Mendocino County Behavioral Health Advisory Board

2018 Annual Report

Prepared by Jan McGourty, MPA, Board Chairman

Mendocino County Behavioral Health Advisory Board
2018 Annual Report

Table of Contents

Mendocino County Behavioral Health Advisory Board
2018 Annual Report

December 2018

Executive Summary

2018 has been a year of refocus and learning. The passage of Measure B marked a new era for Mendocino County Mental Health and, as members of the Behavioral Health Advisory Board (BHAB), we have worked hard to understand its implications and promote positive effective change. During regular meetings and one special meeting, we spent considerable time studying the report prepared by the Kemper Consulting Goup *Mendocino County Behavioral Health System Program Gap Analysis & Recommendations for Allocation of Measure B Revenues.* Our findings and recommendations are included in the addendum.

As chair, I have had the honor and responsibility of representing our board at Measure B Committee meetings and Stepping-Up work. I attended two meetings in Sacramento of the MHSA Oversight and Accountability Commission (OAC) this year and spoke publicly on the work and concerns of our county. I also spoke to the Board of Supervisors twice, at our board's request, to share our recommendations and concerns. Some of our members have attended regional meetings of the California Association of Local Behavioral Health Boards & Commissions (CALBHBC) for training and information. Reporting back from participating in these meetings broadens our Board's knowledge and understanding of mental health issues. In addition, we often hear the first-hand life experiences of people suffering from mental illness. These stories of friends and family are what keep us engaged in this challenging work.

Our meetings are held all over the county. Not one regular meeting in 2018 was cancelled due to a lack of a quorum this year, primarily because every other meeting was conducted by video conference. Video conference has greatly helped ease meeting accessibility. However, there is continuous confusion in appointing and retaining board members. Finding volunteers with the time and resources to attend our meetings and work on committees is challenging. Many of our members are retired and aging; others work full-time. Currently there are three outstanding renewal requests, yet we will started 2019 without them due to glitches in the county process.

Overall I feel the BHAB has made much progress in our relationship with the Mendocino County staff and governing body. District 1 representatives meet regularly with Supervisor Brown and I, as chair, meet regularly with Mental Health Director Dr. Jenine Miller. We look forward to serving Mendocino County to make life better for those suffering from mental illnesses and co-occurring disorders, and helping educate the community on the work that needs to be done. In addition, we are seeking ways to appreciate and support the Mendocino County Mental Health employees who serve one of the most marginal groups of people in our communities.

Submitted by Jan McGourty, MPA
BHAB Chairperson 2018

Status of the Behavioral Health Advisory Board

Meetings:

Regular BHAB meetings were held the 3rd Wednesday of each month and board members traveled from Point Arena to Covelo. Notice of all meetings were made public, and agendas and minutes are available on the County website. One Special Meeting was held to study the Kemper Report in depth.

As our Supervisors are probably aware, distance and aging are always a challenge for individuals who have the time to serve. Our board is the only one that consistently travels throughout the county which makes it extra challenging for several of our board members who have full-time jobs. In order to make our meetings more convenient for members, this year we instituted a policy of video conference between the north coast and inland every other month. This has helped increase participation and eliminated the need to cancel any 2018 regular meetings. What we learned in December, however, is that the success of a video conference is staff-dependent. It requires a tech-savvy attendant who can solve glitches immediately or the whole meeting quickly deteriorates.

Chair:

Jan McGourty has filled the role of BHAB Chair for the second year and has agreed to step forward to serve in that capacity again in 2019

Membership:

At the beginning of 2018 there were twelve members on the BHAB, i.e. three vacancies. We have worked hard to get to a full complement of board members. Unfortunately, there seems to be continuous confusion with the County Administrative Office and the process of appointing and renewing board members. At the end of 2018 we had one vacancy and three pending applications for renewal.

An ad hoc committee of the BHAB is in place to interview potential candidates and submit recommendation to our board. Potential members must be appointed by the appropriate supervisor and then approved by the BOS. There were several glitches in this process at the beginning of 2018, but we worked through it and there are three new board members joining us: Amy Buckingham, Richard Towle, and Lynn Finley. The challenge still remains with term limits issues. The terms of two newly appointed board members were due to expire only a month after being sworn in, and another after having served less than two years. Reappointing several existing board members was also been delayed, because once again the county rules seem to have changed. This could have jeopardized the quorum of our January meeting.

