Mental Health Services Act Implementation Study:

Planning and Early Implementation of Community Services and Supports in Seven Counties

Implementation study team:
Beverly Abbott, Monica Dhillon,
Don Edmondson, Patricia Jordan, Rudy Lopez, Joan Meisel,
Cheryl Milgrom, and Eduardo Vega

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"I gained my inspiration for the painting from living and working in Hawaii."

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This is the second report in a study of the implementation of the Community Services and Supports component of the Mental Health Services Act, funded by the California Department of Mental Health. This report looks at early implementation in seven California counties. We would like to thank the mental health staff, consumers, family members and other stakeholders in each of the seven counties who gave generously of their time and information for this report. In particular, we would like to thank the following people:

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OVERVIEW

This report summarizes the experiences of seven California counties in planning and beginning to implement the Community Services and Supports (CSS) component of the Mental Health Services Act (MHSA).

Under contract with the California Department of Mental Health, a team of eight individuals including consumers, family members, and persons with mental health management and evaluation expertise explored local CSS planning and implementation activities in seven counties. The team reviewed documents and conducted on-site interviews with a wide range of stakeholders. The site visits occurred in the winter of 2006-2007 while the counties were in the early stages of implementing their plans, which had been approved less than one year earlier.

In all of the counties, the planning processes were broad and comprehensive and generally created substantial enthusiasm from stakeholders about the promise of CSS.

Pursuant to state planning guidelines, the counties undertook an unprecedented level of outreach to gather the views of a variety of stakeholders from diverse organizations and communities and then engaged these stakeholders in a lengthy and in-depth planning process. The level of commitment and involvement on the part of such large numbers of individuals and organizations was indicative of a high level of interest in mental health issues within these communities.

The greatest success was the active involvement of consumers in the planning process. Interviewed consumers indicated hopes that this heightened involvement in the planning process would result in a transition to stronger and different partnerships between consumers and service providers, but they were taking a "wait-and-see" approach to how meaningful and widespread such a change would turn out to be.

Counties learned that traditional approaches (inviting people to large public meetings) for reaching underserved, particularly ethnic, communities were not as successful as efforts that relied on personal contacts, approaching community leaders, and going to natural gathering places. While the counties gained experience from these efforts, these are viewed as first steps in overcoming years of distrust and in building more sustained and meaningful relationships with these communities.

All of the study counties found that they underestimated their infrastructure needs to manage the level of activity the new funding has created.

All counties have found the implementation to be more challenging than anticipated and timelines have slipped. For a variety of reasons, the counties did not adequately plan for the augmentations and changes that would be needed in infrastructure (e.g., human resources, contracting, information systems, and space) to implement so many new and different types of programs. The situation was more difficult in a few of the counties that faced major financial cutbacks while they were bringing on new CSS programs.

Counties also are struggling with how to sustain the momentum of stakeholder involvement generated during the planning process. This report describes several ways in which counties are trying to maintain ongoing partnerships with consumers and other stakeholders as they move into the implementation phase.

Most counties used familiar models for their Full Service Partnerships (FSPs), although the study revealed some confusion about how to implement the concept.

The counties generally selected high-need consumers and youth/families for their Full Service Partnership (FSP) programs. Most have followed a high intensity (similar or identical to AB 2034) service model for their adult FSP clients and a wrap-around service model for children-youth in conjunction with other agency partners. Questions about the concept of FSPs were beginning to arise around issues such as flexibility of the priority populations and the intensity and length of service commitment.

System development funds were being used for a variety of programs and services.

The state directive to organize planning around age groups brought greater attention to Transition Age Youth (TAY) and Older Adult (OA) populations, and all of the counties had new services directed to these groups. The most frequently noted system wide

initiatives were in the areas of reorganized and/or expanded crisis and emergency services and the implementation of more evidence-based practices.

The study focused on four special program areas that are being undertaken in most of the study counties.

The study team reviewed the new programs and services of the various counties in the following areas: ethnic-oriented initiatives, forensic initiatives, physical health-mental health initiatives, and consumer-driven services. The diverse county environments and the varying ideas and implementation efforts have led to a range of potential learning, both in terms of successful innovations and challenges. Continued examination of these efforts is expected to lead to a growing body of useful information for other counties and stakeholders.

Optimism for system transformation is high, but counties have concerns about being able to meet all of the raised expectations, and stakeholders want to make sure there is not a return to "business as usual".

All participants reported that they want the MHSA to not just be a means to fund new services, but to be a mechanism to alter the system to improve access, reduce ethnic disparities, increase consumer and family involvement, and bring a wellness/recovery/resilience orientation to the whole mental health system. Some stakeholders expressed concern about creating a two-tiered system in which some individuals in new programs receive intensive and individualized services and others in the currently existing system continue to receive little. In general, however, hopes remain high that the MHSA will result in true system change and new partnerships with consumers, family members and other stakeholders.

INTRODUCTION

This report is the second part of a study on the early implementation of the Community Services and Supports (CSS) component of the Mental Health Services Act (MHSA).

The California Department of Mental Health (DMH) contracted with a study team of eight individuals to explore the planning and early implementation of the CSS component of the MHSA. The study team brings together individuals with consumer and family member experience and persons involved in public mental health leadership, management, research and evaluation, and cultural competence. The overall purpose of the study is to examine the state and county planning processes and the counties initial activities in implementation. The study is not a formal evaluation. It is rather an attempt to identify aspects of the process that have worked well, along with those that have been challenging, and to be useful as planning for and implementation of other MHSA components proceed.

The first phase of the study focused on the state's activities in launching the implementation of the CSS component, specifically the state-level planning activities, the development of guidelines for local planning and for the local plans, and the process of reviewing the plans. The first phase included the launching of a Web-based survey in late summer 2006, as well as a series of interviews of statewide stakeholders in fall 2006 focusing on the statewide planning process. A report on the first phase of the study was released in summer 2007.

This second phase of the study focuses on how counties have conducted their planning processes and have begun to implement the programs and services in their plans. A review of early county CSS plans was conducted in the summer of 2006, and seven counties with approved plans were selected for the study. Two- to three-day site visits were conducted within these counties in the winter of 2006-2007. The site visits entailed structured interviews with consumers and family members, representatives of the county mental health administration including system of care managers, the Mental Health Advisory Board, the Board of Supervisors, the County Administrator's Office, other county agencies, community agencies located in various ethnic communities, unions, contract agencies, and other relevant stakeholders who had been involved in the CSS planning process.

It should be noted that with the exception of some brief update information gathered in May 2007, the report describes the progress of counties up to late 2006, early 2007. Therefore, the report covers only *the very early stage of implementation,* since the county plans had been approved for less than one year at the time of site visits.

Interviewees at the site visits were asked about both the planning process and the progress of implementation. They were queried about their hopes and expectations for CSS and also about their concerns. Attention was paid to contextual factors that impacted the county's planning and implementation efforts.

In addition to the collection of information about overall planning and implementation, the study selected four program areas for special attention. These were selected because of their importance in achieving the goals of the MHSA and their inclusion in many county plans.

- Underserved ethnic community outreach and engagement
- Collaborative efforts with the forensic system
- Collaborative efforts with the physical health system
- Consumer-run programs

This report is based on significant amounts of information that while largely anecdotal reflect common themes.

Given the desire for early results and for obtaining information that could assist with the ongoing planning and implementation process, the study was designed to obtain input from a wide and diverse set of constituencies in an informal and exploratory fashion. The goal was not to conduct a formal review or to assess compliance, but rather to obtain feedback about what had occurred, what was currently happening and what challenges counties were facing.

The input was surprisingly consistent within each county and even across counties, despite differing contexts. While no formal methods for ascertaining agreement were used, the commonality

of experiences provides a reasonable measure of validity to the findings. The report notes instances of variability across counties—particularly where they have major impacts, such as the differing budget situations faced by the counties.

Information about the specific counties is used to illustrate how CSS is working at the ground level. The focus is on programs and activities funded through or resulting from CSS. No inferences should be drawn when counties are not mentioned in a particular section, since omission of a county could mean that a particular activity was not added with CSS because it already existed. For example, a county might not be mentioned extensively in the consumer-family employment section because it already had substantial employment already in place.

Several criteria were used in selecting the seven study counties.

Efforts were made to have some geographic, economic and demographic diversity. The table below shows some of the basic characteristics of the seven study counties.

The timing of the study required that counties that were ahead of others in the approval process be selected for the in-depth site visits. There are at least two consequences of this which could affect the ability to generalize from these results. For one, their planning activity often occurred in tandem with the state planning activity rather than after the state had completed its CSS Plan and Expenditure Requirements. The challenges that resulted from this situation were unlikely to have been as great in

TABLE 1. CHARACTERISTICS OF THE SEVEN STUDY COUNTIES

	El Dorado	Los Angeles	Madera	Monterey	Riverside	San Mateo	Stanislaus	Statewide
Population*	159,000	9,578,960	125,000	404,000	1,559,039	711,031	451,190	34,105,437
Race/Ethnicity*								
White	85.3%	31.8%	47.5%	40.9%	51.4%	50.7%	58.3%	47.3%
African American	0.5%	9.5%	3.9%	3.6%	6.1%	3.4%	2.4%	6.5%
Hispanic	9.3%	44.6%	44.3%	46.8%	36.3%	21.9%	31.7%	32.4%
Asian-PI	2.2%	12.4%	3.9%	3.6%	3.9%	21.5%	4.9%	11.4%
Native American	0.8%	0.3%	1.4%	0.5%	0.7%	0.2%	0.8%	1.0%
Multiracial	1.8%	1.4%	1.5%	2.0%	1.6%	2.3%	23.1%	1.9%
FY 07-08 CSS Planning Estimates*	$2.2 M	$126.9 M	$2.2 M	$5.6 M	$23.2 M	$7.4 M	$ 6.1 M	$454 M
FY 07-08 Mental Health Realignment Base**	$ 3.8 M	$ 357.2 M	$ 4.1 M	$11.2 M	$43.5 M	$ 29.8 M	$ 15.6 M	$1,217 M
Plan Approval	4/06	2/06	4/06	4/06	6/06	3/06	1/06	

* State of California, Department of Finance, *Population Projections for California and its Counties 2000-2050, by Age, Gender and Race/Ethnicity*, Sacramento, California, July 2007

** Source; DMH Letter No. 06-09

***Source: State Controller's Office. Realignment is typically the largest dedicated funding source for county mental health programs.

FY = Fiscal Year

counties that started planning after a clearer picture of state requirements was in place.

A second factor is that this set of counties may represent a sample of counties that were perhaps more prepared for the CSS planning activity and already more in concurrence with MHSA principles.

Interviewees in all seven study counties expressed a universal theme that the initial stages of the MHSA – the CSS planning and early implementation – were unique in their experience with the public mental health system.

The extensive nature of the planning process was unique both in terms of the breadth of input sought and the involvement of stakeholders in actual decision-making. The magnitude of the implementation challenge is enormous with the extent of effort and infrastructure required having been generally underestimated. This report attempts to portray some of the excitement as well as the intensive and exhaustive efforts created thus far by the process. The report includes numerous direct comments as examples to reflect the tenor as well as the content of interviewee views.

The report is divided into seven sections.

The seven parts of this report are as follows:

- Part 1: Planning
- Part 2: Implementation
- Part 3: Full Service Partnerships
- Part 4: Selected Program Focus Areas
- Part 5: Impact on Systems of Care
- Part 6: Hopes, Concerns and Achievements
- Part 7: Next Steps

Each of the sections ends with highlights of significant findings that have a potential impact on subsequent planning and implementation.

The breadth, comprehensiveness, and transparency of the planning process represented a substantial change in the way that counties have traditionally conducted their business.

In terms of the numbers of people involved, the length and depth of the process, and the transparent decision making, this planning process was more extensive and engaging of the community than any prior mental health planning effort. Stakeholders said they felt empowered and that their comments were heard. Those who were actively involved in the process commented repeatedly on how amazing the process was and how useful it was even when they did not agree with everything that occurred.

The state CSS planning process and the state's requirements for the county process set the tone for the kind of broad and open activity that occurred. Some of the counties had a staff member whose sole function was MHSA planning and implementation, others had a combination of staff and outside consultants. Many others also played large roles in the planning effort, most often assuming these roles in addition to their regular jobs. Interviewees repeatedly noted how exhilarating but also demanding the process was. The very factors that were praised as unique and valuable – the openness, the depth, the voicing and hearing of all viewpoints – also contributed to making the process slow and sometimes tedious. Representatives of the study counties all agreed it was worth the effort, but also noted that they doubted they could sustain such an intensive effort throughout planning for all of the subsequent components.

"People were heard, we had a vote, frustrating but democratic."

"As good as it could have been – a social experiment on a grand scale."

"The detailed plan misses the richness of the process – should have videotaped it – amazing how intense it all was."

"Was very slow process, getting everyone's feedback, but it felt good…Process for final decisions – recorded, discussed, voted, very democratic process."

"We cannot do what we did for CSS plan for future funding streams."

It was a challenge to balance the desire for an open process and the need to respond to the planning guidelines as they were being developed.

Some counties began with an almost completely blank slate – asking work groups to articulate what was needed without any programmatic or financial constraints. Others worked in a more structured fashion within the framework of the planning guidelines. Because these seven counties started early, their planning efforts began before there were clear state directions about the types of programs that would be funded. The greatest sense of frustration was expressed by those who began without structure and then had to add limitations as they went along.

For the most part, the planning was conducted absent consideration for the cost of the programs until initial priorities were established. When dollars were then assigned to the programs it became apparent that only some could be funded. Interviewees noted that the real priority setting started when the dollar constraints became known. Interviewees in at least two counties indicated that they would have preferred the attaching of dollars to program ideas earlier in the process to have made the planning more "real." In another county, all the priorities were reexamined when the allocations became known, with a decision to "stick pretty much to the original levels."

Outreach

The outreach to the community conducted by all seven of the counties was unprecedented.

Table 2 includes some of the types of methods and numbers of persons contacted by each of the counties in the initial outreach and information-gathering portion of the planning process. The entries in the table are taken from the counties' plans and are not necessarily uniform as counties used different terminology for varying outreach methods. What is impressive is the variety of methods and the total number of persons who were engaged at some point in the process.

TABLE 2. MAJOR OUTREACH ACTIVITIES

County	Community and Specialty Focus Groups	Public Meetings or Forums	Surveys	Presentations & Discussions - Community Organizations, Key informant interviews	Examples
El Dorado (900)	82 people	1 in Placerville 1 in South Lake Tahoe	5 – 545 responses	23 interviews 2 Latino and 1 Native org	Teleconferencing
LA (11,000)	50-60 total; Done in each of 8 service areas				• Original outreach in 11 different languages • 120 community engagement meetings in languages other than English
Madera		3 in different regional areas	2,000+ responses – mix of closed and open-ended questions		• Paid consumers and family members to go into community (e.g., door-to-door, markets) • Gave prize to county department that got the most survey responses
Monterey (1800)	11 pre-planning	1 kickoff 7 regional 6 focused		14 with unserved groups	40 meetings with collaborative agencies, e.g., AAA, First Five, hospitals)
Riverside	81 community (879 people) 20 specialty (243 people)	4 regional (65 people) – one in Spanish	Multiple (213 responses) – Spanish versions		• 15 focus groups in Spanish • Training and scripts for people to lead focus groups
San Mateo	Focus groups in multiple languages, summarized results and posted on Web	1 kickoff 14 (366)	1,000+ responses in high schools through 2 youth commissioners	9 (118) EPA, Filipino, faith community	Youth/TAY outreach: juvenile justice camps, special programs in high schools (e.g., mother's program, peer health educators), YMCA, Independent Living Centers,
Stanislaus (2,000+)	43 (453 people)	5 – in different parts of the county	Community Feedback Form – couple of simple questions	PFLAG, NAACP, Laotian temple, Lutheran Church	• Client network did mass mailing • Two meetings with Latino community organizations

For example, in Los Angeles' Phase I activity more than 2,000 individuals were engaged in a needs and strengths assessment through 30 different ad hoc groups, plus a subcommittee in each of its service areas. Efforts to engage individuals about MHSA occurred in restaurants, community centers, senior centers, and were communicated in 11 different languages. Phase II planning meetings reached more than 11,000 individuals and included 120 community meetings in languages other than English.

Monterey County held 77 meetings with more than 1,800 people. As one staff person said, "We really went to the community, connected to the public for the first time ever, and it was difficult and frustrating but with lots of rewards."

While not always totally successful, the mental health departments attempted substantial, vigorous and new approaches to reach underserved communities.

San Mateo contract provider: "I've never seen a process that was as inclusive as this. The outreach was astounding."

El Dorado staff person: "Feedback we got was that people were thrilled that mental health was asking them for their input. They also said, 'Where have you been all these years?' This kind of collaborative planning was quite new."

The outreach effort was designed not only to get large quantities of input but also to bring new voices to the process.

Given the prominence of Proposition 63 and the promise of a sizable infusion of new dollars, all the "usual" stakeholders in the public mental system were positioned to participate actively in the process. The state direction to the counties was to try to engage individuals and organizations that do not usually participate, even though they may have needs for and an interest in public mental health services.

Accomplishing this required counties to go beyond their usual means of reaching people. It meant designing a planning process that would be sensitive and responsive to the needs of the usually less-involved constituencies, including those who could not or did not access the system in the past. Some stakeholders needed information about the mental health system and MHSA, but too much information could be overwhelming. Forums in which people felt comfortable participating needed to be developed. Also, it was important to engage at least some representatives from various constituencies to sustain their involvement sufficiently over time to make a significant contribution.

Designing a planning process to obtain wide input and to ensure ongoing participation from unserved/underserved ethnic and other constituencies was an enormous undertaking. All seven counties took this responsibility very seriously and all achieved some measure of success.

Outreach efforts that made use of personal contacts and/or targeted specific community organizations or were conducted where people usually gathered were more successful than general meetings.

Counties have historically encountered difficulties in reaching out to and engaging ethnic and cultural communities. Thus, outreach efforts to constituencies that were not part of the usual mental health network were less successful when counties relied on general public announcements, advertising and large public meetings. Even when meetings were held in the evenings and childcare was provided, attendance was limited. Transportation was a constant struggle.

