focusing on the mental health needs of our students through "Every Young Heart and Mind: Schools as Centers of Wellness."

I am a High School Counselor in Simi Valley, CA, as well as a Board Member of the California Association of School Counselors. I am also an adjunct professor for CLU for the School Counselor and MFT program.

I previously served as the High School Vice President for CASC, and I have provided numerous trainings on Mental Health Awareness and Suicide Prevention throughout the state of California. In addition, I have served as a Professional School Counselor for the past 15 years not only in California, but in Georgia and New York. My background also includes work in the mental health field, which is something I have found to be very common among School Counselors throughout the country.

All that being said, I appreciate the recommendation offered that The State should make a multi-year foundational investment that increases services while also building the necessary infrastructure of programming, data management, workforce and sustainable funding models so all schools are centers of wellness and healing regardless of the economic cycle.

As a professional school counselor, who is licensed in this state, with specialized skills to serve the social and emotional needs of our students, I am curious about the focus of these investments. Is there a specific budget proposal for increasing the number of school counselors throughout the state? The current student to counselor ratio is over 600:1, which is actually an improvement in this state, but well over the recommended ratio of 250:1 by the ASCA. As a previous counselor in New York and Georgia, where the caseloads were much lower and it was in fact mandated for school counselors to be employed at EVERY school level, there is a desperate need to recognize how crucial this role is in serving the mental health needs of our students.

If the plan is to employ outside agencies and community mental health professionals, I believe there is value in that partnership, however, wouldn't the first step to hire more "boots on the ground"? School Counselors have a unique position that develops strong levels of trust and connection with students and families, and we are the Mental Health experts within our schools. We provide mental health training to all staff, offer Social-Emotional lessons to our students, and provide individual and group counseling services. When needed, we refer students and their families to outside agencies for more intensive levels of mental health support. A Wellness Center on every school campus would be an excellent *addition* to provide a seamless transition to receiving that treatment, but not until every school has employed school counselors according to the ratio recommendations from ASCA.

Another concern I'd like to bring up is in regards to the specific therapeutic interventions. As a previous clinician, I'm quite familiar with how these funding sources can be quite restrictive and involve specifics that may or may not be as effective and efficient for serving ALL students within a school environment. So, I wonder if the report uses a medical model of hour-long sessions for a number of weeks with students? And if so, how are the students identified and how many students

are anticipated to be served? Also, as a follow up to that, has there been any thought in how to address the underserved non-medical student?

Thank you again for your time and for taking these concerns into consideration.

Respectfully Submitted,
-Dr. Loren Dittmar

Dr. Dittmar's Bio

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Board of Directors &
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COVID-19 Resources from SVUSD and Ventura County

Crisis Hotline: (800) 273-8255 and crisis text line: 741741

Dear Madam Chair and MHSOAC Commissioners,

I wanted to extend my appreciation to the OAC for including the CRDP into its January 2020 Agenda.

During the public comment, I provided information in an attempt to address Dr. Bunch and Commissioner Danovitch concerns re: a directory for promising practices and how is success measured through the Evaluation component.

The Statewide Evaluation has compiled a data base, made available to the Technical Assistance and Training Providers for the 5 priority populations, that include Community Defined Evidence Practice (CDEP) components, and other key information about each CDEP. This early assessment can be the foundation for building out the supporting documentation essential for replication and dissemination of these community defined practices. Ms. Mena also added that the CRDP website will be launch shortly that will also provide basic information about each Implementation Pilot Project (IPP).

The Statewide Evaluation measures across 35 IPPS (1) Physical, psychological, and spiritual health and wellbeing, (2) Community, social, and cultural connectedness and (3) Functionality in school/work, social and family life. I also want to add, information about the number of or unduplicated participants is captured locally and in aggregate.

I am echoing all the presentation/comments supporting the asks for the OAC to support the CRDP as presented by Ms. Josefina Alvarado-Mena, Esq.

Thank you for the opportunity to provide both public and written comment.

LGBTQ TA CENTER

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Hello,

I am a Los Angeles school counselor and representative with the California Association of School Counselors, making public comment on agenda item 3 for the Mental Health Services Oversight and Accountability Committee meeting January 28, regarding the Every Young Heart and Mind: Schools as Centers of Wellness. Though I appreciate the effort and dedication to see that California schools are “centers of wellness and healing" to empower youth to develop the resilience, especially during challenging times, I am afraid the report misses the mark and following through with such a plan would not seek the intended benefit. School counselors and other school-based mental health providers must have a say in conversations regarding student mental health. We are the mental health providers working with students every day, observing their development and providing them with the skills and tools to build their resilience. The issue lies with the lack of state support to ensure there are more counselors, school psychologists and social workers to be able to effectively serve all students. The skill set is there but the resources are lacking. As you think about student mental health, partner with the experts in the field so that we may all effectively care for our students.

Thank you for your time,
--
Christiana Cobb-Dozier
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