One individual resigned during 2018 due to work conflict. Working for the County, she ran out of vacation time to attend meetings. For this reason, the BHAB is recommending to the BOS that they consider allowing county employees to participate in advisory boards such as ours as part of their job duty so they are not penalized by being willing to serve.

For current board members, see the following table.

Board Member	District	Member Since	Term Ends
Jan McGourty	1	April 2013	12/31/19
Denise Gorny	1	January 2012	12/31/20
Lois Lockart	1	October 2015	12/31/18
Dina Ortiz	2	February 2013	12/31/19
Michelle Rich	2	March 2018	12/31/18
Amy Buckingham	3	July 2018	12/31/20
Richard Towle	3	October 2018	12/31/18*
Meeka Ferretta	3	October 2017	12/31/19
Emily Strachan	4	May 2015	12/31/20
Tammy Lowe Bagley	4	April 2013	12/31/19
Lynn Finley	4	October 2018	12/31/18*
Patrick Pekin	5	October 2016	12/31/18*
Martin Martinez	5	July 2017	12/31/19
Flinda Behringer	5	July 2017	12/31/20
OPEN	2		12/31/20

* Highlighted dates indicated previous term limits. This was randomly changed for two to be 2020.

2018 Committees

There were four committees created at the beginning of the year, and a couple added in the months following. Not all committee work was completed because of intense study of the Kemper report. The 2018 committees were:

1) By-Laws Committee - SUDT: *(Members Martinez, Ferretta)*
Several years the Mental Health Board was changed to include substance abuse and it became the Behavioral Health Board. This committee was created to add substance use duties the BHAB.

2) Flow Chart Committee: *(Members Strachan & Pekin)*
The goal of the Flow Chart Committee was to create a visual diagram outlining the path of obtaining mental health services. Anecdotal experience has declared this to be a formidable challenge, and creating a visual only confirmed it.

3) Project Follow-up Committee: *(Members Behringer & Gorny)*
This committee was created to try and sort out the different projects, particularly involving housing, that are brought before out board. Often the same project will be referred to by different names, which made it very confusing. A solution was to give one name to one project. Dr. Jenine Miller has consequently been very helpful by providing updates on these in her monthly department report.

4) Dual Diagnosis Committee: *(Members Lowe & Ortiz)*
Another obstacle is helping people with mental illness obtain services is the quandary of dual diagnosis. Many individuals who suffer from mental illness may "self-medicate" with drugs or alcohol, particularly if they are undiagnosed. Generally the term "Dual Diagnosis" is understood to be substance abuse/mental illness, but the term can also be when other other behavioral disorders are present in addition to mental illness such as autism, etc. A problem arises when one is in crisis, and the agencies responsible for providing service exclude an individual because of a diagnosis they do not address. Their agendas operate within silos that do not allow collaboration or discourage service for funding purposes. This is a problem at the state and national level so it was quite an ambition for our board members to try and make sense of it.

Two other committees were appointed during 2018. They were:

Appreciation Committee: *(Members Martinez, Ortiz, & McGourty)*
There was concern expressed by board members that the job of looking after people with mental illness is very stressful and can lead to burnout. One idea that took fruit was expressing the board's appreciation of the work with a letter. A letter was drafted with much thought and will be implemented in the coming months.

Nominating Committee: *(Members Ortiz & Behringer)*
In October, as is standard practice, a nominating committee was appointed to select the next year's board officers. There were two members interested in the Treasurer's position, but no one was particularly interested in the other positions. Fortunately this year's officers agreed to carry on and the 2019 officers shall be Jan McGourty, Chair; Emily Stachan; Vice Chair, Dina Ortiz, Secretary; and Flinda Behringer, Treasurer

Site Visits

In addition, it was advised that each board member visit the site of a mental health facility during the year.

Accomplishments

By-laws Committee : Waiting on Board of Supervisors approval for the By-Laws amendment.