The limitation of the general meeting strategy was particularly the case with regard to outreach to ethnic communities, even when they were held at convenient sites. Strategies that utilized personal contacts and visiting constituent organizations worked better. Such strategies included the following:

- Working with someone who was well known and respected in the targeted community to promote a meeting. This worked in Monterey because a Hispanic member of the Board of Supervisors (former social worker) worked with a friend who was a school superintendent to organize a meeting at the school in which bilingual mental health workers helped facilitate small group discussions about mental health and other issues.
- Making contact, sharing information and beginning a dialogue with the leadership of ethnic community organizations of varying types. Discussion topics included legal services, human services, health services and community development.

- In San Mateo County, a dialogue was established with One East Palo Alto, an umbrella organization representing 50 community organizations in East Palo Alto. This led to meaningful input into the plan, as well as the beginning of a longer-term relationship.
- A similar strategy was used in Monterey County, when it engaged the National Association for the Advancement of Colored People (NAACP), which already had an interest and involvement in providing informal volunteer mental health counseling.[1]
- El Dorado County made presentations to two different countywide meetings of Latino organizations; one a monthly gathering of those serving Latinos to exchange information about resources, and another designed to provide sustainable system development for the Latino community.
- Los Angeles held a formal planning meeting and invited all of the Indian organizations and communities in the county. More than 350 people attended a dinner at the American Indian Church.
- Another strategy was to visit forums in which community members would regularly already be present. In Monterey, Latino people were engaged at two migrant education meetings; and in Stanislaus County, mental health representatives partnered with local organizations to make joint presentations to their memberships about MHSA, including a Laotian temple and the NAACP.

Using a strategy of relying on personal contacts also worked with other than ethnic stakeholders. For example, in San Mateo County two Mental Health Board members made personal contacts with faith communities to which they belonged, easing the entry of mental health staff. Also, two youth commissioners co-chaired a youth committee and distributed surveys to schools, resulting in more than 1,000 responses.

While this was the most extensive effort yet made to engage ethnic communities, counties were objective and realistic in their assessments of their success.

Interviewees readily acknowledged both their successes and the limitations of their efforts to reach underserved ethnic communities. Counties perceived this clearly as a first step in an ongoing process of engagement, not as a one-time activity. They intended to use what they had learned to continue the work.

- Riverside County for a variety of reasons noted that they had limited success in advancing their outreach to ethnic communities despite holding 15 focus groups (124 people) in Spanish, and eliciting help from community based organizations in the Desert Region.
- El Dorado County was disappointed in the results of its outreach to the Native-American community. They did a key informant interview with a leader in the local Native-American community. Some Native Americans completed surveys and some suggestions were made. They were not able to sustain the relationship with this group; however, and when their suggestions were not included in the plan, the situation became an additional source of discouragement for both parties.
- Stanislaus County acknowledged difficulty in obtaining adequate representation from ethnic communities, with only one Latino who attended consistently. The county noted that a representative from an ethnic stakeholder organization attended occasionally, but too much pressure was placed on this person as the only spokesperson for a constituency.
- Los Angeles County acknowledged carrying out substantial outreach to ethnic communities, but the actual decision-making body had less than desired ethnic community representation.

As one might anticipate, it was difficult to obtain input from outlying geographical areas and to maintain their involvement in the process.

Two types of strategies were used to deal with this problem. The major one used by virtually all the counties was to hold meetings and forums in different localities around the county. While this strategy yields one-time input, it is difficult to maintain continuity of involvement over time from representatives from outlying areas.

One other technique was the use of video conferencing by El Dorado County to try to maintain continuity between the planning in the central part

[1] These strategies were not uniformly successful. For example, another county attempted outreach to an NAACP branch but the contact did not result in active participation of that organization in the planning

of the county and in the more distant Lake Tahoe portion of the county. The county reported mixed results with this effort – in line with the kind of results it obtains with the use of telemedicine.

Consumer Involvement

Training of consumers prior to planning, who then often assumed official roles in the planning process, opened opportunities for large numbers of consumers to participate in a way that had not often happened before.

The requirement that counties train consumers yielded specialized efforts in most counties, often through contracts with private organizations. For example, in Riverside County, a private contractor recruited 81 consumers, 45 of whom received training, which resulted in 15 being actively involved in the planning process. San Mateo trained 100 consumers. These individuals then took on roles in the planning process and conducted some of the subsequent trainings themselves. Stanislaus provided support for consumers to participate in state trainings and the state planning process, which added to the consumers' involvement at the county level. This effort empowered consumers and gave them a real voice in the process. However, more efforts and strategies to increase ethnic consumer participation were needed.

Counties tried different ways of encouraging consumer participation in the planning process

Almost all of the counties tried to make planning meetings convenient and to offer incentives, such as food, transportation and child care. Several counties provided interpreter services, with varying degrees of success. They all agreed about the importance of providing food for people at meetings (a demonstration of welcome and appreciation in most cultures), although several counties struggled with getting reimbursement for food due to complicated county administrative procedures and prohibitions.

Some of the counties also had pre-meetings for consumers, so that they were better prepared to provide their input in larger stakeholder groups. However, some found this created meetings that were too long for participants who attended both the pre-meeting and the stakeholder meeting.

Six of the counties paid consumers for their involvement in the planning process. Different county experiences in attempting to compensate consumers for their participation in the planning process reflect the complexity of what seems like a straightforward concept of compensating people fairly for their time.

- Los Angeles began by offering $25 to consumers who participated in planning meetings. This was shifted to a $25 gift card when the controller said the cash would have to be considered an income item (rather than covering expenses), and this would affect benefit calculations. Problems began to emerge later in the planning process as it appeared that some consumers were appearing mainly to receive the gift cards and did not engage with the planning effort.
- Madera County used a private group to compensate consumers because of the length of time required to go through the county auditor's process.
- Monterey County was unable to provide compensation directly to consumers at the onset and so it utilized a private contract agency to offer store gift cards for consumer participation. This became problematic when this was also considered income impacting on benefits.
- Riverside County paid consumers through a private contractor.
- In Stanislaus County, consumers received store gift cards for every half hour of participation. No problems were noted.
- In San Mateo County, consumers and family members received store gift cards for every hour of participation.

Efforts were made by some counties to obtain input from consumers who were not able to attend planning meetings.

Involvement in the regular planning process was not possible for many consumers, and efforts were designed specifically to obtain their input.

- Stanislaus sought input from consumers who were not part of any official organization, for example by going to residential care facilities.
- San Mateo sought input from consumers in locked mental health treatment facilities.
- Monterey organized a series of focus groups specifically for consumers to provide input in addition to the open planning process.

The choice of whether to use official consumer groups was complicated. Using such groups validates the consumer organizing effort but can leave out consumers – especially ethnic consumers, who have an important stake and are interested but who do not belong to a consumer organization. One consumer noted, "[The process] only reached consumers who were members of the client coalition which does not adequately represent all consumers." Particular concern was expressed about the lack of involvement of many consumers who are living independently, are not connected to a consumer group and had no way of knowing about the CSS planning activity.

Many consumers (and others) felt that their involvement in the planning process represented a major and positive change

A sense of partnership seemed to be a critical component of the process when real change was perceived to have occurred. When consumers reported actual change, they described it as feeling like they were perceived as true partners in the planning efforts. For example, Stanislaus County noted a shift from simply getting input from consumers to having them as real partners in the whole process. This was reflected also by El Dorado County, in which the gap between consumers and professionals narrowed after the county actively sought help from consumers. In many cases, the greater impact of consumer involvement was articulated by other stakeholders – sometimes even more strongly than by consumers themselves.

Despite believing they had taken some significant steps forward, a number of consumers interviewed did not yet trust that the CSS planning process had altered the consumers' role in any on-going meaningful way.

Consumers generally acknowledged that they had a place in the process and that the county was seeking input. But they did not always believe that the county had changed in the fundamental way in which it related to consumers. Consumers would say: "The county listened, but…" The major concerns that consumers articulated in interviews included the following:

- There was selective consumer participation with the county choosing only those consumers whom they knew, had worked with and/or would not "cause trouble."
- The actual plans did not include enough consumer-run services.
- The power balance and the attitudes of management and line staff toward consumers did not change.

As one consumer put it, "Most of decision-making still remains the same, although there has been some input from consumers. Transformation is a fundamental realignment of relationships – a true partnership – we don't have this."

Family Involvement

The level of involvement of family members differed across the counties.

In some counties, parents played an ongoing active role in the planning process – participating on committees and on leadership groups – while in others obtaining consistent engagement was difficult. The lack of evening meetings limited the participation of certain constituencies, including working parents. Those counties that had greater success seemed to have either an active National Alliance on Mental Illness (NAMI) group and/or already established experience with parents playing active roles in both the planning for and/or provision of service.

- In Madera, for example, there is no active NAMI group, and the only way to obtain ongoing involvement was to use an existing parent partner. The county was concerned that its plan lacked strong input from families.
- The San Mateo NAMI group was very organized and came to all the meetings, delivering a consistent message that created a strong voice in the planning process.
- Riverside has utilized family members in its planning structure for some time and was able to continue with these same committees.
- In Los Angeles, NAMI was involved in the stakeholder process and the family respite program in the county's CSS plan is one fruit of that involvement. However, the size of the county with multiple chapters creates challenges for consistent and widespread involvement.
- El Dorado worked diligently to keep a family member as a participant on every work group.

Other Stakeholders

Stakeholders who have traditionally played a role in the public mental health setting were active participants in the CSS process.

Two such groups are private mental health agencies that rely heavily on the counties for contracts and the public employee unions, which play a varying role in counties in decisions made about how certain services should be provided. Not surprisingly, the views of the two entities are often conflicting as their interests often diverge.

The experiences of the contract agencies differed by county, in part based on historical relationships and on new opportunities created by the CSS process.

- In San Mateo, contractors were generally pleased with the planning process and its results and said they felt like there has been an improvement in the relationship with the county. The county made an early decision not to alter the relationship between the proportions of programs contracted versus county-operated.
- El Dorado contract agencies report starting the process with a measure of cynicism but feeling more involved because of the county decision to do more contracting. Relationships between the county and contractors have clearly improved as a result. El Dorado has an agreement to check with the union on contracts over $40,000. It has experienced no problems thus far with the five new CSS contracts.
- The unions are a powerful factor in Los Angeles. Salary increases are negotiated with the Board of Supervisors, and the county incorporates those salaries into its budgets. The contractors in Los Angeles expressed ongoing concern over the lack of cost-of-living increases, which result in salaries being significantly lower than in county programs. Ongoing issues exist around the extent of contracting. An original decision was made to maintain the balance in the CSS funding between county-operated and contract programs, but the addition of county-operated wellness centers with expansion funds has caused some concern about whether this commitment continues.
- Riverside County has traditionally not used many contract providers, due in part to the lack of available providers operating in the county. No contractor association exists, despite the large size of the county. One representative of a contract provider who was involved in the planning process felt planning input lost its focus when it went to the county for actual decision making. Despite an apparent desire on the part of the county to do more contracting, only about 20 percent of the initial CSS funding is anticipated to go to contractors. A union representative attended planning meetings but has not played a major role in decisions.
- Monterey has two Service Employees International Union (SEIU) units, which had routine participation in planning meetings. The union holds monthly meetings with members that include updates on MHSA.

El Dorado contract provider: "It has been wonderful…it has caused a lot of collaboration. It is not as much about the money as connections." "A contractor is going to a CiMH FFT [California Institute for Mental Health Functional Family Therapy] training which wouldn't have happened without MHSA."

The roles of other county agencies, organizations and community groups varied within the different counties.

The CSS principle of expanding cooperation with other organizations clearly impacts the relationships with other county agencies. In some counties, the opportunity for involvement in CSS planning led to the development of new and or improved relationships. A few examples follow:

- The older adult planning in Riverside County engaged the Office on Aging in a new way.
- Los Angeles County received a commitment from the Department of Public Social Services (DPSS) to refer 50 of its clients to a Full Service Partnership (FSP). LA County Mental Health is working in conjunction with DPSS and with the sheriff and hospitals in pilot efforts to get benefits to persons leaving these settings prior to their discharge.

Some representatives noted the ongoing difficulties

that county agencies have in working collaboratively, e.g., prohibitions on data sharing. Additionally, ethnic and some other populations access health care through primary care clinics, which struggle to meet their mental health needs. Some of these clients could benefit from increased access to the specialty mental health services offered through public mental health, e.g., case management, rehabilitation services and housing supports.

A number of counties were able to work with the faith community to obtain input into the planning process from their congregations. However, among the study counties, no known examples exist of representatives of the faith community playing a sustained role or having a major influence in decisions about CSS services.

Efforts to engage the physical health system met with mixed success.

There is an increasing awareness of not only the regular medical needs of persons with serious mental illness but also the special health care risks that such persons face. At the same time, physical health care systems in most counties are feeling the strain of trying to accommodate the special needs of this population that has difficulty in sustaining an ongoing primary health care connection. Emergency rooms are often left with the task of providing care, and access to the regular mental health system is often difficult. Efforts to enhance collaboration between these two systems is one of the four areas of focus for the study (see the Health Initiatives section).

Counties tried with varying levels of effort to engage the physical health care community in the planning process. This was a new effort in almost all the counties and there were not generally any already established relationships upon which to build. The health care system structure and dynamics are not easily understood by outsiders, so mental health staff did not always know who was important to include. Additionally, the health care community itself was not always receptive to the county mental health system, having faced ongoing difficulties in obtaining access for their clients. It was also not always clear what benefit might ensue for a health care provider participating in the extended mental health planning process.

As a consequence of these complexities, while the effort was made to engage the physical health system there was room for improvement. For example, although El Dorado County reached out to its local hospital, representatives did not know who best to contact. After the MHSA plan was submitted, one group of hospital staff was upset about having had no knowledge of the plan and, therefore, no input. The community clinics in Stanislaus participated in the planning, but were unhappy about the plan as it emerged. Representatives of the primary care clinics in Los Angeles complained about their lack of full participation in the process.

The intensity and length of the planning process meant that some stakeholders found it difficult to participate fully.

In each county, aspects of the planning process were extensive, often involving lengthy weekly or biweekly meetings. This was often at the workgroup level, but in some counties (like Los Angeles) this was also true of the leadership group. It is difficult for some stakeholders to commit to this level of involvement. The meetings also occurred mostly during the day, making it more difficult for some people to attend.

The problem was magnified for new groups of stakeholders who were not familiar with the mental health system and did not find the planning atmosphere particularly welcoming. The most notable example mentioned in a number of counties was the Transition Age Youth (TAY) population. As one person in Los Angeles said, "We just couldn't keep TAY involved in the process – in the end, the agencies were advocating on their behalf."

The problem also was acute for persons who attended as part of their professional responsibilities, including both contractors and mental health line staff. This factor was often expressed by contract agencies, which had an enormous stake in the process but often felt they couldn't spend the kind of time that was required. Counties' efforts to ensure that newcomers to the process were given adequate information and brought up to date, and encouragement of everyone to participate was sometimes frustrating for those more familiar with the system.

A particular disparity was felt among county staff who were active participants in the planning process and those who only heard about it through periodic updates. The former group was exposed to both the philosophy of MHSA and the excitement generated by the planning process, while the latter went about their business as usual. Because of this, some counties felt that in the early stages of

implementation, some of their staff found it difficult to feel a part of the changing environment the MHSA is intended to bring about.

Some counties found strategies that worked to engage selected stakeholders, e.g., Riverside County held its Criminal Justice Committee meetings at a location near the courts and held the meetings at lunch hour to encourage more active participation of the court-related persons on the committee; El Dorado County representatives attended weekly standing meetings held by the local consumer group.

Planning Structures and Processes

Some counties were able to take advantage of the credibility of prior planning efforts.

At least three of the counties utilized as a base the planning process structures that had been used successfully in prior planning efforts. Los Angeles had utilized a broadly representative stakeholder effort directed by an outside consultant to prioritize potential areas for budget cuts in the year prior to the passage of Proposition 63. The fact that the Department of Mental Health changed its plan for the cuts as a result of the work of the planning effort established credibility as they began the MHSA planning effort, which built upon the prior effort. Riverside found it particularly helpful to use its standing Child and Youth Committee, since the county had prior experience in developing a Children's System of Care (CSOC) grant which required community input through a formalized planning process.

Six of the seven counties used a variety of committees and workgroups which greatly expanded the number of active participants in the planning process and seemed to work well.

Table 3 contains basic information about the nature of the leadership group, workgroups, and process by which information was gathered, priorities set, and decisions made.

The general intent of all the counties was to involve a large number of individuals in the actual planning process. The usual role of review and comment was significantly expanded to encompass a more proactive involvement in the processing of detailed data about the county mental health system

TABLE 3. PLANNING STRUCTURE AND PROCESS

County	Leadership Group	Workgroups/ Committees	Process
El Dorado	• Mental Health Advisory Committee – 18 members • Representatives selected by management	• Four age groups • Additional Outreach-Engagement and Family Support • 106 total community participants	• Workgroups met weekly or biweekly for a couple of months – made recommendations to Advisory Committee • Advisory Committee acted as a review group which made recommendations to Director • Worked by consensus • After got allocations, came back around again. Ended up sticking pretty much to original levels • 31 people on writing groups who did actual plans for four of the major initiatives
Los Angeles	• Stakeholder Delegate Committee - 63 delegates representing 40 stakeholder organizations with clearly specified membership	• Four age groups plus an Under Represented Ethnic Population (UREP) in each region – 40 total workgroups • Did Needs Assessment in each Service Planning Area for the five groups:	• Decisions made by Stakeholder Delegate Committee using a consensus model with Gradients of Agreement – 17 meetings with average participation of over 200 • Went from 45-page document with basic ideas to 600-page written plan with this work done largely by consultant

Table continues on next page

Madera	Leadership Group • 30+ members • Made final decisions on priorities	• Three age groups: C/Y/TAY, Adult, OA • Latino	
Monterey	Transformation Team • Run by Department • Grew by just adding people with no formal structure or representation	No workgroups	• Recommendations made by Transformation Team are forwarded to Mental Health Commission
Riverside	Stakeholder Leadership Committee • Membership included heads of agencies; CAO and 2 BOS reps, and Union reps • Advisory and oversight	• Three main age groups C/Y, A. OA • Two other main committees (Criminal Justice and Housing) with recommendations going to Adult • Other task force committees: crisis/post hospital, consumer/ family support6, vocational/ employment, TAY, juvenile justice • Weekly meetings of committee heads • Most comm. chaired by mental health board members and included neutral facilitators and mental health staff liaisons	• Committee's task to develop needs, populations, priority strategies • Developed list of priorities before costed anything out; then went down on priorities as far as could – wanted focus on system before consider dollars • Draft plan reviewed by Leadership Group and Mental Health Board
San Mateo	Steering Committee • Co-chaired by Board of Supervisors and Mental Health Board • All Mental Health Board members on the committee • About 60 people including all major stakeholder groups	Four age groups	• Workgroups met at least four times each, reviewed data and did priorities which were reviewed by Steering Committee • One-day meeting of workgroups and Steering Committee where put dollars to priorities - actual voting • Limited number of county staff on groups – 18-25 members on each group
Stanislaus	Stakeholder Steering Committee • Co-sponsored by Mental Health Board and BHRS • 40 members • Reviewed draft plan	Four age groups	• One-day meeting for each committee which came up with priority list of strategies that went into plan • Steering Committee voted on priorities using Gradient of Agreement Form – important who was there that day • Recommendations taken by BHRS and turned into programs • Plan review process led to three significant changes in plan

and in articulating how the county should utilize its CSS funds in accord with the state guidelines.

All the counties except Monterey relied on age-related workgroups as the basic building block for the planning process.

Five counties utilized workgroups by the four age categories, and one had three age group committees (no TAY). Four of the six also added other committees as a reflection of their particular community concerns and emphases – two added workgroups to deal with ethnic issues, one added a group for criminal justice and another for housing issues, and one added groups for outreach and engagement and peer and family support.

The purpose of the committees was to develop initial recommendations on community needs, priority populations, and potential strategies for their particular area. These recommendations were then passed up the ladder to some central leadership group.

These group meetings were seen in most counties as the place where most of the work was accomplished. Efforts were often made in almost all cases to vary the membership of these groups so they were not dominated by county staff. One strategy was to have shared leadership of the groups between staff and consumers or family members. Another was to utilize skilled outside facilitators rather than staff. The content of the meetings was often very detailed and complex, which made it difficult at times to sustain the broad participation of stakeholders.

Because it is so large, Los Angeles had a unique challenge with its planning structure.

Los Angeles County had a structured regional planning effort, but the extent of regional decision making turned out to be limited. Representatives of the service areas had hoped that the needs assessments and priority setting done for CSS at the regional level might form the basis for the CSS plan. Each region had two delegates on the central stakeholder group, but the overall plan design became a uniform one across regions. Other stakeholder interests were organized at a county level, which led to discussion and debate about overall county needs and ideas. The result was that some people felt the needs of individual service areas got lost.

The structure of the leadership groups varied in the formality of the membership selection process.

The membership of the leadership group was in some counties very carefully and specifically structured in order to represent important constituencies. In these cases, the members were intended to represent the interests of their stakeholder group and were often selected by the constituency group rather than by the Department of Mental Health. In other instances, the selection of members was more informal with department leadership selecting both representatives of constituencies and persons knowledgeable and interested in mental health issues. The leadership groups generally lacked sufficient numbers and diversity of ethnic representatives. Thus, while the goal of providing culturally competent services was assumed, a direct voice and advocacy for this were muted.

As noted in Table 3, some counties had leadership groups of more than 30 people; Los Angeles had a group of 63 delegates representing 40 different constituencies. The effort to be inclusive was seen as positive by many, but for some the tradeoff for this breadth of representation was a perceived lack of workability.

Planning Process Input

In addition to community input, the CSS planning requirements played a significant role in shaping the final county CSS plans.

As noted earlier, the counties engaged in the most elaborate planning endeavor they had ever undertaken. It is unlikely that all counties would have done this absent the state requirements

The plans that resulted from the planning process were different from what might have resulted without the guidelines. The factors cited most frequently included the following:

- The requirement for separate planning for TAY and older adults at a minimum created a forum within which these constituencies could advocate for services. The attention and level of funding for these groups would most likely not have occurred absent the state requirements.
- The concept of Full Service Partnerships (FSP) would not have developed in some of the counties and the use of at least half the funds for this service model would probably not have been the result in many of the counties.
- Certain underlying principles would not have emerged or certainly not with the weight of

attention they received. This is particularly the case with reducing ethnic disparities. Also, the attention to closer working relationships with community organizations would likely not have been as strong.

There were programs/services that counties believe might have emerged if there had been no parameters for the planning process. The examples cited ranged from items that people believed were important to the community to specific programs that had been in the planning stages prior to MHSA. They included:

- Services aimed at earlier intervention
- Housing programs for clients other than those in FSPs
- Inpatient beds, including beds for mental health clients with medical problems
- Involuntary services

Some consistent concerns about mental health services emerged in a number of counties – the strongest of which was a lack of access, openness and a welcoming environment.

Mental health administrators are familiar with concerns from community organizations that the doors to their public mental health system are not open wide enough. As funds (particularly realignment funds) have been scarce, definitions of target populations and medical necessity have tightened to the dismay of the mental health system, other health and human service agencies and the community. But the input that was heard in the CSS process in the study counties went beyond the mere lack of access to services – it included a perceived spirit of unwelcoming and an offering in some instances of services that were perceived to be neither appropriate nor helpful.

In two counties, the new information led to changes in policies and practices even before their CSS plans were completed.

One indication of the power of the input received from the community was the fact that in at least two counties major changes in the organization and delivery of existing services was initiated even before the CSS plan was finalized. In both instances – San Mateo and Monterey – the changes were instituted as a result of concerns from constituencies about a lack of access to services. Both counties initiated pilot changes in regions of their county to address this issue.

Monterey County had limited services available in the southern part of the county and these were not well utilized. Input from those communities suggested that the services were not being used because the staff members were seen as "intruders from Salinas who did not understand the lifestyle of the southern part of the county." In response, new positions have been added and an existing staff member who resided in "south county" for many years has been assigned to provide services in local churches, schools and other community locations, while efforts are underway to remodel a new clinic for occupancy in late summer. Similar efforts are underway as part of a pilot program in East Palo Alto in San Mateo County.

"…can't access services, way too complicated, don't feel welcome."

"We learned how the community observed us and that we were not providing services to a wide range of communities"

"Openness and welcoming a big issue – believe the input because there was so much commonality across types of information gathering."

Representatives in El Dorado County indicated that the planning process itself has led to better relationships among organizations and an increased openness of mental health to referrals.

Results of the Planning Processes

Generally, participants in the planning process felt satisfied that the decisions made by the planning bodies were reflected in the final plan documents.

Most of the counties indicated that there was good consensus on the final plans that were adopted. However, it was a challenge to move from planning to final decisions about what would go in the actual plan. For example, in Los Angeles the Stakeholder Delegate Committee agreed to a 45-page document that contained the priorities and general ideas. This was then converted into a 600+ page document. Inevitably such efforts result in questioning by some stakeholders about the integrity of the final plan document to the original intent. Some counties purposely adopted a strategy of including a number of smaller strategies in their plans in order to provide something to most of the constituencies who had participated in the process. It was important for some "to see their words" in the actual plan.

Four of the counties used some element of formal decision making by which either the committees and/or the leadership groups voted and/or indicated their approval with a Gradient of Agreement system. These sessions were described as intense and dependent on who was in attendance on a particular day and who was good at lobbying and making deals. In the other counties the decisions of the leadership group were clearly advisory to the department with the latter holding decision-making authority.

Surprisingly few complaints were made about the results of the planning process.

Some instances of disagreement or disappointment occurred on actual priorities established by the county. In most cases in which there were strong constituencies for items that didn't make it into the plan (e.g., a mental health court, direct funding to substance abuse or to primary care clinics) or when an allocation decision was not to someone's liking (e.g., how to determine split of dollars among the age groups) the decisions had been discussed by so many people for so long that those who didn't get what they wanted felt that they had been heard and that the issues might be revisited in the future.

Planning Process Challenges

Counties spoke about the dilemma of balancing an open community planning process with the constraints of the MHSA and the CSS requirements.

The tension between an open process and the parameters imposed by the MHSA and the CSS guidelines appeared to be felt more in some counties and by some stakeholders more than others. A few comments highlight the frustrations felt by some.

Riverside: "[They] asked what we want to do and then we had to deal with the frustration of being constrained by requirements."

San Mateo: "Conflict between what we want and what we could do – had an open planning process and then had to come back to the plan requirements."

Los Angeles: "The state guidelines overrode the impulse for community planning."

As noted earlier, counties that began their planning processes before the CSS requirements were finalized had some unique challenges in managing the planning process.

Having to deal with the plan guidelines was particularly difficult for the study counties because they undertook their planning efforts before the guidelines were formulated. As a result, they often had to make multiple changes in their plans as the state became clearer about its expectations. Those who started later could present the requirements to the planning participants earlier in the process.

Riverside: "Changing target all the time – always having to redefine and retarget the effort – moving target left us feeling off balance because things were changing at the state level."

Monterey: "Changing state rules – frustrating to have to keep redoing things – in retrospect not sure it was such a good idea to be so quick."

Los Angeles: "Understandable that there were changes as process went on but it was frustrating."

Learning From Planning Efforts

The breadth of outreach and depth of engagement in planning for how to use a significant amount of funding within the public mental health system was unique and almost everyone agreed it was positive and laid a foundation for new and different kinds of partnerships.

Even more than the state level of planning, the counties took seriously the mandate to design a process that would both be open to a broader range of stakeholders and that would engage them at a greater depth of participation than had prior planning efforts. For months, significant portions of the county mental health leadership were engaged in outreach to every conceivable stakeholder and then in ongoing education and deliberations leading to establishing community needs, priorities and services/programs. There are some disadvantages in this prolonged process, however. The process sacrificed speed in order to be comprehensive and thorough. The intensive process also made it difficult for certain stakeholders to play a major role because they simply could not afford the time required. In spite of these limitations, almost all stakeholders interviewed agreed it was important to start off with this breadth and depth.

Future planning efforts should build upon this initial process, rather than trying to duplicate its breadth and depth.

Counties were clear about the fact that they did not feel they could sustain the intensity of this planning process for other MHSA components. They suggested that future planning efforts could target specific stakeholders, as appropriate, and make more efforts to reach out to those who found it difficult to participate in the initial effort or who felt left out of the process. Finding the right balance between speed and efficiency versus comprehensiveness and inclusion will be important for future planning efforts

Meaningful outreach to underserved ethnic communities requires a set of focused long-term strategies.

For most of the study counties, this was the most serious effort to date to reach out to ethnic communities both for input into the planning process and for the beginning of building of partnerships. Strategies that were successful included using personal contacts, identifying and contacting community leaders, going where people already congregate, and asking for help from ethnic community organizations. Counties also learned that it was more important to listen than to make formal presentations. Strategies like providing food and meeting at familiar community settings were important in creating an informal and welcoming environment. Counties were straightforward in their assessment of where they succeeded and in the many instances in which more work needs to be done to continue to build partnerships to fully understand needs and ensure the provision of culturally competent services.

Consumers felt more positive about the process when they saw it as the beginning of a true partnership, not just a process to obtain their input in planning for how to spend CSS funding.

The planning process in all the counties involved obtaining input from consumers – in many instances in a broader and more extensive fashion than ever before. But input from consumers (in interviews) suggested that many expected more than just a seat at the table and willingness to listen to their ideas. They want a fundamental change in their relationship with the county. They want to become "real" partners with not only input but also decision-making responsibility. Real transformation will require not only consumer input, but a true partnership.

Counties agreed that it would have been better to have the CSS requirements clear before they began their planning processes.

Finding an appropriate balance between fully open community planning and state direction is critical to maintaining active and positive community planning. The study counties faced particular challenges because they began their planning efforts before the state had completed its planning guidelines. The more community members understand about the allowed and required elements of the plan *at the beginning of the planning process,* the more productive and positive their involvement is likely to be.

State direction and guidelines, while sometimes challenging to work within, influenced county planning and results positively.

Without the model of the state planning process and the CSS planning and implementation requirements, it is unlikely that the counties would have engaged in such an extensive planning process. Transition Age Youth (TAY) and Older Adults (OA) would most likely not have received such a large focus and proportion of the funding. FSPs would not likely have emerged as a priority in some counties and might not have received the majority of funding in any of the counties. The emphasis on ethnic disparities produced a substantial effort at engagement of ethnic communities in the study counties.

Some counties were surprised by how strongly some groups in their communities voiced the perception that the public mental health system as a whole was not open and welcoming.

Much of the input from the focus groups, surveys and community forums was about issues that were familiar to the counties. However, representatives of at least four of the study counties learned that community concerns were about more than just a lack of access to under-funded mental health services. Feedback from community members indicated an uncaring attitude about the community or the people who were referred for help. The intensity of the concerns led to immediate efforts in some of these counties to ameliorate the situation before major program changes could be made. All counties completed the process with an increased understanding of the importance of providing a welcoming environment.

PART TWO: GENERAL IMPLEMENTATION

This section describes early implementation efforts in the seven study counties.

This section includes information about factors that facilitated implementation, as well as barriers and challenges. It is important to remember that these initial site visits were conducted at a time when counties had just finished a very vital and inspiring planning process and were moving into a very stressful time of trying to accomplish all of the administrative and bureaucratic tasks necessary to get new programs off the ground. What we heard from all stakeholders often reflected the stresses and frustrations at this point in the process of building and changing their systems.

Contextual Factors

Every county in California is unique in terms of its demographic, geographic, political, fiscal and cultural environment. For these reasons, comparisons among counties are not usually productive. In the following section, we identify some factors that either aided or impeded implementation progress.

Differing fiscal situations among the counties had a major impact on the implementation of the CSS.

Implementation went more smoothly in counties that were able to maintain existing programs and add new staff and contracts as they carried out their CSS plans. Those facing budget reductions at the same time found implementation difficult. Implementing the CSS component of the MHSA, which study counties see as a culture change in addition to building new programs, is hard enough; but doing so at the same time other services are being cut is extremely challenging. Those facing budget cuts had to deal with community concerns and all of the bureaucratic and administrative ramifications of budget reductions.

- Stakeholders were confused and upset about the fact that services were being cut at the same time that new dollars were coming into the county.
- Delays emerged in hiring and implementing new programs because of complicated employee transfer plans that were instituted to keep from having to lay off anyone.
- The counties were unable to hire staff specifically for the new programs because civil service requirements allowed many employees, whose jobs were eliminated in budget reductions, to transfer into the new programs.
- Enormous management energy was diverted to handling the budget cuts and to ensuring that the new programs that were started would not be supplanting services[2] that were being reduced or eliminated

The table on page 24 describes the fiscal situations in all of the study counties.

As seen in Table 4, two counties were faced with concurrent budget cuts, and one other county is anticipating a cut within the next fiscal year.

Riverside: "Some of the basic funding for mental health is being cut. Everyone has heard about MHSA and what it will do, and now we will have to explain why we are cutting something here while adding something new over there – It is hard for everyone to understand this and it will be a challenge and will lead to people saying, 'We knew it wouldn't work.'"

Stanislaus: [We had to do a] reassessment of the whole caseload as a result of the clinic closures and figure out where people could get services. This took us a solid 8 months."

Los Angeles: "Transformation is happening due to pressures from two different directions: the addition of new program models coming from MHSA and the erosion of traditional clinic services for non-disabled indigents due to budget reductions."

- Los Angeles was dealing with a $55M budget cut involving 142 positions. The county's 2006-2007 CSS allocation was $90.7M. A hiring freeze was instituted and a major voluntary transfer of employees was undertaken. A number of services were in the process of being curtailed with the potential of 20,000 consumers losing services.
- Stanislaus had cut $17M since 2003-2004, including $4.4M in 2006-2007. The county's 2006-2007 CSS allocation was $4.3M. Three of five outpatient clinics had been closed in

[2] The MHSA prohibits counties from supplanting existing mental health services funding as of FY 04-05 with MHSA funding.

TABLE 4. COUNTY BUDGET SITUATIONS

	Past Reductions	*Current Reductions (06-07)*	*Future Projected Reductions*	*Comment*
El Dorado				No problems – positive fund balance
LA		$55 M and 142 positions		Identifying positions and people given choice to switch – hope to do whole thing without layoffs
Madera				Fiscally conservative county; never any overmatch
Monterey				No overmatch but very limited services for the uninsured (non-Medi-Cal) so now facing increased demand
Riverside			In 07-08 facing cut ($14M) almost as large as CSS allocation ($17M)	Will revisit the plan to deal with cuts
San Mateo				Flat county general fund contribution so only minor cuts
Stanislaus	Cut $17 M since 03-04	Closed 3 of 5 outpatient clinics; 365 clients lost services; cut 45-50 staff positions; reassessed whole caseload to see who would be seen in remaining clinics	Facing additional cuts from hospital shortfalls	Major staff reductions– very few layoffs but no new hires and people were put in new positions who didn't necessarily choose to be there

2004-2005, and over the last two years 45 to 50 positions had been cut and 365 consumers had lost services. Voluntary transfers resulted in not having to lay off anyone.

- Riverside is facing a $14M budget cut in 2007-2008. The county's anticipated CSS allocation is $17 M.

Six of the seven counties faced significant leadership and management changes or challenges in the year or two before and/or during MHSA implementation.

The CSS planning and implementation required a concerted focused effort by the leadership and management of the county mental health department. The task became more difficult when those persons were either in transition or faced other large issues or problems.

- The Madera leadership had recently experienced the challenge of taking over the responsibility of managing the entire mental health system from a private contractor.
- Monterey was undergoing management reorganization with future plans to move from a centralized to a regional system.
- El Dorado, Riverside and Stanislaus all had changes in directors during the planning or early implementation stages.
- San Mateo had very recently undergone a major system change in converting its Medi-Cal managed care system from case rates to fee-for-service.

None of these changes or challenges were overwhelming but they did require additional effort.

A continuity of leadership below the director's position was helpful in two of the counties and, in a third county, the change in leadership became a positive impetus for change.

Infrastructure

Virtually all the counties lacked adequate infrastructure to manage the magnitude, complexity, and bureaucratic hurdles of implementation.

Counties do not have the infrastructure to implement new CSS programs in a timely and efficient manner. In the desire to focus on services, insufficient attention was paid to these infrastructure issues during the planning process. In some instances, specific decisions were made by the Boards of Supervisors that funds would not be used to build department infrastructure. And even when staff positions could be added, this was not allowed to happen until after the funds had been received by the county.