Flow Chart Committee : Goal in progress.
Members Pekin and Strachan have worked hard on creating a flow chart for mental health services. The first draft is complete and the work continues with the help of County staff to create a simple visual that is easy to follow. (See Addendum)

Site Visits: Goal partially met.
Some sites were visited during the year, but not necessarily mental health facilities. A tour of the old Howard Hospital was scheduled to coincide with the May BHAB meeting in Willits, and several board members were able to view that site. It has been presented as a potential mental health facility by the Howard Hospital Foundation. Also, some board members were able to tour the proposed respite quarters at the Round Valley Indian Health Center after the April BHAB meeting in Covelo. This is the result of the MHSA Innovation Plan we worked so hard on. Members Strachan and McGourty toured the Ukiah Manzanita offices, and members Towle and McGourty attended the opening of the NAMI Mendocino office.

Data Notebook: Completed.
The Data Notebook is a tool developed by the California Mental Health Planning Council (CMHPC) to gather, compile, and communicate information among the counties/local jurisdictions to the state of California. In 2018 the topic chosen was "types of services and needs in the behavioral health systems of care for children, adults, and older adults." Dina Ortiz completed the Data Notebook with the help of staff and contracted service providers.

Crisis Intervention Training - Still in Progress
For several years the BHAB has been concerned about the Crisis Intervention Training (CIT) for Law Enforcement in the County. CIT teaches conflict resolution and de-escalation techniques for potentialy dangerous situations and is highly regarded in reducing stigma and decreasing needles injuries including death In March of 2018 a formal recommendation was made to the BOS stating specificallythat the model best suited for our Mendocino County would be to train local trainers who could then be contracted for service as required by agencies within Mendocino County. Mental Health Director Dr. Jenine Miller and Chair McGourty identified some qualified individuals, but their appointments were not acceptable to the Sheriff's Office, which took on the coordination effort. Thankfully, 2019 will finally be the year some CIT training is accomplished, and the first round is scheduled for February. Unfortunately, the training has been contracted out of county, and local people will not subsequently be available for followup trainings.

Stepping-Up Initiative: Keeping it Alive

The Stepping-Up Initiative began in 2015, and Mendocino County was the first county in California to pass a resolution supporting it. A Mendocino County contingent attended the California Summit held in 2017, but subsequent efforts to take local action were dropped because of County personnel issues. The BHAB has not lost sight of the objective, which is to prevent mentally-ill people from being incarcerated, and Chair McGourty and Mental Health Director Dr. Jenine Miller have pushed to keep it current. Stepping-Up requires multi-agency collaboration; mental health, law enforcement, probation, courts, etc. This had been difficult, but reaching out to Court Administrator Kim Turner turned around the progress of this initiative. Regular meetings are now being held and a public meeting for greater awareness is being planned for 2019.

New BHAB Member Handbook

The Handbook for BHAB members was very outdated, with much information dating back to 2010. Chair McGourty took it upon herself to revise the Handbook and, with the help of BHRS staff, a reformatted and updated Handbook was presented to members in January of 2018.

MHSA Reversion Plan 2018-2019, 2019-2020

BHRS staff was required to create a plan for spending unspent County MHSA dollars in order to avoid fiscal reversion to the state. The BHAB carefully reviewed the plan with public input and was able to approve it in a timely fashion.

Advisement

One of the primary jobs of mental health boards, as stated in the Mental Health Services Act, is to advise our Board of Supervisors (BOS) on issues and concerns regarding mental health in our county. With this responsibility in mind, the BHAB conducted an in-depth study of the report prepared by the Kemper Consulting Group, *Mendocino County Behavioral Health System Program Gap Analysis & Recommendations for Allocation of Measure B Revenues,* in depth. The report itself was general in its recommendations regarding program services, action and policy, so after many hours of consultation we clarified a number of details for the BOS to consider. (See Addendum)

The BHAB needs to work with the Board of Supervisors to establish an effective way to share our recommendations regularly. We are excited to know that we are scheduled to appear before the BOS in February 2019.

BHAB 2018 Recommendations to the BOS

1. **Create a policy for County employees to participate on boards as part of their job description.**
   We have several Board members who work full-time. If they are not in an administrative position with the flexibility to attend meetings such as ours, they must take personal vacation time to attend. We lost one board member this year because of this. We recommend that the county encourage its employees to participate in the community by joining advisory boards such as hours by including it in regular job duties so the time and expense of participating is covered financially.