Interviewees repeatedly noted that the timelines for program implementation were too optimistic. Below are just a few examples of what counties reported:

Madera: "We have a lot of zeros in our reporting because there was a lull in getting things started."

Los Angeles: "We had unrealistic timelines for getting the FSP RFPs out into the field." "We have brought up programs before but never so many at one time."

San Mateo: "We were way too ambitious with the timeline… we were supposed to have FSPs fully enrolled and we are nowhere close…we did not have the infrastructure to do such rapid implementation."

El Dorado: "We underestimated the need for infrastructure and support…it is tough getting new programs going."

Stanislaus: "generally not enough put into infrastructure and support."

Inadequate infrastructure was identified at all levels. Not only are there not enough people to support the day-to-day needs of hiring staff, selecting and initiating new contracts and developing all of the necessary policies and procedures, but there is also a lack of experienced managers to oversee all of this activity. New management staff need to be trained, and are not as experienced in overcoming administrative hurdles, which adds to delays and frustrations.

From one county: "We don't have time to train people. You have to have experience and relationships…need higher-level folks…need people willing to make decisions and take risks."

All of this creates frustrations within the mental health system and the community.

- Some stakeholders are frustrated at the slow progress, particularly those who began the process without a strong relationship with the county. In addition, a stakeholder expressed concern that if the process gets dragged out: "It will start to feel like business as usual and (we will) lose the enthusiasm and commitment to the process…so this is a very crucial time."
- County staff responsible for implementation are experiencing a great deal of stress. Many noted that they have never worked as hard and under so much pressure.

Los Angeles: "Everyone is moving as fast as they can." "I have never been so busy in 33 years…a lot of pressure because we want to get things done."

San Mateo: "Biggest challenge is exhaustion…just too much…we are telling people they have to take their vacations."

In order to deal with communication and implementation challenges, some counties have created special implementation workgroups that meet to review progress.

Most of the counties have organized at least weekly meetings of a core group of persons who have active roles in implementation. In Los Angeles, for example, the staff group is large and includes representatives of all the regions as well as central program and infrastructure/support staff. The focus of the group is moving forward. They are hiring staff for county-operated programs and getting "money on the street" to contract providers. It is a very task-oriented group.

Everyone working on implementation meets weekly in San Mateo and twice a week in Madera. In Riverside, regional and central managers along with program chiefs routinely review progress on each of the work plans.

Another feature in a few counties is regularly scheduled meetings with contractors who are implementing CSS programs – these occur monthly in Stanislaus and every six weeks in San Mateo.

Workforce and Training

Workforce issues presented the most critical implementation challenge in each of the study counties.

An often-repeated comment of interviewees was that the Education and Training component of MHSA should have been implemented before CSS or, at least, at the same time. This comment reflects the most basic of human resource challenges – the statewide shortage of mental health professionals and paraprofessionals. This problem is all the more acute for staff who are bilingual and bicultural. Every county in the study faces a challenge in recruitment and retention. If talented people are available, county direct operations and contract providers are competing for the same people. In one county, the leader of an ethnic planning group and ethnic services agency was hired by the county, in part, because of her strong leadership in the CSS process. That left the planning group with fewer experienced candidates from which to choose.

A second challenge is the shortage of experienced managers who have the expertise to implement new programs. Many of the managers, particularly in some of the infrastructure units, lack experience with the systems and rules and ways to move through obstacles.

The third daunting challenge is civil service, which moves slowly and bureaucratically. The process of hiring new staff is always cumbersome, and the scale of additions required by the influx of CSS funds created unique challenges. Counties tried to address these difficulties by notifying human resources staff members about upcoming staffing needs and by engaging in some joint problem solving.

In every county, the addition of consumers and family members to the mental health workforce is one of the most significant factors in the implementation of the CSS component of the MHSA.

San Mateo: "Bringing in the new hires – fingerprints, physicals, paperwork – normal function – has tripled her workload – pretty overwhelmed – getting the fingerprint appointments – lots of favors – not doing business as usual."

Los Angeles: "There are MOUs between civil service and the unions. Mental Health can't open a list itself and can't create new classifications. Mental Health competes with 38 other departments for attention. We have no control after something leaves our office."

El Dorado: "We are trying to build more collaborative relationships so we can get things done – We address stumbling blocks together. Human Resources used to be thought of as a place where things go to sit – now it is different."

Monterey: "We have a very complicated process to add, recruit and hire new positions. Recruitment of licensed staff and bilingual staff has been a big challenge."

The hiring, training, orientation and job roles for consumers and families represent a major new or greatly expanded activity for counties. No "best practice" has been established for how to do this, so counties have used their best instincts and joint wisdom. Counties are putting a lot of effort into learning how to do this most efficiently and effectively

Two different approaches to job classifications and consumer/family member employment are being tried.

Five counties (Monterey, San Mateo, Stanislaus, El Dorado, Madera) use regular job classifications with minor variations (e.g., San Mateo's deleting the requirement for a driver's license). In order to promote the hiring of consumers and family members, the counties either state that preference will be given to people who identify as consumers and/or family members or give added benefits for such experience. But the basic job classifications are the same as for non-consumers.

Two counties have created separate classifications.

- Riverside created a new three-tiered "Peer Specialist" classification. The decision to create

a new classification was based upon their prior unsuccessful efforts to hire parents into existing job categories.

- Los Angeles has developed a "Mental Health Peer Advocate" classification which is not part of any other job series. The county created a separate classification because this action allowed it to exempt this classification from the general hiring freeze and move forward more rapidly with consumer hiring.

Counties also expressed some differing philosophies around consumer and family member employment. For example, Monterey believes that its consumer and family member new hires should fulfill standard job classifications with no special job specifications. Although this does not exclude reasonable accommodations, the county expects its consumers in case management positions to function as case managers, not as peer advocates. County representatives discussed having their consumer employees "taking on professional identities as they progress through the ranks." Other counties like Riverside and Los Angeles think it is important to emphasize the peer nature of the consumer and family members' tasks. These counties want and expect consumers and family members to perform separate and special functions that only they can do, based upon their experience.

It is too early to determine whether one of these practices will emerge as more promising or effective. The decision to go one way or the other often depended on the county's and consumer advocates' emerging philosophy about consumer/family member employment, the way existing job specifications were written and/or the degree of flexibility counties have in their hiring policies and practices.

All of the larger study counties either have or are planning to add consumer and family members in top management positions.

- The top tier in the new Riverside classification is a "Policy and Planning Specialist." There are three such positions at the management team level.
- Stanislaus, San Mateo and Los Angeles have "Family and Consumer Affairs" managers, which are senior positions.
- Monterey is hiring a full-time parent partner to join its existing cadre of four. The focus of the job is to develop and support an advisory committee and to do program development and evaluation to ensure family involvement throughout the system.

Counties also are trying different methods of recruitment, training and on-going support for their consumer/family member workforce.

San Mateo evolved a special initiative – Inspired at Work – to undertake a culture change with regard to consumer employees. The county contracted with two private organizations to do a very wide recruitment for potential consumer employees, including mailings, 15 community meetings, outreach to churches and ethnic communities, and word-of-mouth contacts in the Spanish- and Asian-speaking communities. This resulted in 330 applications, followed by 86 personal interviews, for 14 positions. Most of the applicants were persons who had not had prior contact with the public mental health system. The county conducted six full days of interviewing with multiple panels, which included consumers and family members. San Mateo also utilized special contract staff to assist in the hiring process to facilitate all the benefit issues, as well as fingerprinting and background checks. Once hired, the San Mateo consumers underwent an orientation and a 20-hour training program.

Riverside also utilized a private contractor to assist consumers in work readiness and training to fill 72 positions (36 Full-Time Equivalents-FTE). Consumers receive a 70-hour training program and will have an ongoing support group. As in San Mateo, extra help was provided for benefits counseling and for things like background checks.

El Dorado has developed its own "home grown" 15-session consumer training program described as both "global and extremely specific." The county also held a one-day training with staff, consumers and family members to look at their own biases and relate them to barriers that are created when hiring consumers.

Los Angeles developed a standardized curriculum for all peer advocate training programs, with input from consumers, family members and community agencies, as well as county mental health staff. The county then contracted with community agencies to provide two intensive peer advocate training sessions in 2006, and have prepared more than 70 consumers and family members for staff positions in the mental health system.

Several counties are proactively addressing workforce concerns such as confidentiality and stigma.

From a county staff member: "MHSA's focus on consumer recovery and employment and the director's seriousness in implementing this vision has stirred up hidden stigma present within staff." From county management: "Discussion needed to happen about confidentiality and boundaries and ethics."

From a consumer: "Process is slow on getting staff to really understand and accept consumer employees. Stigma and discrimination are rampant in the clinics and need to be addressed. Nothing will change without this."

San Mateo has the most ambitious initiative – Paving the Way – which evolved a set of principles and strategies to prepare the workforce for consumer employees. The county tried to create an environment that was acceptable to openly discuss, challenge and raise questions about the hiring of consumers with the ultimate goal of creating a welcoming environment. County representatives held meetings and brown-bag discussion groups with line staff. Existing parent partners met with the leadership at each of the clinic sites, and a four-hour training was held with supervisors.

Riverside tried to anticipate issues by holding a half-day training with staff around issues of confidentiality and boundaries.

El Dorado management acknowledged the surfacing of staff resistance to consumer employees around the issue of confidentiality and is making an effort in monthly meetings to address these issues as they arise.

Consumers voiced concerns about staff resistance to consumer employment and "hidden stigma." This concern was not as strong in counties with a longer history of consumer and family member employment.

Several of the study counties also face some specific workforce recruitment and retention challenges.

A number of counties noted special situations in which they had to compete for staff with other geographically near entities that offered higher salaries – El Dorado (Sacramento), Monterey (Santa Cruz), Madera (Tulare), Riverside (prison system).

San Mateo noted that particularly strong competition for bilingual bicultural staff exists across the San Francisco Bay Area. And Los Angeles management noted that there is already competition with contract agencies for bilingual bicultural staff and that the MHSA additions only heighten that problem.

The high cost of housing and living was a particular problem noted in Monterey.

As previously noted, the other special circumstance was the concomitant reduction in staff in the two counties facing budget cuts – Los Angeles and Stanislaus. Hiring freezes were in effect while staff reductions and transfers were determined, causing delays and concerns as people moved into new and unfamiliar positions.

Contracting

The greater involvement of community organizations in CSS planning and the desire to reach out to unserved communities resulted in an increase in the quantity of services contracted to private organizations.

San Mateo: "We didn't have a strong [contracts] infrastructure to start with, and we have had to hand hold some contractors getting to use the Management Information System (MIS). The contract monitoring is a stretch with the Quality Assurance and Medi-Cal audit requirements."

Los Angeles: "Board of Supervisors wanted competitive bidding even though the existing contractors were really the only ones who could do [the FSPs]. It added enormous bureaucracy…we couldn't get new agencies certified for Medi-Cal or trained to do the work."

Monterey: "A proposed contract with (one agency) had to be broken into two smaller ones because risk management wouldn't approve a traditional mental health services contract because the agency is basically a volunteer operation. We hope to work with them so they can get Medi-Cal certification."

El Dorado: "Contracting is slow and small agencies can't hire until they have the money. Challenging for contract providers – billing, paperwork, but we are working closely. Contracting and invoicing issues are significant. Bureaucratic stuff."

With the infusion of significant new dollars into the county mental health systems the question arises about how much to contract out to community-based organizations and how much to increase county operations. In some counties, a decision was made to use the CSS funding as an opportunity to expand the use of contract agencies (El Dorado and Riverside), or open the contract opportunities to more than the existing contractors (Los Angeles). The Los Angeles Board of Supervisors instituted a 5 percent add-on for bidders who subcontracted with smaller organizations as a way of trying to open up the process to new entities. Even when decisions were made not to alter the balance of county-operated and contract programs (San Mateo, Los Angeles), an increase occurred in the number of contract programs because of the added dollars.

Additionally, the emphasis on reducing ethnic disparities led most of the counties to begin the building of new and/or stronger relationships with ethnic organizations. Outreach and engagement dollars were in many instances set aside for contracts with these organizations (see section on Ethnic Initiatives).

The resulting increases in contracts added to the administrative workloads within the counties by both the addition of contracting work and the need to accommodate new kinds of contracting arrangements.

For many counties, the volume of additional contracts that needed to be developed in a very short period of time was very difficult to handle for existing staff. In addition to the sheer increase in volume was the inclusion of new agencies that did not previously have contracts with mental health. Most of these new organizations lacked the internal management or financial resources to meet the requirements of contract agencies. This was particularly the case with regard to becoming certified as a Medi-Cal provider. The result was either far more work for staff to help the organizations develop the capacities and/or the need to adjust requirements to allow the process to proceed. Either alternative added time to the process and was another source of delay.

Facility Expansion and New Program Site Selection Issues

Finding space and sites for new programs has been a significant challenge in all of the study counties.

The search for space for new staff and new programs has complicated implementation. This was noted in San Mateo where managers are reviewing detailed staff schedules to orchestrate an office-sharing arrangement. It is a problem in all regions of Riverside County and was noted as a significant issue in Monterey and Madera counties. El Dorado says, "A huge challenge in MHSA expansion is the facilities issue… [and it is] only getting worse."

In its recent Implementation Progress Report, Los Angeles lists "siting problems" as one of its major implementation challenges that impacted almost all programs. The county reported that the inability to find new sites threatens to obstruct the implementation of recovery-oriented mental health services. To combat this, stakeholders have supported the investment of one-time funds to develop and initiate ongoing strategies to improve efforts to find sites for programs.

Stanislaus located one program in a facility that subsequently was found to fail fire clearance standards. The program had to be relocated until the problem was fixed.

Maintaining Stakeholder Involvement During Implementation

Stakeholder involvement in the planning process was unprecedented; counties are now trying to define an appropriate level of involvement in ongoing implementation.

As noted at the beginning of this section, the initial site visits conducted in this study were subsequent to the broad and comprehensive planning efforts in each county and early in the counties' implementation processes. Since much of this effort is uncharted, counties are struggling with how much to involve stakeholders in the actual implementation, as well as how to keep them informed about what is happening, while still operating in an efficient and timely manner. Little precedent is available for working out new collaborations, new partnerships and maintaining an open and transparent implementation process. Concerns were expressed that counties may lose the partnerships developed with stakeholders in their desire to speed up implementation. Here we present the different ways in which the study counties are trying to handle these challenges.

- Los Angeles has added a System Leadership Team (SLT) to its stakeholder process, which already included workgroups and a delegate committee structure. The SLT is responsible for monitoring progress on implementing the CSS plan, as well as developing process and structural frameworks to support an overall system transformation. The SLT consists of 25 members and was agreed upon by the stakeholder delegates and the Department of Mental Health as a way to facilitate and improve the overall stakeholder decision-making and action-taking processes. In the recent update conversation with Los Angeles, the director reported that he believes the SLT feels itself to be "robust and powerful" and has helped structure the process for decision making.
- Riverside County convenes its stakeholder group as necessary to provide oversight needed for MHSA planning activities and future MHSA component rollouts. The main planning committees continue to meet even though attendance has dropped off. The county tries to keep people informed about implementation through regular reports to the central and three regional Mental Health Advisory Boards. When the county got feedback that consumers and family members didn't know what was happening, it instituted a monthly open meeting to provide updates, but attendance was also sparse. In addition, the county regularly posts project updates on its Web site.
- Stanislaus maintained its stakeholder group, holding periodic meetings. The county reports about a 35 percent turnover in membership. The county acknowledges that it is difficult to keep this group actively involved because there are so many details about implementation that, unless one is directly involved, it is hard to really know what is happening. The county notes in an Implementation Report that it has no formal method for counting or tracking the involvement of consumers and family members in ongoing implementation efforts. Based on sign-in sheets, it has had 36 consumers and 17 family members attend at least one of 105 committee or workgroup meetings. Stanislaus also just recently began publishing a newsletter.
- San Mateo anticipates keeping its Steering Committee, which reviewed the expansion plan. It is revising other parts of its planning structure, including the folding of the age group committees into the comparable groups within the Mental Health Board structure. The Mental Health Board is also holding consumer-led stakeholder meetings for the annual plan update and for the plan expansion.
- El Dorado has held some meetings of its Steering Group, but attendance has been skimpy and the group is not intimately involved in implementation. The current plan is to hold quarterly MHSA Advisory Committee meetings. The intended role for the group is to identify unintended consequences, make course corrections, and look at whether the plan is doing what was intended.
- Monterey continues to use the same stakeholder group for implementation as used for planning. It meets monthly to review progress on implementation. The roles and responsibilities of the group have not been clearly articulated, and the issues of when to meet, what to cover, and who should be involved continue to be open for discussion. Monterey also has added a few committees to its structure, including marketing and communications and evaluation.
- Madera County notes that its best communication channel to stakeholders is a monthly town hall meeting at its new consumer-run Hope House. Staff members attend and the meeting has become a forum in which to introduce new ideas as well as to provide updates on what is happening. Also, the county's Evaluation Committee has taken on new responsibilities for not only tracking implementation of CSS but of reviewing plans for other MHSA components – in effect becoming a new steering committee.
- Two counties – Stanislaus and Monterey – have begun issuing newsletters, which update CSS implementation progress and are addressed primarily towards consumers and families.

Reporting Requirements and Information Systems

All of the counties expressed concerns about the reporting requirements for CSS.

Four of the counties reported difficulty in being able to track information by the three major funding types – FSPs, System Development (SD), and Outreach

and Engagement (OE). Some programs clearly have elements of more than one type of service. One solution – utilized by Riverside – added two digits to the reporting unit which identifies the particular CSS identity of the staff person who enters the unit of service. But this does not solve the issue of clients who receive both FSP and SD services.

While most of the counties already had some means for gathering and entering the FSP-type data because of AB 2034 programs, they have to change these methods either because of changes in the requirements and/or because of the mere scale of the endeavor (Los Angeles). At least two other counties reported difficulties in implementing the FSP data reporting requirements and concern about lack of clarity from the state on various aspects of the effort, but these noted recent improvements.

San Mateo, Madera and Monterey made explicit decisions to start a large number of smaller work plans in their CSS plan (as opposed to concentrating on a few things) in their desire to show stakeholders that their ideas had been heard and are being implemented. They are now finding that they not only have all of the attendant start-up problems with a lot of new programs, but that the reporting by each work plan requirement is particularly difficult.

"[We have] too many work plans which complicates everything. We wanted everyone to see their thing in the plan but this makes all the tracking and reporting far more difficult."

A major concern is potential liability in response to audits which may require the county to clearly document the distinction between funds for existing programs and funds for new programs. A few counties stressed the importance of obtaining information about future audits as soon as possible.

Finally, CSS requires substantial resources to not only implement but also to meet all the state's detailed requirements about funding and reporting. Counties realize that CSS is just the first of at least four other components, and they worry that the requirements and details will just multiply and soon be beyond their capacity to handle.

All seven counties are actively pursuing major information system upgrades and enhancements which will incorporate an electronic medical record (EMR).

- Monterey plans to issue an RFP for a new system which will incorporate an EMR tied to billing.

County Director: "There is so much detail, it is way too complicated… People do not realize how hard and complicated it is…all the components on top of CSS is too much. We do not have the confidence that the state can respond to the level of work that is going to come from this, for example in processing plans."

County Director: "We never envisioned six separate plans. We will have to get our Mental Health Board going through hearings on all the other components; it has become a churning bureaucracy. Part of it is what the lawyers do with it."

They plan to begin the process by hiring staff from one-time CSS funds.

- Riverside plans to obtain a new system which will have EMR to replace their ECHO system.
- Madera is in the process of implementing a new management information system, including an EMR.
- San Mateo will be moving ahead with an EMR with money it has been accumulating over the years for investment in information technology (IT) improvements.
- LA hired a consultant to design its EMR and will issue an RFP in 2008. The county anticipates implementation of the EMR to take two years. The system will be used only for county-operated programs.
- El Dorado has implemented a new Avatar claims and billing system and intends to add an EMR component.
- Stanislaus decided to postpone final decisions about system design and direction until funds are available for information technology enhancements.

Two concerns were expressed about the state's activity with regard to IT. One was from a few of the very early implementers who felt disadvantaged by the earlier rules (later eased) about limitations

on the use of CSS one-time funds for IT use. The more significant issue was concern about differing timelines for county actions and state requirements. These counties are eager to proceed with their IT plans, and they fear that they will get started only to find out that their efforts run counter to requirements for the EMR which will be coming later.

Learning From General Implementation Efforts

Implementation is more difficult and complex than was anticipated.

All of the counties were too optimistic in their timelines and underestimated the difficulties and the consequent delays that would occur. Some stakeholders are frustrated and county staff are overworked and stressed. All of the counties cited similar barriers in their implementation efforts, including inadequate infrastructure, workforce issues and space, and facility site issues. The danger in the delays is that old distrusts will reemerge and that the positive efforts and feelings generated in the planning process will diminish with a perception or reality of return to business as usual. Counties hope the situation will ease as more programs actually move into implementation and the results of the planning efforts are tangible. The lessons about the need for infrastructure and for realistic time frames should be built into subsequent planning efforts.

Counties that were able to hire new staff and execute new contracts found implementation went more smoothly.

As noted earlier, implementation went more smoothly in counties that were able to maintain existing programs and add new staff and contracts as they implemented their CSS plans. Counties that faced budget cuts and staff reductions faced hiring freezes and situations where they had to offer their new positions to existing staff whose jobs were in jeopardy, regardless of whether or not those staff had skills that were optimal for the new positions and programs. When you are trying to make major conceptual and philosophical changes, the ability to hire people whose interests are compatible with those concepts is extremely beneficial.

The issues of hiring, training, and integrating many consumer/family member staff are being addressed aggressively and creatively.

Two main strategies have emerged for establishing county positions for consumers and family members with the choice of how to proceed determined more by past experience and the current human resources environment than by any yet clearly determined best practice.

- Creating a new job classification or job series specifically designed for consumers and/or family members
- Incorporating the hiring of consumers and family members into existing job classifications, sometimes with minor changes, including giving preference for life experiences.

Counties also are trying new proactive ways of developing consumer and family member workforce pools, including the use of private organizations to do marketing, interviewing, and handling of the technicalities of the hiring procedures and using a variety of methods for training.

Counties are working hard to get new and expanded contracts in place.

The influx of new funding resulted in new contracts and contract expansions in all of the counties. The counties that had less experience with contracts, like Riverside and El Dorado, found the whole process challenging and time consuming. Also, in most counties, the CSS effort led to an expansion of contract opportunities for smaller organizations which often lack the infrastructure to respond to and/or meet both the fiscal and management requirements of such contracting. Additionally, these agencies are finding it difficult to do everything necessary to become Medi-Cal certified which will limit their capacity within the county systems of care. Counties are providing additional assistance and trying to accommodate their rules to this new situation, but the process is slow and complex for bureaucracies. It would be helpful for the state to provide training and technical assistance to both the small agencies and to the counties in order to enable them to better address this infrastructure need.

Counties are trying to find effective ways to maintain on-going stakeholder involvement.

The breadth and depth of stakeholder involvement in the planning process created expectations about on-going involvement with implementation. At a minimum, stakeholders want and need to be informed about what is happening with implementation. Further, appropriate roles for

stakeholders in designing and implementing more detailed actual programs have yet to be clearly defined. Again, this is new territory for many counties, and the study identified several ways in which counties are trying to find the appropriate balance between keeping stakeholders informed and involved and being able to move ahead with implementation in a timely and efficient manner. It's currently too early to say if one or a combination of these strategies will prove most successful.

This next section looks at the implementation of FSPs in the seven study counties. CSS plans were required to budget more than 50 percent of their funding request for FSPs, and five of the seven study counties were required to implement FSPs for all four age groups in the first year. The information in this section is primarily descriptive, since none of the FSPs have been in effect long enough to draw any significant conclusions about them.

PART THREE: FULL SERVICE PARTNERSHIPS (FSPs)

As was noted about implementation in general, FSP implementation through the third quarter of FY 06-07 was below plan projections.

The table on page 34 indicates the relative extent of implementation of the FSPs in the study counties. The programs are ranked as "none," if no clients have been served; "slight," if less than half have been served; "moderate," if between 50 and 75 percent have been served; "substantial," if the county is serving between 75 and 95 percent of its projected clients; and "full," if more than 95 percent of the total targeted number of clients are in FSPs. Where counties have reported FSPs separately (because of a different initial population or program structure within an age category), more than one "X" is indicated when the degree of implementation differs.

The overall sense from the table is congruent with the previous findings that the implementation challenges were more significant than anticipated.

In general, counties have selected high need populations for their initial FSPs.

Tables 6 and 7 show the initial priority populations identified by the counties in their CSS plans.

Five of the counties designed adult FSPs which generally fit the AB 2034 model.

Riverside, Los Angeles, Stanislaus, San Mateo and Madera designed adult FSP programs that are similar to the AB 2034 model in their low staff-to-client ratios and intention to provide intensive services for undefined lengths of time.

Two kinds of variations on the model are apparent in the counties' plans.

- *Housing:* Los Angeles will use one-time money for housing supports for FSP clients. Madera encumbered one-time funds to be used over the three-year planning period to pay for housing (and food, education and transportation) services specifically for its FSP clients. San Mateo has a separate contract with the Mental Health Association to obtain housing for FSP clients.
- *Extent of service integration.* Not all counties plan to have the FSP team provide all mental health services. Madera's FSP staff views its role as primarily case management, relying on other parts of the mental health system for other needed services. Stanislaus anticipates that its FSP clients will utilize other services funded by System Development funds.

The other two counties are using models for adults which diverge from the original AB 2034 model.

For adults and older adults, Monterey is using a more flexible definition of FSP. The county believes that a consumer's need for intensive services fluctuates over time, so that the notion of a "lifetime" FSP may be appropriate for only selected consumers, e.g., the chronically homeless or certain older adults. Monterey has designated FSPs for clients who are in supported housing and clients who will be in a short-term court program. The county intends to track the transitions from the more- to less-intensive services through its data system in order to meet the state's FSP reporting requirements. The other different feature of the Monterey approach is the spreading of FSP clients among providers, rather than concentrating them within a single program.

El Dorado is using FSP funding for adult and TAY consumers living in a single supported housing setting. The program has a dual diagnosis focus and has staff on site. The intended length of stay in the program is two years.

TABLE 5. ACTUAL ENROLLMENT IN FSPS COMPARED WITH PROJECTED (3RD QUARTER 2006-2007)[3]

	None	Slight (<50%)	Moderate (50-75%)	Substantial (75-95%)	Full (>95%)
El Dorado					
Children		X			
TAY-					X
Adult			X		
Los Angeles					
Children/youth		X			
TAY		X			
Adult		X			
Older Adult		X			
Madera					
Children/youth		X			
TAY			X		
Adult		X			
Older Adult				X	
Monterey					
Children/youth		X			
TAY	X				
Adult					X
Older Adult					X
Riverside					
Children/youth		X			
TAY	X				
Adult		X			
Older Adult	X				
San Mateo					
Children/Youth			X		
TAY				X	
Adult		X			
Older Adult			X		
Stanislaus					
Children/youth			X		
TAY					X
Adult					X
Older Adult					X

[3] From Exhibit 6 submitted by counties to state DMH.

TABLE 6. INITIAL POPULATIONS FOR ADULT AND OLDER ADULT FSP PROGRAMS

County	*Homeless*	*Forensic*	*Substance Abuse*	*Health or High Emergency Depart. Use*	*Ethnic*	*Locked Facilities*	*Adult Protective Services*
El Dorado	X	X	X				
Los Angeles	X	X		X	X	X	X (OA)
Madera	X	X			X		X (OA)
Monterey		X	X				
Riverside	X	X	X		X		X
San Mateo	X	X	X	X	X	X	
Stanislaus	X	X	X	X	X		

TABLE 7. INITIAL PRIORITY POPULATIONS FOR CHILDREN AND YOUTH FSP PROGRAMS

County	*In or At Risk of Out-of-Home Placement*	*Juvenile Justice*	*Substance Abuse*	*Other Seriously Emotionally Disturbed*	*Ethnic*	*Wards and Dependents*	*At Risk of School Failure*	*0-5 At Risk*
El Dorado	X							
Los Angeles	X	X			X		X	X
Madera	X	X					X	
Monterey	X	X	X				X	X
Riverside	X	X	X			X	X	
San Mateo	X	X		X	X	X		
Stanislaus		X		X				

Six counties have separate FSPs for older adults. Five of the six counties (Los Angeles, San Mateo, Stanislaus, Madera, and Monterey) will apparently operate older adult FSP programs with the same basic model as they are using with their adults, with some additions or modifications.

- In Los Angeles about one-quarter of the total funding for older adults will go for FSPs. Madera notes that while the general model it is using is the same, its partners are different with the older adult FSP including the Public Guardian and Adult Protective Services.
- Riverside will operate its older adult FSP more flexibly than its adult FSP and will work in conjunction with other human services agencies for seniors.
- San Mateo is assuming a much more intensive medical/nursing component to provide support for management of medical conditions that might otherwise have kept the older adult in an institution.
- El Dorado is the only county that did not have a specific older adult FSP in its original plan, but the county plans to include older adults in its supported housing setting. Also, its expansion funds have now allowed the county to create a specific FSP component within its new older adult program.

Five of the counties have designed specific FSPs for their TAY consumers, while two other counties will include TAY consumers in their child/youth and/or adult FSPs.

For the smaller counties, the distinction is just a different case manager; however, the larger counties have wholly separate FSP models for TAY clients.

- Riverside is implementing three organizationally separate FSP teams for TAY, one in each region.
- Madera has one case manager specifically for TAY who is transitioning between the child and adult systems of care. The person is housed with the Behavioral Health Court Day School, and the initial populations to be served are youth aging out of the child welfare system or involved with juvenile justice.
- San Mateo will operate a separate team for TAY in conjunction with its child/youth FSP. The TAY FSP also includes a youth drop-in center and supported education.
- Los Angeles has FSPs specifically for the TAY population with specific initial population targets: 30 percent at risk of homelessness, 30 percent from institutional settings, 30 percent from probation, and 10 percent are experiencing their first episode of serious mental illness.
- Monterey is expanding its Transition to Independence/AVANZA program, which provides educational and vocational services in addition to intensive case management for TAY. The county is also contracting with a local group home agency to implement supportive housing and mental health services for TAY exiting the Probation Department's Youth Center.

Two counties reported spending time trying to reconcile their design for child/youth FSPs with the requirement that every county have an SB 163 program or provide substantial evidence that such a program is not feasible in the county.

In Madera, the Department of Social Services does not have an SB 163 program and does not want one because the county does not want to commit any general fund dollars. Mental Health proceeded with the development of its FSP program using the conceptual and philosophical elements of the SB 163 model. Mental Health feels it has better control of its FSPs than it would with an SB 163 model, since it can be more flexible about who gets served in FSPs. They want to initially prioritize children with severe emotional disorders (SED) and their families, rather than children with behavioral issues who are the high-profile children from the perspective of Probation and Social Services departments. They continue to study the issue of implementing SB 163, as required under CSS, with a new report due in summer 2007.

The discussion in San Mateo led to a shift of families served under SB 163 into the new FSPs, an arduous but positive step from the perspective of Mental Health. The SB 163 program was never fully funded, and no one was happy with the allocation of the treatment slots. San Mateo County Child and Family Services (child welfare) supported the change in the FSP model and is providing some funding, since 30 of the 80 FSPs are targeted for their families. The FSPs are designed to have a one-to-eight staffing ratio and provide all-inclusive services, including housing,

supported education and flexible funds. TAY consumers will be part of the program for the first time.

Madera: "We had free-spirited discussions about whether [SB 163] is a model, a philosophy, or a process – we are taking the position that it is a philosophy – not billing under SB 163 is the only real difference – we feel the service model has fidelity to the actual model."

Three of the counties started new FSPs unrelated to their existing SB 163 programs.

Three counties decided to implement new programs with their FSP funding:

- Los Angeles' new child and family FSPs use a conceptual model that is similar to their SB 163 program. The new FSPs are easier to access than the SB 163 program, will target a younger age group, and will focus more on families with children who have SED.
- As a result of a very early 1994 Substance Abuse & Mental Health Services Administration (SAMHSA) System of Care grant and in conjunction with its social services department, Stanislaus County has developed flexible wraparound services, including the availability of flexible funds for all children with SED and their families, not just families with child welfare involvement. They believe this is a good workable model which differs in only minor ways from the SB 163 model. They designed new FSPs which will be for high-risk SED youth on formal or informal probation with Juvenile Justice. The target youth are primarily ages 13 through 19 who have not responded to other mental health services. The county continues to track developments with the SB 163 model to ensure that its FSPs are providing all needed services.
- Riverside County has selected two Evidence-Based Practices (EBPs) as the cornerstone services for its FSPs: Multidimensional Family Therapy and Multidimensional Treatment Foster Care. Priority populations are court wards and dependents, and those at risk of out-of-home placements.

Los Angeles is the only county that has FSP targets by ethnicity, initial priority population by region, and percentage uninsured.

While other counties identified ethnic populations as part of their priority FSP groups, it was not always clear how those ethnic populations will be engaged, enrolled, or how success in enrollment would be tracked. Los Angeles established firm numerical expectations to ensure the clients served match its targeted estimates by ethnicity, initial priority population, and percentage of uninsured consumers. This task is startlingly complicated, since it must be applied to 31 contract providers and 13 county-operated programs. Each region is tracking the number of consumers assigned to each of these providers in relationship to these three targeted categories. Navigators within each region authorize FSPs for both county and contract providers. There is substantial concern about what will happen when a provider and/or region reaches its maximum capacity for an ethnic group or an initial population, but has not reached overall FSP capacity. The county has not yet had to deal with turning an otherwise eligible client away because the FSPs in that region have filled their target number for a particular category.

Counties and contractors are experiencing challenges with FSP implementation.

Challenges that were noted by interviewees include learning to work within a team framework, having to maintain a focus on engagement while also providing services to already active clients and how to use flexible funds effectively. San Mateo found that even an experienced contract provider has taken longer

Stanislaus: "There are significant training issues for people who go to work in FSPs. Traditional outpatient clinics do not prepare people, for example, for team building issues. We are using two experienced teams to mentor our new teams. We are really talking about team development and leadership. If you do not have that, it is a problem."

San Mateo: "A major challenge has been the amount of energy to get the FSPs off the ground and functioning, how to help the contractors with their organizational capacity. We are focused on very, very ill people. It is slower and more staff-intensive than anticipated"

Los Angeles: "Most of the children/youth FSPs are contracted out and the contract agencies are having trouble hiring sufficient staff to implement their programs."

than anticipated to contact and engage adults and older adults.

The diversity in models, budgeting and initial priority populations will make the comparison of estimated average costs per FSP client difficult.

Reviewers of county plans reported (see State Report) that they were sometimes not sure whether the estimated average costs per FSP client were too high or too low. The diversity in models and accounting for all of the supporting costs (e.g., housing) makes the estimated average costs difficult to understand. It also appears that counties differed greatly in their assumptions about other revenues. Additionally, counties may well be serving consumers with different levels of disability. Below is the range of projected per-person costs for adult FSPs (from the original plans) for the five counties with generally comparable models:

- Los Angeles: $15,000 - $22,600
- Madera: $13,200
- Riverside: $13,300
- San Mateo:$24,400 - $28,100
- Stanislaus: $9,700 - $11,250

Learning From FSP Early Implementation

Counties that started with FSPs that provide intensive services to high-need populations are raising critical policy and practice questions.

County director: "People are targeting different populations. We have talked with lots of folks who are not targeting the people we are."

It is not surprising that most counties selected the AB 2034 model for adults, older adults, and older TAY and "Wrap Around-Like" model for children and youth. These have been demonstrated as effective for high-need clients, and the state guidelines included the concepts that FSPs have low caseloads and provide "whatever it takes." But such an interpretation raises a series of questions and concerns:

- Can a dual system, in which a few clients get "Cadillac" services while others get very little or none be sustained with stakeholders?
- How can this model accommodate the fact that clients needs and desires for services vary over time (levels of service issues)?
- Should there be exit criteria for FSPs, and if so, what should they be and what happens for clients if there are exit criteria, i.e., where do they go and who is there to help them if they need it?

Early implementation has resulted in the broader need to clarify the concept and definition of FSPs.