2. **Become the vanguard in California in demanding insurance parity for mental health.**
   There is still much disparity between services provided by MediCal and private insurance companies. County services provided by subcontractors only serve the severely mentally ill (SMI) and those who qualify for Medicare. Those without such insurance, for example the indigent or people with private insurance are only marginally served by county providers with "patch" funds, i.e. non-reimbursable realigned state funds. Those who can qualify for Medicare are assisted by staff since their services are reimbursable. However, those with private insurance have few or no services available to them. We recommend the BOS contact state legislatures and state organizations to pursue this goal of parity.

3. **Pressure state legislature to review the Innovation component of the Mental Health Services Act.** Our county had great difficulty preparing first MHSA Innovation Plan (four years later) and continues to struggle to comply with the state's idea of innovation. In addition, there seems to be a bias favoring larger counties and technology in general. For example, Los Angeles submitted a technology plan that was vaguely worded and hardly innovative by the MHSAOAC's own standards, which was changed in implementation and again goes against the regulations of MHSA Innovation. We recommend the BOS contact state legislatures to oversee the OAC's Innovation actions for accountability.

4. **Implement all recommendations of the 2018 Kemper Report.**

5. **Implement the BHAB's specific recommendations regarding the 2018 Kemper Report.**
   See Attached.

Meet the Board Members

District 1 (Carre Brown)

Jan McGourty: Joined the Mental Health Board in 2014 after retiring from teaching. She is an active NAMI member, serving on the NAMI Mendocino Board and as a Family-to-Family Facilitator. Ms. McGourty holds a Master's degree in public administration and infrequently attends the MHSA Oversight and Accountability Commission meetings.

Denise Gorny: Ms. Gorny has been a member of the BHAB since 2012. From her early childhood experience with a mother periodically institutionalized for mental illness, and her experiences both a single mother and foster parent, she developed a passion for advocating for the mentally ill, the disabled and the disadvantaged. She has done this professionally by serving at both state and local organizations. Currently she works for the State Council on Developmental Disabilities and continues to advocate for disabled rights, services and systemic change.

Lois Lockart: Ms. Lockart, a.k.a. *Redwood Flower*, joined the BHAB in 2017. A First Nations tribal elder, she holds an associate degree in business administration. She retired after working many years as a. licensed cosmetologist/hairdresser and cosmetology instructor, and as a tribal administrator. Ms. Lockart is informed in all tribal government issues and has collaborated with federal, state and local governments on such issues as education, housing, transportation, law enforcement, and all aspects of health and welfare. She is particularly conscious of the spiritual and environmental components of our community and is concerned about the state of the world for following generations.

District 2 (John McCowan)

Dina Ortiz: Dina Ortiz was appointed to the Mental Health Board in 2014. Ms. Ortiz is a Licensed Clinical Social Worker with a specialty in nephrology mental health. She has been working in the mental health field for over 30 years. She is currently employed at the Dialysis Clinic where she educates and supports patients and their families. Besides serving on the BHAB, Ms. Ortiz volunteers at Plowshares and Red Cross as a mental health provider.

Michelle Rich. Michelle Rich joined the Behavioral Health Advisory Board in 2018. She brings with her a background in non-profit development and grant writing. She holds a B.A. in Linguistics and a M.A. in English Literature. She is employed by the Community Foundation of Mendocino County where she is currently the Director of Grants & Programs. Ms. Rich chairs Healthy Mendocino Steering Committe and helped create their website. She is an alumna of Leadership Mendocino Class XXV.

District 3 (Georgeanne Croskey/John Haschak)

Richard Towle

Richard Towle moved to Mendocino County in 2012 after a rewarding career in healthcare I.T. at Alta Bates/Sutter Health in the Bay Area. He left work after being diagnosed with a rare form of adult onset Muscular Dystrophy that led to his ongoing major depression and generalized anxiety. He is seeing a Psychiatrist in Santa Rosa and a local therapist/LCSW. He had been living as a recluse until April of 2018 when he started volunteering in various capacities at the insistence of his therapist. We are so happy he joined the BHAB in 2018.