As the counties that selected a high-intensive service model develop policies to deal with the above issues, the diversity in their service models will increase. Added to this is the already existing diversity from counties that are starting with a more flexible FSP model. This is particularly noteworthy in counties that are using time-limited evidence-based specific clinical interventions for children and youth for their FSPs and other types of services that are of limited duration. This flexibility in the first attempt may have been inevitable and may produce some useful learning, but given the centrality of the FSP concept to CSS, it is critical that these issues be clarified soon.

Clarifying FSP definitions is critical to being able to demonstrate positive outcomes.

At this point, FSPs are the only sources for collecting and analyzing individual client outcome information. The ability to show positive outcomes from AB 2034 rested on a relatively consistent eligibility for clients and an explicit program model. Showing positive outcomes at the client level becomes far more complex and problematic as the kinds of clients and the kinds of programs multiply. This does not imply that evaluation needs should drive program design, but only that greater clarity in definitions makes the evaluation task less difficult.

PART FOUR: SELECTED PROGRAM FOCUS AREAS

As noted at the beginning of this report, this study is not undertaking a comprehensive review of all programs being implemented under CSS. Instead, four major programs were selected as focus areas due to their emphasis in the MHSA and the fact that specific initiatives in these areas were included in most of our study counties' CSS plans.

Ethnic-Oriented Initiatives

According to the 2001 supplement to the Surgeon General's Report, ethnic populations experience greater disparities in mental health services received than Caucasian Americans; those disparities include access to services, utilization, quality of care and mental health research. Research studies indicate a greater success in acceptance, engagement, retention, stigma reduction and treatment outcomes when mental health services are provided in a culturally competent and linguistic environment that is easily accessible to ethnic populations.

Reducing ethnic disparities has been a central goal of state and local CSS efforts.

The state planning guidelines were explicit in articulating this goal of requiring extensive analysis of such disparities within each county and requiring the county to indicate the specific ways in which their CSS plans would address outstanding disparities. Data about prevalence and service usage by ethnicity provided by the state combined with the analyses the counties undertook locally have highlighted local disparities and provided counties with a great deal of information which will be helpful in addressing this issue. As implementation progresses, the study will examine programs which are successful in reaching ethnic communities and engaging persons who suffer from mental illness in culturally appropriate services.

The planning section of this report reviews the outreach efforts made by counties to engage underserved ethnic communities in their planning processes. The effort was more extensive than any prior one, but all acknowledged that much work remained to be done.

This part of the report documents the efforts made by each of the study counties to address ethnic disparities. It is not always clear how much of any initiative began with CSS as opposed to being energized or augmented by CSS. Initiatives are included that were determined to be a result of CSS even if work was already underway. Not included are generalized activities, such as the hiring of bilingual staff or general cultural competence training, unless these efforts were specifically targeted with CSS funds as a major new or expanded activity.

All seven study counties are implementing a series of strategies to address ethnic disparities.

Table 8 indicates the range of such strategies across the counties. It will be critical to track the success of these strategies over time in ensuring greater access to unserved/underserved ethnic groups.

El Dorado

El Dorado County has undertaken a specific Latino Engagement Initiative

The mission of the Latino Engagement Initiative is to address isolation in the Latino adult population and peer and family problems in the Latino youth population by developing services designed to engage Latino families and provide greater access to culturally competent mental health services.

The county has developed contracts with two community-based organizations to implement this initiative.

The county has contracted with the Family Resource Center (FRC) in South Lake Tahoe to augment its bilingual bicultural staff and provide individual and group services for 60 persons, including undocumented individuals. The second contract is with Family Connections in the Western Slope using a promotora model to provide peer education, outreach and engagement services, as well as additional funds to contract for bilingual bicultural counseling services. Community health workers (promotoras) typically live in the communities that they serve, and their expertise is often based in knowing the communities where they live. The FRC in South Lake Tahoe has been quite successful in hiring bilingual bicultural staff and engaging clients and families. In contrast, the FRC in the Western Slope is struggling with its bilingual/bicultural counselor recruitment. The factors making the difference between the two are (1) The FRC in South Lake Tahoe has a specific Latino focus and was already well connected to the community, while the

TABLE 8. ETHNIC-ORIENTED STRATEGIES

	El Dorado	*LA*	*Madera*	*Monterey*	*Riverside*	*San Mateo*	*Stanislaus*
Contract with community organizations to provide mental health services	X			X			X
Enhanced training on ethnic issues	X			X		X	
Strengthened CC structure, management, or responsibilities	X	X		X	X	X	
Target FSPs to ethnic communities		X	X				X
Develop specific community-wide plan						X	X
Open mental health services to a broader population on a pilot basis				X		X	
School-based services				X		X	
Hiring of bilingual and bicultural staff	X	X	X	X	X	X	X
Add outreach workers and clinical staff to specifically develop service component for underserved communities		X	X		X	X	

FRC in the Western Slope serves a more generic population, and (2) the FRC in South Lake Tahoe is located in the heart of the Latino residential community and has a larger population of Latinos to draw from, while Latino residents in the Western Slope are more geographically scattered and isolated.

Despite the recruitment difficulties in the Western Slope, the county anticipates a greater need than can be met with either existing contract and so is requesting expansion money to augment both agencies.

Efforts continue to develop better relationships with the Native-American community.

The lack of good data about the demographics and prevalence of mental illness within the Native-American community inhibited planning efforts. Prior to MHSA, the Native-American community reportedly avoided county mental health services, finding them insensitive to their world views and not helpful. As noted in the Planning Section, efforts to engage the community were largely unsuccessful. At the time of the first site visit, the county had a Native-American representative on its MHSA Advisory Committee and reported that it had recently had some productive meetings with the tribal leadership. Native American Partnership Training is planned in Placerville to address improved collaboration, increased understanding, and ideas for moving forward to establish an effective mental health system of care for the Native-American population.

Los Angeles

Los Angeles made a major commitment to reducing disparities by creating specific ethnic enrollment targets by service areas for its FSPs.

Using information from ethnic population-based data, Los Angeles established specific expectations for clients in its FSPs by geographical service areas for each ethnic group. Targets also were established for priority populations, based on community need or type of problem.

The biggest challenge to date in implementing this approach has been attaining the expected levels for Latino clients. For example, two initial priority populations for adult FSPs are persons in, entering or leaving the jails, and individuals coming out of institutions. These populations tend to be disproportionately non-Latino. The county did not sufficiently consider the interplay of referral source and ethnicity when it set its targets. The county is finding that Latino families tend to support their loved ones in their homes as long as possible. To achieve ethnicity goals, the county will have to reach out to Latino families with potential clients living at home in addition to more outreach within the jails and institutions.

The FSPs are not yet close to their maximum enrollments, so the county has not had to face the issue of potentially turning away clients who would otherwise qualify except for their ethnicity. Turning qualified persons away is unlikely to occur for ethical and political reasons.

A Service Area Navigator Initiative and Outreach and Engagement Teams are designed to address ethnic disparities and enhance access to the mental health system.

Each service area has an Outreach and Engagement Team, as well as four county-operated Service Area Navigation Teams, with an age-based focus. The navigation team model generally consists of a Service Area Navigator (SAN), a case manager and a consumer or family member advocate. The composition of the team may vary slightly, based upon the needs of the age group and the region. The purpose of the SANs is to link new potential clients to the appropriate service in the region. One of the early functions of the navigators has been to find, engage and preauthorize persons that meet priority and ethnic criteria for the FSPs. The original plan also called for the navigators to build community resources in addition to linking individual persons to services, Most of the activity in this area to date has been in the TAY teams.

One county person describes the SANs, "Like a concierge – a super case worker. To make contacts, to learn to expedite a path to services. Never say no. Major service is linkage and outreach."

The activities of the Outreach and Engagement teams are designed to establish and strengthen relationships with local community organizations and leaders. The goals are to increase awareness about mental health and mental health services, reduce stigma and obtain their ongoing input into the MHSA planning process. Efforts are directed at underserved ethnic communities through outreach activities with schools, the faith-based community and community events like fairs and forums. A Homeless Outreach and Engagement Team was created for the skid row area and a late edition to their plan was a second team to serve individuals throughout the county.

Los Angeles had originally planned a large-scale outreach effort using one-time funds. Curtailments in clinic services resulting from budget cuts led to a decision to forgo such an initiative at this point in time for fear that the system would not be able to accommodate the additional client volume that might be generated.

The county created a new committee to oversee the MHSA efforts, directed at underrepresented ethnic populations.

While LA County Mental Health recognizes the importance of considering ethnic representation in all of its planning committees, the county decided to increase the salience of the issues through a separate workgroup. An Under-Represented Ethnic Population (UREP) workgroup was created to attend specifically to these issues. The workgroup had a significant impact on the original plan and is being reconstituted to have an ongoing role in the monitoring of the ethnic-related aspects of the plan as it is implemented.

Madera

The major initiative in Madera County is the creation of an active outreach effort supported by new clinical staff to serve the additional clients.

The county initially created these as two separate functions: outreach workers who would work in underserved communities to identify persons needing services and an expansion of program staff who would serve those identified. As the program was implemented difficulties arose in recruiting for the former positions because new graduates who might normally want these jobs were discouraged from applying, since the position does not entail clinical treatment hours that count toward licensing.

The expansion clinical staff provide services in ways that are more accessible and acceptable to clients, i.e., doing most of their work outside the office. The expectation is that caseloads will be small and that there will be about 15 to 20 contact hours per week, allowing for this non-traditional model of service. Two of the three staff are bilingual, although the effort is broader than ethnic communities, i.e., including a component for older adults.

A bilingual bicultural psychiatrist is enthusiastically engaged as part of the expansion program. She appears to be combining the outreach and clinical functions going to sites "where people are naturally – churches, community meetings, health clinics." She is doing a Spanish-speaking group for single mothers at Healthy Beginnings, which provides support and also case finding. The ideas for outreach currently exceed the capacity of the outreach workers to implement them.

The structure of this effort is still under development. It appears as if it might be better structured to combine the outreach and the service provision activities so there would not have to be a "hand off" of potential clients who are identified. They are struggling with finding the best ways to track outreach encounters and check on whether referrals are completed.

Madera included Latinos as one of the priority populations for its FSPs.

Planning information revealed that while Latinos were an underserved group in the mental health system, they were over represented in the criminal justice system. As a result, a priority population for the adult FSPs is Latinos with criminal justice exposure. The county is undertaking special meetings with the police and jails to ensure that persons who might be appropriate for FSPs are referred, as opposed to automatically being taken to jail.

Monterey

Monterey is developing a new relationship with the local NAACP.

Prior to the MHSA, the local NAACP had become involved in counseling services because of a unique set of circumstances. Emotional and behavioral problems that would become apparent in the course of the NAACP's work with families on other legal-related issues were addressed through informal counseling services offered by a social worker who had worked in the county mental health system. The services were not reimbursed nor recorded anywhere. In recent years, the organization decided to pursue becoming a social service agency as well as a legal one. This desire arose from a feeling that other organizations to whom they referred their clients were not serving them well.

With CSS funding, the county is developing a contract with the organization to provide mental health services. The program will have two full-time counselors and two staff members to do outreach, engagement and training in the community. The strategy is based on the belief that adults and families will accept services from the NAACP which they would not seek out from the mental health system because of stigma and the lack of comfort with traditional mental health services. The contracting process is complicated and requires the county to adjust some of its usual requirements, for example, with insurance issues. Medi-Cal certification also has been problematic. The result is that a contract for training, outreach and engagement has been finalized while the contract for direct service provision is still not finalized after two years of efforts.

The primary Latino outreach strategy is to contract with two community organizations.

The county awarded two organizations a joint contract to provide mental health services. One organization works on housing issues with farm workers and the other on citizenship issues. The former organization provides health services and will pay special attention to the way in which counseling services are offered to avoid stigma associated with mental illness. Issues will be addressed using more neutral language, such as terms like "stress" and "grief" and will link services with general health care issues, such as care for high blood pressure. Training will be provided from the Natividad Medical Center's family practice program.

The Central Coast Citizenship Project has added staff who are directing their effort towards recruiting and training promotores. Outreach activities began in January 2007, and training has been provided to the Promotores de Salud. An additional strategy is the contracting for parent education classes in English and Spanish to be provided in a variety of settings, including adult education, Healthy Start and school districts.

Efforts directed at the Asian-Pacific Islander and the Native-American communities are in a more exploratory stage.

The county has initiated contacts with various Asian cultures, including Filipinos and Koreans through a number of organizations such as churches, service agencies and community leaders. The lack of a unifying entity has made the effort more difficult. An RFP focused on the provision of mental health services to Asian adults and families did not result in any proposals. The county is providing technical assistance for capacity building to find an organization that will be able to provide services.

There are no formal tribes of Native Americans in the county, so outreach efforts have been limited.

Monterey is struggling with the broader issue of how to make its own services more culturally competent.

The general approach used by the county to deal with ethnic disparity issues has been to contract for services in the underserved communities to overcome stigma, to make persons more comfortable, and to ensure more culturally sensitive and appropriate services. The county also wants to improve its directly operated services – something that the ethnic communities would appreciate but apparently have little hope will actually occur. County leadership reported discouragement at not being able to hire sufficient bilingual bicultural staff. They also note the failure of their training efforts to make a marked difference.

The county is undertaking a reexamination of its cultural competence efforts. The county has contracted with the California Institute for Mental Health (CiMH) to do an assessment of its cultural competence and make recommendations. One result to date has been to create a more active cultural competence committee.

Riverside

The county's main strategy to reduce ethnic disparities is to hire an outreach coordinator to work with the management team.

The major tasks for the person in this position are to work with the management team to reduce cultural barriers and work with community groups to develop specific outreach plans. As of May 2007, the county was still recruiting for this position, having gone through one unsuccessful hiring attempt. In an effort to move forward while recruiting, individuals in each region have been identified to provide outreach activities, but the failure to fill this position seriously delayed the implementation of the county's outreach and engagement efforts to reduce ethnic disparities and reach out to underserved communities.

The county has opened a satellite clinic in the southeastern part of the county in which a large Latino population lives.

Because transportation and poverty issues make it difficult for this population to access services in Indio, a two-day-a-week clinic has been opened in the city of Mecca. Again, it is apparent that more effective outreach is necessary if mental health is to successfully engage with this community, as service utilization has been very limited.

San Mateo

San Mateo has instituted a major effort to partner with the ethnic communities in East Palo Alto.

The foundation for a new partnership between Mental Health and the East Palo Alto community began during the CSS planning. The relationships established with One EPA – a network of more than 50 organizations in East Palo Alto representing local leadership interested in community development – during the planning process continued with a series of regular meetings and a contract with One EPA. The contract will be carried out by three organizations with experience providing services to ethnically diverse populations in the community. The purposes of this one-time, two-year contract are to develop and support an advisory group, which will design a plan to improve access to services, reduce the stigma of seeking services and provide technical assistance to mental health staff to improve the acceptability of their services to the community.

Another part of the East Palo Alto strategy is a pilot program to open access through a same-day walk-in service. A longer-range goal for East Palo Alto is the development of a multicultural wellness center. A multi-ethnic group of consumers, family members and community leaders is meeting to plan outreach strategies to obtain input on what the center should be and where it should be located.

Efforts are underway to institute an outreach effort to the Filipino community in the northern part of the county.

Daly City has had a resource center for the past 15 years but it provides services only to persons who meet the criteria for serious emotional disturbance or serious mental illness (SED/SMI). The center is lacking Filipino bilingual and bicultural clinical staff, and efforts to engage the Filipino community in the planning process initially yielded mostly input from providers rather than families or consumers and identified stigma about mental health as a major obstacle to the use of services. Ongoing dialogue resulted in a contract with a local community-based organization[3] for outreach, to learn about the community and its resources, and to develop a plan to grow the capacity of the community to provide mental health services.

San Mateo utilized a private contractor to increase its success in hiring bilingual bicultural staff.

Special outreach activities were conducted by the private contractor including in-person outreach sessions. The county developed special language-specific hiring lists for clinical and community worker positions. Of 42 new county positions, 27 were filled by bilingual staff from different ethnic groups, including individuals of Chinese, Latino, African-American and Filipino ethnicity.

San Mateo County also added additional staff to support its ethnic initiatives

The county used MHSA funding to create a mental health/health disparities initiative manager, a full-time position to provide management-level support to the county's cultural efforts. In addition, San Mateo funded a full-time community program specialist to create a specialized focus on critically underserved Pacific-Islander communities and engaged in focused planning with this group, including holding a seminar that involved the United Nations Ambassador from Samoa as a keynote speaker.

[3] The contract had to be subsequently amended to remove some of the specific references to the Filipino population to avoid legal anti-discrimination concerns.

Stanislaus

Stanislaus' major initiative is to build the capacity of ethnic community organizations to provide mental health services.

The county issued an RFP to which five of 14 community organizations that attended the bidder's conference responded with proposals. Two contractors were selected. Prior to issuing the RFP, a major outreach effort solicited information about potential organizations that had not previously had relationships with mental health. The expectation is that the capacity building will result in these organizations being able to provide services by year three.

One contract agency, El Concilio, is a certified Medi-Cal health clinic based in San Joaquin County with a 3-year-old satellite clinic in Modesto. The clinic plays a community role through holding community meetings and forums and hosting monthly Latino coalition meetings. El Concilio held four focus groups about mental health needs as part of the planning process in response to a specific request from the county mental health program. The clinic also hosted a visit to Modesto by Assemblyman Steinberg. The information gathered about specific problems and difficulties for farm workers and working and middle class Latinos in accessing mental health services were useful to the development of the underserved ethnic strategies. El Concilio will hire a quarter-time clinician and one outreach worker and hopes to have the capability to serve clients with serious mental illness.

The other contract agency is West Modesto King Kennedy Neighborhood Collaborative. The program is designed to be jointly funded by CSS and United Way. The contract calls for the clinic to conduct a needs assessment to guide the development of a service model. Three neighborhood outreach workers will be hired – one African American, one Asian and one Latino. West Modesto was selected as a site because issues around the need for mental health services have arisen in community forums and needs assessments in the area for a number of years. Preliminary needs assessment information suggests that stigma is the number one barrier to services,

followed by a lack of information about available services.

Another strategy is to establish targets for all its MHSA programs to serve clients from underserved ethnic communities. All of the FSPs have contract requirements that at least 50 percent of the new clients be from underserved ethnic communities. Targets also have been set for other new programs funded with system development dollars.

Learning From Ethnic-Oriented Initiatives

Several counties are placing their greatest emphasis on creating capacity within community-based organizations in ethnic communities to provide mental health services.

Four counties (Monterey, El Dorado, Stanislaus, San Mateo) heard a very clear message from their ethnic and cultural communities that despite the best efforts of the traditional mental health system, the county programs would not be able to overcome the stigma, distrust and lack of understanding of the culture necessary to serve the community appropriately. In response, the counties are attempting to build the capacity of local community-based organizations – some of which have never provided mental health services – to respond to the mental health needs of their communities. Contracts have been signed with health clinics, family resource centers, human services organizations, and advocacy organizations. This is a long-term challenging and a promising strategy that requires the establishment of a partnership between mental health and the community-based organizations. It also requires the county to adapt some of its usual contracting mechanisms to accommodate the structure and size of the community-based agencies. An unresolved issue is whether or not services provided in these agencies can or should be certified for Medi-Cal reimbursement. Initial efforts prove to be challenging, and providing services in non-traditional settings may be hindered by strict Medi-Cal regulations.

Some counties also are implementing a more traditional strategy of strengthening the accessibility and capacity of the traditional mental health system to serve these communities.

Three different approaches have been used by the study counties.

- Los Angeles has added staff (Service Area Navigators and Outreach and Engagement Teams) in each of its service areas to specifically conduct outreach to persons in underserved communities and then provide them with an easy linkage into the mental health system.
- Madera has added both an outreach component and specific clinical staff to work with the individuals so identified.
- San Mateo and Monterey counties are piloting more decentralized access and providing more responsive front line receptivity to persons from underserved communities who seek services.

All of these efforts are based on trying to make the public mental health system more accessible and responsive to the needs of ethnic communities. Challenges to these strategies include the ability to hire sufficient bilingual bicultural staff, the limitations of training in creating a culturally competent staff, capacity constraints which may impede the ability to encourage additional access, and the distrust of the public system existing within ethnic communities.

Setting targets for ethnically diverse clients in programs demonstrates commitment but will only work if linked to aggressive outreach and engagement.

The experience of Los Angeles has been very useful in demonstrating both the benefits and challenges of making a serious commitment to addressing ethnic disparities by establishing priority populations for its FSPs by service area. Such an action has clearly highlighted how seriously county mental health and the whole stakeholder process take this goal. But unless the underlying issues that create the disparities are addressed through culturally competent outreach and practices, the goals will not be met.

Any ethnic-oriented strategy requires a strong and effective management structure.

The study found different management structures and differing degrees of expertise and experience in persons directing the ethnically-oriented initiatives. While there is consensus that consideration of outreach to ethnic communities should be part of every program, almost all feel that a separate focus on ethnic initiatives is warranted at this point in time. The structure and strength of that special focus is likely to make a difference in its success. The CSS

planning process led to the creation of new and potentially stronger management to plan and oversee the implementation of ethnically-oriented strategies. Assessing the effectiveness of these efforts over time can make an important contribution.

Forensic Initiatives

Uncertainty and limitations on the use of funds complicated the design of forensic initiatives.

Integrated services with law enforcement, probation and the courts was one of the strategies identified in the CSS Plan and Expenditure Requirements. Two limitations on these services shaped some of the forensic initiatives and also caused some concern and a great deal of discussion at the local community level. The first of these was that services provided in jails and juvenile halls had to be for the purpose of facilitating discharge. The second, which was more politically charged, was that in collaborative programs, for positions with blended functions, only the proportion of costs associated with the mental health activities are allowable. This became an important issue for law enforcement staff who were hoping to get some funding for court, probation and other law enforcement personnel working with mental health clients. In the end, the distinction of how much of law enforcement's activities were mental health in nature (and therefore could be funded under CSS) was based upon the counties' individual descriptions of their programs.

Six of the seven counties are implementing some forensic initiatives.

Virtually all of the study counties had some prior generally positive experience in joint programming with law enforcement, probation and the courts through recent Mentally Ill Offender Crime Reduction (MIOCR) grants. Some managed to continue at least some of these existing programs while others abandoned them when the MIOCR funding ended. The availability of new MIOCR funding at about the same time as the CSS planning added impetus to the reformulation of these partnerships.

Some of the initiatives started with CSS funds are being augmented by the receipt of newly funded MIOCR grants. Of the seven study counties, two received mentally ill juvenile offender and six received adult mentally ill offender grants. In at least three of the counties, the new grants will augment initiatives begun with CSS funding.

El Dorado

A Mental Health Court with supporting services was created in South Lake Tahoe with CCS funds.

The idea for the Mental Health Court was formulated and supported by a planning group, which included all the relevant participants including the sheriff's department, the presiding judge, the probation department, the district attorney, and the public defender. The National Alliance on Mental Illness (NAMI) also played an active role and provides outreach and family education and support regarding the program.

The court started in April of 2006 and was near capacity from the start. The program integrates the judicial, law enforcement, probation and mental health treatment systems in providing intensive case management for mental health clients. Mental Health is contributing one and one-half positions (one for adults and a half-time position for TAY). The population served is clients with a serious mental illness who have been charged with a criminal offense and are at risk of re-offending due to untreated or under-treated mental illness. A number of the clients have a history of incarceration, homelessness and substance abuse. It is generally a population that has not sought nor accepted services.

Clients experience either positive or negative consequences, depending on their adherence to the court's requirements. One of the reasons the program is popular with clients is because there is some transitional housing associated with it. A challenge has been staying consistent with the model and keeping it focused on priority populations. Program staff members have learned to take a longer time to do evaluations to ensure that persons are appropriate for the program.

"(The program) has given clients hope. For a number, this is the first time in years that they have done this well. No longer have the stigma – now they have hope."

"[Clients] get credit and acknowledgement in court for their accomplishments. The judge will often ask people directly how they are doing. Very dynamic, very unusual court session – close to the old classic drug court model."

The program will be expanded with the receipt of a MIOCR grant, which will add more positions including a program coordinator, a mental health clinician, a job developer and additional transitional housing resources.

Los Angeles

Prior to CSS implementation, the county was providing a range of mental health services for the courts and jails.

The Los Angeles courts and jails serve an enormous number of persons with mental health problems. Interviewees estimated roughly 1,200 to 3,000 persons are in the jails at any one time who have mental health problems, with hundreds of new persons being booked every day. County Mental Health has more than 200 staff members assigned to the jails, including 15 psychiatrists, and the jail has a 50-bed inpatient unit. All new entrants are briefly screened; those with the most acute illness or the most serious behavioral problems receive attention first. Waits for medications can sometimes be excessively long. Jail representatives indicated that recent efforts by County Mental Health have enhanced the quantity and quality of the jail mental health staff.

Social workers and psychologists are located in 26 of the county's 50 courthouses. They work on alternative sentencing; for example, they work with potential incompetent to stand trial misdemeanants to keep them from going to Patton State Hospital.

The county had two MIOCR programs – an Assertive Community Treatment (ACT) team with probation officers for men and a "For Moms" team for women. The programs were disbanded when funding ceased.

Various law enforcement and court constituencies attended planning meetings.

Representatives from the sheriff's department attended planning meetings but felt like they were being perceived "as the enemy" and that their ideas were being pushed aside. A strategy of inviting other stakeholders to the jails to see what they were doing was successful in increasing understanding and gaining advocates.

NAMI advocated for a Mental Health Court and a jail linkage program. A visit was arranged to the court in Orange County by the public defender who is a vocal advocate for such a court. Law enforcement and the Probation Department would support a Mental Health Court, but the judges in general were not strong advocates. Law enforcement was a stronger supporter of jail linkage services. When it came time to vote, the jail linkages effort was supported by NAMI with a commitment to consider establishing a Mental Health Court in the future.

Two Los Angeles MHSA linkage initiatives are designed to improve the linkage from incarceration to the community.

One program is focused on transition age youth (TAY) in probation camps. A multidisciplinary team of clinicians, probation officers, parents and peer advocates will work with TAY in probation camps. The purpose is to assist in the transition of such youth back into the community, including providing linkage as necessary to FSPs or other mental health services.

The other program is for adults in jail to ensure appropriate follow-up on discharge[4]. A linkage and engagement team of eight social workers with one in each region will identify persons still in jail who might qualify for an FSP with the authority to pre-qualify them and then ensure that referrals to an FSP are completed. Those who don't qualify for an FSP will be linked to Service Area Navigators to assist in linkage to appropriate mental health services. An estimated 77 persons who could benefit from this service are discharged from the jail each week. An ancillary part of the service will be four rehabilitation counselors who will work with WorkSource Centers to ensure that anyone wanting employment when they leave jail will be appropriately linked to this resource.

Implementation challenges included finding and appropriately outfitting (telephones, computers) space in the jails for the new mental health linkage staff. The women's jail in particular is expressing concern about lack of space and the additional responsibilities the program places on their deputies, such as escorting inmates to meetings with the linkage staff.

Madera

The primary forensic initiative in Madera is the choice of the jail population as one of the priority populations for adult FSPs.

[4] This is not a discharge planning responsibility which already exists and is responsible for ensuring housing on discharge.

The Madera County Department of Corrections was well represented at the CSS planning meetings and advocated for some assistance in dealing with mental health problems in the jails. The chief reported that 72 of the 300 inmates were on psychotropic medications. A result of this advocacy was a focus on adults with jail involvement as one of the priority populations for the 20-person adult FSP. The program site for the FSP team was specifically chosen to be close to the jail. This program has since been augmented by the addition of capacity for 20 more clients, funded by a new MIOCR grant.

The county considered using CSS funding for the jails and juvenile hall, but in the end both mental health and probation went with a plan to have the county contract with a private provider using non-mental health funds to provide services in both facilities. Mental Health staff members are working on collaborating with these workers as adults and youth come out of institutions. Those interviewed said they found this arrangement the most cost effective and the best way to leverage funds.

Monterey

Overcoming a history of strained relationships to establish a plan was a significant accomplishment.

In the 1990s, law enforcement and mental health agencies had divergent views of responsibility for persons with mental illness who were in jails, with both sides feeling as if the other was not fulfilling basic responsibilities. As a result of some very serious law enforcement incidents with persons with mental illness, a partnership developed a crisis intervention training program for law enforcement officers, which was conducted by county mental health staff. This collaborative work led to a MIOCR grant in 2000. When MHSA planning began, law enforcement participated in the community meetings and suggested things that would assist them in dealing with persons with mental illness – crisis workers to respond to incidents, more training for first responders, and a social worker at the jail to make linkages and connections.

Law enforcement officials were angered to learn that MHSA funds would not be used for law enforcement costs, only for mental health costs associated with forensic programs. This issue became another strain on working relationships. Law enforcement officials pressed the issue at the state level, which ultimately resulted in a letter from the Attorney General supporting the State Department of Mental Health's position on limiting funding to mental health costs only. Feelings from this struggle still present a challenge to implementation of MHSA forensic and MIOCR programs.

The major activity in Monterey is an expansion of the adult Mental Health Court and a new juvenile Mental Health Court made possible by MIOCR grants which will use matching CSS funds.

As previously stated, the county had a MIOCR grant in 2000, which included establishment of a Mental Health Court. Supportive services for the court were severely restricted after the grant ended. Funds were allocated in CSS for support services for a Juvenile Mental Health Court and to expand service capacity to the adult Mental Health Court. This CSS funding as well as additional in-kind support were used as a matching commitment for MIOCR applications for Mental Health Courts which were both subsequently funded. These programs are under the direction of the Probation Department for the juvenile grant and the Sheriff's Department for the adult grant. Programmatic and administrative details are being worked out for both programs. One of the major challenges has been role definitions for mental health and justice personnel.

An additional activity is an expansion of first-responder trainings for law enforcement from twice to four times a year.

Riverside

A pre-existing work group was augmented and energized by the CSS planning process.

Prior working relationships had been formed through a limited Mental Health Court program begun in 2000, and followed by a two-year SAMHSA grant. The program allowed for a broad range of supportive services, including two mental health staff at the courts, five to ten staff providing specialized treatment, and a structured day program. After the SAMHSA grant ended, the program was reduced to a single staff person who tried to ensure connections to outpatient treatment.

The existing group of collaborative partners formed the Criminal Justice Committee to participate in the CSS planning process. Meetings were held at noon near the courthouse to encourage active

participation with resulting attendance averaging 20 to 30 participants per meeting.

"[Our] perspectives were different but our goals matched."

The top priority was the reestablishment of components of the program that supported the Mental Health Court.

The program has added a specialized staff person in each of three regions to act as a liaison. They initiate contact with clients while they are in jail and provide specialized assessment, linkages and follow-up case management as part of the Mental Health Court. Case managers connect clients to appropriate outpatient services, including actually meeting clients at jail discharge and driving them to a first appointment. Efforts are being made to link data systems so that existing linkages to mental health programs can be determined.

The second adult forensic initiative is the addition of follow-up services for individuals with serious mental illness who are coming out of the jails.

The county has hired staff in all regions to work with people coming out of the jail. Implementation has been delayed by lengthy security clearances, which are necessary for working in the jail. Another challenge in this program is the lack of resources for co-occurring disorders and the high need for these services with this population.

For children, youth and TAY, CSS dollars have funded clinicians in each of their three juvenile Mental Health Courts and probation liaisons with three of the juvenile halls.

The Juvenile Court liaison staff consult with judges and attorneys and provide linkages for minors and their families. The probation liaisons will work in the Mid-County, Western and Desert Regions. Their function is to assist youth on probation or leaving juvenile detention facilities and to facilitate their getting appropriate services within the regions. As with adult programs, hiring has been slow, due in part to security clearances.

San Mateo

Law enforcement, the court, and probation department staff members were actively involved in the planning process and the design of the Pathways program.

The county had prior good working relationships stemming from a MIOCR grant, which was funded for three years. The presiding and assistant presiding judges chaired a series of workgroup meetings which included probation department staff members, the district attorney, public defender, sheriff and correctional health staff in addition to mental health. The result was Pathways – a Mental Health Court and post adjudication program – staffed by a clinician, a parent partner and a consumer liaison. The county contributed general fund dollars to fund deputy probation officers who are part of the program. The initiative is designed to ensure linkage to appropriate mental health services as well as to provide a full range of services to selected clients.

The program has been successfully implemented and is providing services, but enrollment in the program through the official court system is slow. Clients want the services but are not eager to accept a required yearlong commitment.

The county received a MIOCR grant for a Pathways program for women but implementation of that has also been slow.

Law Enforcement: "[Planning was] very collaborative – great outreach – overwhelming job."

The county also has a strong history of other collaborative efforts with local law enforcement.

Prior to the MHSA, mental health had an active Community Intervention Team (CIT) program that provides a 40-hour training two to three times a year for up to 40 law enforcement officers. CSS expansion funding is being used to expand this effort even further.

Stanislaus

Law enforcement and the courts were well represented during the planning process.

There was successful engagement of the forensic constituencies in the planning process. Interviewees noted how the planning experience was extremely useful for the court and sheriff's department personnel who do not usually engage with consumers on equal footing.

With participation comes expectations, not all of which could be met. Participants were disappointed that a Mental Health Court was not part of the plan. While it was a high priority in the planning process, the court could not commit to funding its portion of the program. The planning effort led to the submission of a MIOCR proposal for this purpose, which was subsequently funded.

Mental Health: "It was enlightening for the judge who never saw consumers before who weren't in her court."

Law Enforcement: "(it was an) opportunity for all of us to hear from people face-to-face …just listening to someone else's perspective of how they see us."

FSPs for adults and juveniles with law enforcement involvement are the major Stanislaus forensic initiatives.

An integrated forensic FSP to serve TAY, adults and older adults was established, based on a prior MIOCR grant program that used an ACT model. The program can serve 40 clients, with 10 reserved for drug court clients. Staffing consists of two clinicians, two behavioral specialists, a peer recovery specialist, and one probation officer supplemented by a nurse for four hours a month and a psychiatrist for four hours a week. The program focuses on co-occurring mental health and substance abuse issues with staff being trained on the SAMHSA Integrated Dual Diagnosis Treatment (IDDT) model. Cooperation with the sheriff has been good, with data matching to find people at booking who have had contact with Behavioral Health and Recovery Services Department (BHRS). About 35 percent of all bookings have had contact with BHRS.

The juvenile justice FSP will augment an existing collaborative team. All entrants to juvenile hall are already screened with referrals made to a team including clinicians, case managers and probation officers. The addition of the CSS funds will allow for FSPs for 25 youth, including 24-hour-a-day, seven-days-a-week coverage with low caseloads. The priority population will be youth ages 13 through 19 who have not responded well to traditional mental health services. Aggression Replacement Therapy (ART) will be the primary service model. Some of the details (lack of transportation and space) have made implementation difficult, but the program has found the availability of flexible funds to be extremely useful thus far. A follow-up call indicated that a number of youth have come off probation as a result of their involvement in this program.

Another initiative entails more joint crisis response with law enforcement.

A significant part of Stanislaus County's overall CSS plan is a redesign of the crisis and emergency services resulting from a community desire for more effective community based crisis response. A part of this effort has been to better coordinate with law enforcement personnel who face emergency mental health situations. In the Modesto area, CSS dollars are funding trained clinicians who are paired with police officers, working together in the field to respond to situations involving individuals with mental health issues in order to provide early intervention and prevent hospitalization.

Learning From Forensic Initiatives

The courts, law enforcement and probation department staff members have been active participants in CSS planning in all study counties.

Over time, forensic constituencies have become more involved with the mental health system so that most counties did not have to do too much outreach to engage them in the CSS planning process. Making meetings convenient (location and times) and focusing on just the forensic parts of the plan helped to maintain engagement. The participation of judges, particularly presiding judges, added weight to the deliberations. A number of interviewees cited this planning process as different to the extent that these stakeholders engaged in discussions for the first time with consumers who were on more equal footing – an exchange that both sides seemed to find productive.

The MIOCR program grants (both the earlier one and the recent one) have had a major impact on the design and impetus for CSS forensic programs.

Most of the study counties had received a prior MIOCR grant that had initiated positive discussions and collaboration between law enforcement and the mental health system about the opportunity for new programs. Much of the prior dialogue focused on problems (jails not getting enough support from mental health; police not knowing how to handle

mental health crises; judges dealing with recidivist misdemeanants with mental health problems). The collaborations formed with the MIOCR programs were generally positive, although the dismantling of most of the programs when funding ceased was painful. The opportunity for new MIOCR funding at about the same time as the CSS planning broadened the horizons of what the counties could plan for. MHSA funding was used as the required match for MIOCR grants in several of the counties, thus leveraging funds to enrich program services and capacities. The fact that law enforcement and mental health representatives both supported the re-creation of these programs and the fact that they had been successful in the past underscores the point that mental health and law enforcement know what works for these clients and that stable funding is critical to maintaining these programs.