Amy Buckingham: Amy joined the BHAB in 2018. She is a Mendocino County native, having been born and raised in Covelo. Presently she works as the Director of Emergency Services at the Adventist Health Howard Memorial Hospital.

Meeka Ferretta

Meeka joined the BHAB late in 2017. She is a third generation resident of the most northern part of the 3rd district of Mendocino County. She holds a B.A. in Psychobiology from UC Santa Cruz. She served on the Shelter Cove Resort Improvement, District #1 in Southern Humboldt County for four years and has worked with children at Camp Winnerainbow in Laytonville. Ms. Ferretta is currently in a Master's program in Marriage and Family Therapy at Northcentral University and plans to serve as an LMFT in this county.

District 4 (Dan Gjerde)

Emily Strachan: Emily Strachan joined the BHAB in May of 2015. She has retired from work in the Bay Area as an Information Systems Manager and has extensive experience managing large organizations. She holds an MA in Political Science and worked overseas in business. She is an active volunteer on the coast, serving on the board of the Mendocino Volunteer Fire District, and also volunteers as a crisis worker for Project Sanctuary.

Lynn Finley, RN, MPA: Lynn joined the BHAB late in 2018. She has been involved in healthcare since 1988 when she began her healthcare path inAnderson Valley as a volunteer on the Ambulance Service. She attended the Nursing Program at the Fort Bragg campus of College of the Redwoods. Her path took her to Sonoma County and then to Colorado where she got to experience different Healthcare systems and experiences which she brought home to Mendocino County. Finley has a Business Associate degree in Business Management, as well as a Master's in Public Administration with an emphasis in Healthcare. She is passionate about bringing the services we need to out communities.

Tammy Lowe: Tammy joined the BHAB in April of 2013. She holds a degree in Business Management from Colorado Mountain College and is employed as a home health worker. She is a community volunteer for the Paul Bunyan Day Association and serves as volunteer outreach for families navigating the mental health system.

District 5 (Dan Hamburg/Ted Williams)

Patrick Pekin: Patrick Pekin is an attorney who currently practices Criminal Defense. He often runs into mental health issues while serving his clients. Mr. Pekin has worked overseas as an English teacher, and is a volunteer firefighter with the Mendocino Volunteer Fire District. He joined the BHAB in 2016.

Flinda Behringer: Flinda Behringer was seated in September, 2017. She comes to us from the east coast, where she holds a MPA and a MS in Social Work. She is a LCSW and has worked as a SUDT and VA counselor, has supervised primary care for the VA, and has developed educational programs for a variety of mental health venues. She volunteers with the Littleriver Environmental Action Group and the Mendocino Community Library, and previously volunteered as president of the board of directors for Hospice Care in New Hartford, New York.

Martin Martinez: Mr. Martinez also joined the BHAB in 2017. He is currently the Director of the Social Service Department of the Redwood Valley Rancheria and has served in many tribal positions. He holds an associate degree in Alcohol & Drug Program and has served in various local and state committees representing his community and creating policy in mental health and substance abuse. He is recognized as a spiritual advisor, facilitates the Red Road program for sobriety and is active in preserving many Pomo traditions. Mr. Martinez speaks the central Pomo language.

ADDENDA

RECOMMENDATIONS

Mendocino County Behavioral Health System Program Gap Analysis & Recommendations for Allocation of Measure B Revenues

by Kemper Consulting Group
August 2018

MENDOCINO COUNTY
BEHAVIORAL HEALTH ADVISORY COMMITTEE

Jan McGourty, Chair

November 14, 2018

Amended December 17, 2018

KEMPER'S RECOMMENDATIONS FOR PROGRAM SERVICES (page 41)			
*	**Service**	**Details**	**Consultative Results for Recommendations**
1	PHF or other inpatient psychiatric care	Ave. 3-5 days Max. 30 days	☛:Put out a detailed RFI (Request for Information) for all pre-crisis and crisis facilities including staffing and maintenance requirements for each type of facility
2	Crisis Residential Treatment (CRT)	3 mos. maximum	☛: It is imperative to create a CSU/CRT facility in Fort Bragg that can serve pre-crisis and 5150 holds in collaboration with coast community and agency partners. ☛: Create a multiple use facility to consolidate staffing needs
	Types of Involuntary MH Holds 5150 - 72 hours 5250 - + 14 days 5270 - + 30 days		
3	Crisis Stabilization Unit (CSU)	24 hrs. *pending legislation to extend 72 hrs.* (??)	☛: Explore other venues besides RCS Orchard Street Project and old Howard Hospital
4	Expanded outreach	3 mobile teams: 4 days/week 8:00 a.m. - 6:00 p.m.	☛: Expand the Mobile Outreach Program Services (MOPS) to serve more locations with more hours. ☛: Verify that each MOP team has two persons (sheriff tech & MH employee)
5	Outlying/Remote areas of county		☛: Mendocino County should take the lead in promoting legislation to provide private insurance parity with mental health Medi-Cal services. ☛: Focus on collaboration with clinics around the county for MPS/RQMC continuation of care, using teleconference service if necesary.

KEMPER'S RECOMMENDATIONS FOR PROGRAM SERVICES CONTINUED			
*	**Service**	**Details**	**Consultative Results for Recommendations**
6	Expand support programs & wellness efforts	• *med management* • *employment services* • *family support*	☛: Create common definitions for "wellness" and "cultural competency." ☛: Expand existing TAY (Transitional Age Yourth) services to include adult care. ☛: Encourage and support employers and physicians to integrate physical, emotional and spiritual personal wellness so health needs are met. ☛: Expand hours of wellness coaches to navigate MH system into outlying areas ☛: Provide more family support, particularly non-traditional methods.
7	Day Treatment	*Definition:* • *Licensed facility* • *BH treatment* • *outpatient care* • *MD supervision* • *written client plan*	☛: Include a Day Treatment in any facility's program
8	Supportive Housing		☛: Build a range of integrated supportive and inclusive housing throughout the county. ☛: Fund fiscal barriers for housing.
9	Partial hospital care Rehabilitative care Board and Care		☛: Build at least one board and care facility that is Medi-Cal billable.
10	Expansion SUDT		☛: Hire more counselors, particularly in outlying areas. ☛: Collaborate with schools for prevention, particularly in tribal communities,.
11	5-Year Plan *Develop continuum of care*		☛: Review the proposed 5-year plan of continuum of care by all stakeholders and collaborative partners.

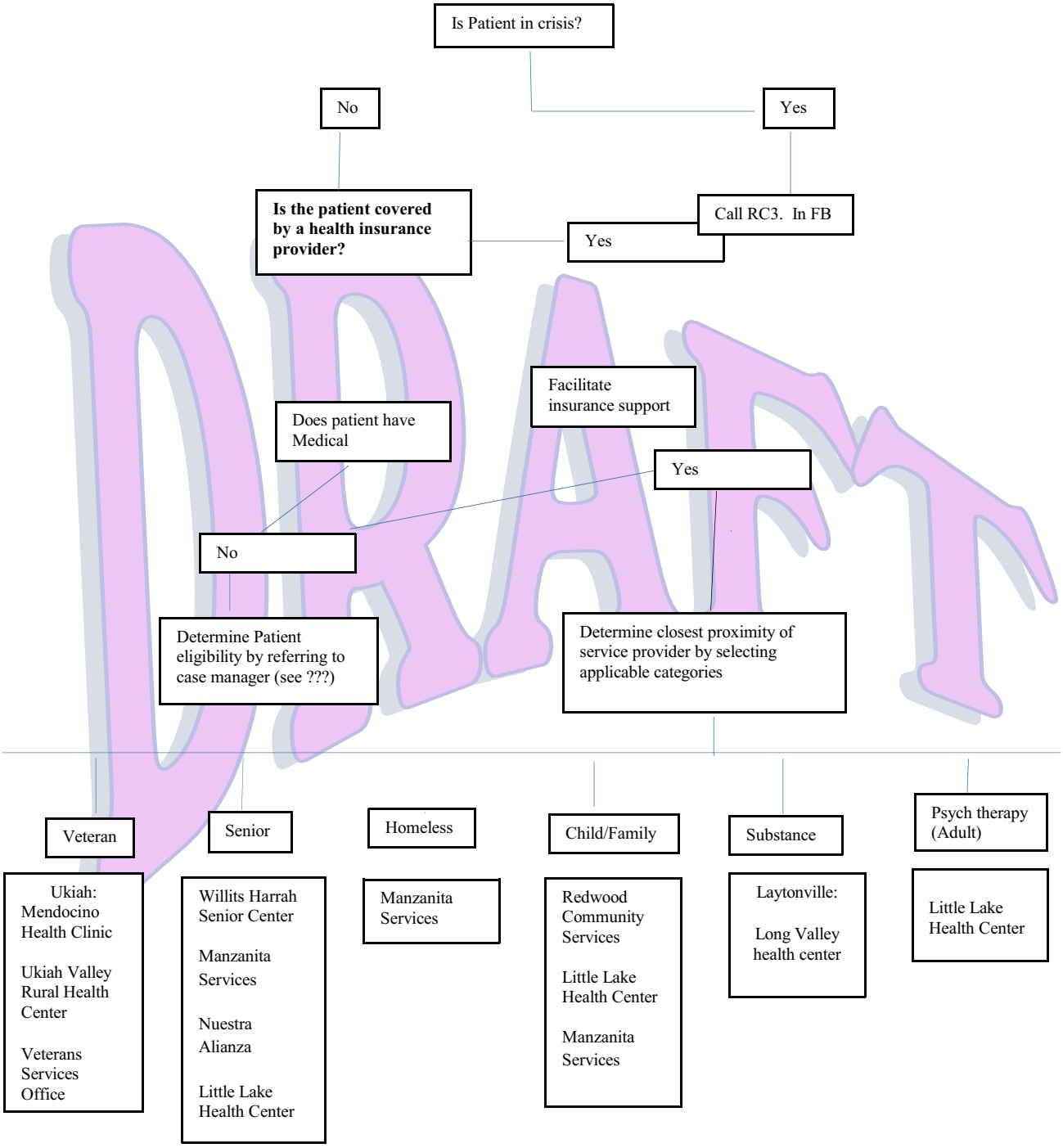
KEMPER'S RECOMMENDATIONS FOR ACTION & POLICY (page 43)		
1	Supplement services NOT supplant services	☛: Hire a dedicated Project Manager to oversee implementation of Recommended Actions on Measure B and manage all contracts.
2	Biannual Review Process	☛: Review the progress of services and their cost every six months, noting any barriers to service.
3	Prudent Reserve of Measure B Funds for years 6-10	
4	Separate annual accounting of Measure B revenues/ expenditures	☛: Collaborate annual Measure B accounting with Project Manager and County Auditor.
5	10-Year Strategic Plan	☛: Plan for future sustainability. ☛: Annual review of plan with flexibility for amendment.
6	Restructure data provided by BHRS, RQMC & subcontractors	☛: Report data by program & region in both children and adult systems of care. ☛: Monitor trends quarterly.

✻ Key:

Administrative	Services	Facility

WILLITS

Obtaining County Mental Health Services



CO-OCCURRENCE DISORDERS

Submitted by Dina Ortiz, LCSW
1/2019

I Definitions/Key Concepts:

Co-Occurrence disorder- the occurrence of mental health disorders and substance abuse and/or dependence (alcohol and/or drug abuse or dependence) at the same time.

Dual Diagnosis- refers to cases in which the individual has both a substance use disorder (also referred to as a chemical dependency or addiction) and a coexisting psychiatric illness, such as depression, schizophrenia, borderline personal disorder, anxiety and other mental illnesses.

Individuals who have this syndrome in various combinations are found throughout the substance abuse and mental health systems. They may also drift outside the systems and are seen in the homeless population and the criminal justice system.

Sciacca (1996) has developed acronyms that define the idea range of dual disorders. The following two terms are most helpful in diagnosing and treating dual diagnose disorders:

MICAA: Mentally Ill, Chemical Abuser/ Addicted. This term refers to a person with severely mentally ill chemical abusers. These individuals have a co-existing mental disorder which can be diagnosed according to the DSM diagnostic criteria.

CAMI: Chemical Abusing Mentally Ill: Refers to chemical abuse or dependence co-existing with personality disorders, does not have a severe mental illness.

Dual Diagnosis disorders are characterized by the following:

- Severe/major mental illness and a substance disorder(s)
- Substance disorder(s) and a personality disorder(s)
- Substance disorder(s), personality disorder(s) and substance induced acute symptoms that may require psychiatric care.
- Substance abuse, mental illness, and /or organic syndromes in various combination. Organic syndromes maybe a result of substance abuse or independent of substance abuse.

II. Statistics/Prevalence

Documentation and literature on overall percentages of people diagnosed with a mental illness and suffering with a substance disorder vary from 29%, 51% to 80%.

37% of individuals with an alcohol disorder also have a mental disorder

53% of individuals with a drug disorder other than alcohol also have a mental disorder

Dual diagnosed clients frequently have a lower adherence to treatment as well as poorer outcomes than the clients with single disorders. However, many clients do stop ingesting mind altering substances, but may still suffer from mental illness.

III. Problem Statement

1. Defining the dual diagnosis treatment dilemma
   a. Historical separation of the diagnosis and treatment for substance abuse disorders and mental disorders
   b. Professionals with diverse education, training backgrounds and philosophy of treatment
   c. Different treatment models
   d. Diverse funding sources

2. Difference in philosophy and treatment of disorders
   a. Mental health professionals may tend to view substance abuse as a result of a deeper psychological or mental disorder, as separate physiological/genetic disorder needing treatment. Mental health professionals may deny the primacy importance of addressing substance abuse thereby unknowingly enabling or colluding in their client's substance abuse/dependence.

      Historically, mental health professionals have been trained to believe that if a neurosis or psychosis is thoroughly analyzed and treated in insight-oriented psychotherapy; then other secondary symptoms such as impulsive/destructive acting-out or addictions will naturally drop out.

      Another view is that a person can stop using if he or she "really wants to". And furthermore, the person will not be treated by mental health professionals until she/he stops ingesting alcohol or other mind altering substances.

   b. Substance Abuse professionals tend to see mental disorders as the result of or consequence of substance abuse. Substance abuse is viewed as the primary disorder which causes or elicits acute symptoms of mental illness. This approach grossly underestimates the prevalence of true underlying mental disorder.

3. Treatment models

a. Parallel model involves the client receiving treatment for his/her psychiatric disorder in one system and treatment for his/her substance disorder in another system at the same time.

This model can work, but there are too many variables (different philosophies, developing relationships with two different treatment professionals and /or teams, the different geographic locations and the different expectations of the two treatment agencies) that may end up being barriers to treatment.

b. Sequential model focuses on stabilizing the most acute disorder first ~~than~~ then addressing the other disorder. The issue with this model is it is not an easy task to distinguish between primary and secondary disorders. There have been successful outcomes with this model once the person is stable form psychiatric symptoms and ~~are~~ is participating in a structured drug/alcohol rehabilitation program with minimal support and attention ~~on~~ to the psychiatric symptoms.

c. Integrated model involves clients receiving treatment by the same treatment team that addresses both disorders as well as the interaction between the disorders. This approach reduces the chances that an untreated disorder may increase the vulnerability of relapse of other disorders.

d. Integrated treatment approach

i. Based on a cultural competency approach. Culture is often thought of in terms of race or ethnicity, but culture also refers to other characteristics such as age, gender, geographical location, or sexual orientation and gender identity. Behavioral health care practitioners can bring about positive change by understanding the cultural context of their clients and by being willing and prepared to work within that context. This means incorporating community-based values, traditions, and customs into work plans and project evaluations

ii. No time line

iii. Assertive outreach

iv. Never give up on the patient

v. Develop a strong supportive relationship with the client

vi. May use group and individual counseling

vii. Uses education, motivational interviewing, behavior strategies and peer staff

viii. The approach is recovery orientated; the client is the "leader" in the process of recovery.

ix. The goals are

(1) Reduce hospitalization
(2) Reduce interaction with legal system
(3) Symptoms to remission or reduction
(4) Improve cognitive, behavioral and interpersonal coping skills
(5) Reduce or eliminate risky sexual behavior
(6) Develop a support system
(7) Become part of the family

Recommendations:

1. Develop a dual diagnosis program that will involve both County Public Health AODP and county mental health department.

2. The County will provide resources, support and ongoing training for the clinicians who will be working in this program.

3. Develop a system that will track the successes and the failures of each participants

4. Develop and support peer only 12-step dual diagnosis groups throughout the county.