Mental Health Courts were a major initiative in three of the study counties.

Two of the study counties – Monterey and Riverside – had prior experience with Mental Health Courts and were eager to restore models of supportive services, which they felt had been effective. The effort is new for El Dorado County, where they are extremely pleased with how the program is operating. The possibility of Mental Health Courts was discussed in all the other counties and had strong advocates in Los Angeles and Stanislaus but did not rise to the top of the priority list for CSS funding.

Another major type of initiative was enhancing the linkage with mental heath services for individuals involved with the criminal justice system.

The major effort in Los Angeles is the establishment of special jail linkage staff to engage and preauthorize jail inmates for participation in FSPs. A component will be added to the juvenile probation camps in Los Angeles to ease transition back to the community. The San Mateo Pathways program is designed to connect persons at any step in the legal process to appropriate mental health services.

Three counties have established forensic populations as a key priority for FSPs.

While those who are involved with criminal justice are a priority population for most of the counties, three have created a particular emphasis on this group. Los Angeles is making a particular effort to engage the jail staff to heighten linkages to its FSPs for Latino consumers (see Ethnic Initiatives for more discussion of this effort). The selection of this population in Madera came from advocacy from corrections staff, and the program will be augmented by a MIOCR grant. The Stanislaus effort is the most focused, since it includes probation staff as part of the FSP team.

Mental Health/Physical Health Initiatives

Four of the study counties had initiatives directed towards enhanced coordination between mental health and physical health services.

Integrated physical and mental health services, particularly collaborative efforts with primary care, were identified as potential strategies in the CSS plan requirements. This section highlights the intended plans in this area of four of the study counties and their initial efforts at implementation.

While many counties agree that integration with primary care clinics is desirable, operationalizing this integration is complex because of different cultures, ways of operating, methods of computing costs, reimbursement mechanisms and rules and regulations. This has generally been the slowest of the study's four specific topic areas to be implemented.

Monterey

The major Monterey initiative is to co-locate mental health staff at county primary care clinics.

The seven county-operated health care clinics are all Federally Qualified Health Centers (FQHC) and are under the authority of the Health Department, with strict direction to operate in a fiscally responsible fashion. They provide some basic mental health support and medications for clients with anxiety and depression which they bill as regular medical visits. The clinics have had a major complaint about the lack of access for their clients to the mental health care system, particularly for clients who are not on Medi-Cal. The clinic leadership was consulted yet not actively involved in the CSS planning process and so did not contribute to the design of the co-location model, which they now worry does not address their primary concern about access and also adds to their responsibilities.

County Mental Health Services hired a nurse practitioner with mental health expertise to work

in the health clinics. A memorandum of agreement provides that administrative control rests with the clinic, but responsibility for training, supervision and oversight is not clear. The clinics see an advantage if the mental health staff can help the primary care physicians manage the care of some of the persons with mental health issues, but they do not want to see an increase in the level of mental health acuity seen in the clinic, and they want the arrangement primarily to facilitate access to regular mental health services which their clients need. Space is also an issue; the clinics are not sure that the reimbursement they would receive for mental heath would cover the cost of the use of the room which they can currently recoup under FQHC cost-based billing. There is a commitment on the part of the leadership of the Health Department to make this work, so continued progress on working through all the implementation details is expected.

"A warm handoff is a nice idea but doesn't mean anything if [the client] can't get in [to the mental health services]."

Riverside

The initial plan was to co-locate mental health staff in primary care clinics to implement a model of care for older adults, but implementation has been slow.

The county's CSS plan calls for the implementation of the IMPACT model of collaborative care management of late life depression. The intervention was designed to take place in the county's primary care clinics, with mental health staff co-located in the clinics. This program is still in the planning stages. Data indicating that the clinics did not see as many older adults as originally thought has necessitated more study and in-depth planning. A consultant has been hired to work with the two departments around implementation strategies.

San Mateo

Prior to MHSA, San Mateo had an existing successful collaboration with county medical clinics and has expanded this work with CSS funding.

This collaboration has complementary co-locations, with mental health staff located in the health clinics and health professionals co-located in the mental health clinics.

San Mateo County inaugurated a mental health and primary care interface program in 1994, which currently funds through Mental Health a marriage and family therapist and a social worker at four county primary care clinics. They do triage, assessment, brief eight-week solution-focused interventions and referrals to mental health clinics and services for those with serious problems. About 70 percent of the cases are diagnosed with depression. They receive about 30 referrals a month, of which about one-third become open cases. There have been ongoing concerns about the lack of consistent and sufficient psychiatric coverage in support of primary care physicians who provide ongoing psychiatric medications and are able to obtain consultations only on a case-by-case basis from county mental health psychiatrists. Interviewees said that approaching mental health issues through the primary care system was particularly effective with Latino clients – their caseload tends to be over half monolingual Spanish speaking.

Two nurse practitioners who are paid for by primary care are located in three of the five regional mental health clinics. They provide medical services for those clients who have difficulty in using the regular health care system and fail to keep appointments with a primary care physician. Interviewees noted the difficulty of this work with staff working at about 60 percent of usual productivity standards. A strong ongoing integration with the "medical mother ship" was cited as critical to supporting people in these positions. An additional resource was an interdisciplinary team for older adults, consisting of two geriatricians, one psychologist and a part-time psychiatrist – all of whom are employees of primary care. This team meets with mental health service staff on individual cases on a weekly basis, does some joint case management with mental health, and triages clients with serious mental illness to mental health services.

CSS funds are planned to augment these already successful models.

CSS is funding a field-based team for older adults that provides brief mental health interventions with clients remaining under the basic care of a primary care physician. The team consists of two half-time clinicians, a nurse and a half-time psychiatrist. The service is being marketed to physicians through the

county's organized health care plan for Medi-Cal clients. The hiring of a gero-psychiatrist has been a challenge for the program.

The other CSS plan was to augment the mental health staffing in the primary care clinics with the addition of an adult and youth psychiatrist three days a week and two half-time youth clinicians – one with Spanish and the other Chinese language and cultural competencies. This plan has run into unexpected obstacles. One is the lack of space for the new staff. While the clinics requested the additional mental health staff, they have been unable to provide sufficient attention to the details of converting space for appropriate usage. A second is the difficulty in hiring psychiatrists, in part because of the competition with the aggressive hiring being undertaken by the prison system.

The county's expansion plan will also fund a primary care-based initiative at Ravenswood Health Center (FQHC) in East Palo Alto.

Stanislaus

Stanislaus has an FSP team specifically for individuals with serious mental illness and high-risk medical conditions.

The team consists of a nurse, a clinical services technician, a psychologist, and two behavioral health specialists. They are supplemented by an internist for three hours a week and a psychiatrist for 12 hours a week. A decision was made to focus on the conditions of hypertension and diabetes because the former has higher prevalence in underserved ethnic communities and the latter has higher prevalence in the population diagnosed with schizophrenia. Both can be affected by lifestyle changes and both have medical treatment protocols. Services are targeted for 50 individuals.

An implementation challenge was that the county was unable to hire staff who had either special expertise or interest in the program, having to rely instead on transfers from other parts of the mental health system as a part of the overall budget cuts and staff reassignments. However, interviewed staff members seemed enthusiastic about the program, but need to start from scratch in conceptualizing and implementing services.

Developing referral relationships for the FSP is a challenge because of the health care dynamics in the county.

The FSP staff has been working to develop relationships with medical providers to obtain referrals and work collaboratively as appropriate, but there are obstacles to overcome. The county clinics are under severe fiscal pressure and in the process of transitioning to FQHC status in order to increase reimbursements. As in Monterey, the clinics express frustration at not having access to mental health services when needed, particularly for their indigent clients.

The largest private provider has had a strained relationship with the county clinic system and Behavioral Health and Recovery Services (BHRS). Viewing the county health clinics as competitors, they are opposing the county's application for FQHC status. The health clinic provides some of its own mental health services and had sought a larger role in the CSS plan than occurred. Relationships are gradually improving with BHRS giving priority to the health clinic's clients in several of their programs.

Learning From Mental Health/ Physical Health Initiatives

The need for enhanced cooperation between systems to deal with co-occurring health and mental health issues emerged clearly from the CSS planning process.

The impact of persons with serious co-occurring mental health and physical health issues is increasingly apparent to both the mental health and the physical health systems, as well as to consumers and family members. Interest in "doing something about the problem" was strong enough in four of the seven study counties to result in specific plans. In most cases, however, the planning did not go much beyond this felt need to do something. More detailed program design was needed, and implementation has been subsequently delayed as details have been worked out.

Full involvement of appropriate health care leadership in planning can avoid false starts.

Some of the planning for the mental health/health care initiatives occurred without input from persons who understand health care systems and the unique dynamics of the particular health care system in the county, as well as those who have the authority to implement plans. As a result, some of the initiatives

were misdirected – either by false assumptions about where people seek care or about the ability or willingness of particular providers to engage in desired partnerships.

While co-location is a valid and effective strategy, it requires substantial effort and willingness to meet a partner's needs.

The experiences of San Mateo County demonstrates that co-location in both directions can be effectively implemented. But even with this history of past success, expansions have not always happened easily. Efforts in other counties that lack experience working together highlight the difficulty of blending health and mental health service cultures, reimbursement and financial models, space considerations and a host of other implementation details. The mental health system must acknowledge that the antagonism of many health care providers is caused by their inability to obtain access to public mental health services for their clients. Co-location models must be able to promise some increased access to mental health services for clients with the greatest acuity and most severe psychiatric disabilities.

Consumer-Driven Center Initiatives

Consumer involvement in all aspects of the mental health system is a core value of the CSS component.

The CSS planning guidelines made crystal clear the vital importance of involving consumers at the policy level in planning and designing services, at the implementation level in being employees of and contractors with the system, and at the individual client level in directing one's own recovery plan and services that flow from that.

One of the main areas of focus for the study was consumer-driven centers.

This section focuses on that set of center initiatives which have as a key component consumers being the major force in determining what happens and how it happens at the particular center site. The National Mental Health Consumers Self-Help Clearinghouse defines consumer-driven programs as follows:

> *Consumer-driven programs must include a significant contribution from mental health consumers in design, administration, executive leadership, service provision and/or day-to-day program decision making. Some, but not all, of these organizations have consumer involvement as an essential part of their charter or mission statement, requiring, for instance, a majority of consumers on their Board of Directors or staff.*

Selected for inclusion here are System Development initiatives which entail a center that has as a core element – either a major component of consumer direction in the design of activities, consumer leadership or more than 50 percent consumer hires. This is an evolving concept, so not all the counties were initially clear in their intentions and further refinement has occurred during implementation. Not included are programs that may be consumer-driven such as Warm Lines, nor centers (such as the Wellness Centers in Stanislaus) which have significant consumer hires but no particular role of consumers in the design of the intervention nor the decision-making about operations. The Wellness Centers in Los Angeles are included because of the early stages of development of their center concepts and because of the critical role such centers are likely to play over the next few years.

Six of the study counties embarked on efforts to establish some element of consumer-driven centers

A sign of the embracing of the consumer movement is the fact that six of the study counties have a significant consumer-driven center program as part of their CSS plans. They are in different stages of development and have different concepts of what is entailed. The following sections highlight the concepts as they have developed to date and the early implementation of these programs in each of the counties.

Los Angeles

The concept of consumer-driven centers has evolved in Los Angeles.

Los Angeles has a major initiative to develop consumer centers. The concept in the original plan was generally defined as being client-run drop-in centers, which would have a comprehensive array of self-help, educational, social and recreational activities. Helping clients develop Wellness Recovery Action Plans (WRAP) was cited as an example of one of the services the centers would offer.

With further planning and changes in county needs, the focus moved to developing two types of centers: wellness centers and client-run centers.

Continuing discussions abut the concepts underlying the programs resulted in their being viewed along a continuum, which could accommodate consumers who no longer need the intensity of clinical services offered through FSPs. The wellness centers are now designed to have 50 percent consumer employees and offer peer-led recovery services, clinical services (primarily physician-prescribed medications) and physical health services. The client-run centers will be 100 percent consumer staffed with no clinical services.

As budget cuts led to the curtailment of clinic services, the importance of the wellness centers grew as an alternative for many of the clients currently seen in the clinics. In August 2006, the Board of Supervisors approved the plan for 14 directly operated wellness centers and $2.4 million went out to bid for privately contracted wellness centers ($2.43 million). Attention to the effectiveness of these centers has heightened as they are designed both to address a system need and to embody the new values of recovery and consumer direction.

The client-run centers are in more of a developmental stage with $2.9 million having been authorized for contracts.

The resolution of all the design issues is now transferring from the theoretical to the practical level.

The discussions about the design of the structure and the services in the wellness centers as well as their relationship to the client-run centers have continued. There continue to be "healthy discussions" about the model(s), with different views about the extent of consumer control and the role of clinical services. Implementation of some of the centers also has been delayed due to site issues, with community concerns surfacing in several service areas about locating programs in certain neighborhoods. As the centers are implemented, design decisions are expected to be worked out, perhaps differently in each service area to accommodate particular needs.

Madera

The concept in Madera was for a drop-in center that would provide peer services as well as facilitate access to other needed services.

Hope House was inaugurated through a contract with Turning Point of Central California and opened in October of 2006. The director is a Turning Point employee who sees his job as supporting consumer staff and envisions being able to relinquish control of the center to consumers within a few years. While the choice of groups is determined by the consumers and everyone has a choice of what to attend, program members expect people to participate and not just use the site for socialization. An incentive system has been instituted by which attendance at group meetings earns points, which can be exchanged for snacks.

The lack of transportation is a problem and consumers from outlying areas cannot easily use the center.

Determining how to deal with the use of Hope House by individuals who are homeless, but are not mentally ill led to the transition to a membership program.

Hope House has laundry and shower facilities and is located near the site of free breakfasts for individuals who are homeless. As a consequence, Hope House became a drop-in site for these individuals. This created a challenge because of the conflict between wanting to be open to the community and worrying that the presence of individuals who are homeless due to a variety of factors would turn some individuals with mental illness away and that it would be more difficult to provide the kind of environment that would be helpful for those individuals.

"We don't want to be exclusionary but [we are] trying to offer more peer support and stuff and [want to] turn off the TV."

The answer to the problem evolved over time as Hope House has become a more structured program. Consumers were involved in the development of the concept of a membership program. The concept was presented at a town hall meeting and accepted with a show of hands. Membership is automatically offered to those who are or have been in treatment. The center is open to members only four days a week and to the general public the fifth day. After the switch, some homeless persons asked for treatment, but most have simply stopped coming.

At the time of the study's update conversation, Hope House had 186 members with the majority being in treatment. Staff from other programs often come to Hope House to meet with their clients.

Consumer employees of Hope House who were interviewed were particularly positive about their experience.

Consumer employed interviewees expressed considerable appreciation for the opportunity to work at Hope House. The director has job applicants work first as volunteers to assess how well they do. Once hired, consumer staff are expected to pick some special process or group or project to work on. He is currently getting more qualified applicants than he has available jobs, and would like to establish a job development component at the center. Two consumers are now working full time at Hope House and are no longer receiving disability benefits.

"Being employed here has given me a chance to give back. The program changed my life. I wouldn't come out of my apartment for months at a time because I was so depressed. Now I am working and becoming an outreach worker. During the CASRA training, I found out there were other people in the same boat and two of us made a pact that we could do it."

"Our families are proud of us when they notice how happy we are now."

"I couldn't do it in another environment because the hours (here) are flexible and otherwise supportive."
"The director's message is that I got hired because I have the capacity to do the job."

"My children are proud of me"

Monterey

While Monterey had an initial conception for its adult wellness center, the design was actually not well developed prior to issuing an RFP.

Monterey County's plan called for an adult wellness center that would encompass a full range of functions, including drop-in and socialization, peer-support and self-help, and employment assistance. This resulted from planning focus groups that recommended a wellness center but did not provide details about what it should be or do.

Interim (a non-profit community-based agency) was hired as a contractor. Interim had experience operating drop-in centers with United Way funding but had become disillusioned with that model since it lacked a recovery and empowerment focus. The Interim staff person assigned to this program conceives his role as being a business manager to the center. An advisory group was constituted, which met weekly for a number of months to further refine how the center should be structured and what it should do. A consumer director was hired, a name selected (OMNI), space leased, and an open house was attended by more than 200 people.

The current concept is for a prevention-focused center that will assist consumers in their personal recovery journeys.

The leadership does not want it to be a drop-in center that offers meals or life-skill groups; they also don't want it to be restricted to only those who are clients of the mental health system. In May 2007, the center had an average attendance of about 10 consumers a day and four structured peer-to-peer groups, including a NAMI-trained group leader. The leadership also plans for the center to have a Latino focus. Center staff members are utilizing Spanish-language radio and contacts with the migrant community to publicize the center. In the update conversation held with the county, the county MHSA coordinator described OMNI as a "true consumer-driven center" and noted that some of the consumers involved with the center have become members of some of the county's MHSA workgroups.

The county also has contracted with the same community-based organization to provide vocational services at a second wellness center for TAY.

At the present time, the agency is still looking for a site for this center. To date, there has been a lot of family and youth involvement in the planning for and development of this program.

Riverside

Riverside envisions its peer support and recovery centers as step-down programs.

Riverside County's design for these three centers, regionally located, is to function as a step-down, transition and support for current clients and their families in the county mental health system and for those no longer involved with specialty mental health services. The centers are intended to be for mental health "clients who are ready for something else." A referral is not required from mental health, but the client must be a former or current mental health client. This restriction to current or former mental

health clients results from the county's concern about cuts in other parts of the system. The county wants to ensure that there is something for clients who might be cut off from more traditional services. They also view the necessity for transition from the county mental health system as a way to ensure that the consumers who use the centers do not have needs that are greater than the centers were designed to handle.

The centers are to provide peer support, educational and vocational services. They are not designed to be socialization or drop-in centers. Another clear feature is that they are to serve both adults and TAY, but the program designs and operations for the two age groups are to be separate.

The concept is being developed further by the two contractors who are implementing programs.

Using two different contractors has led to some differences in implementation. Jefferson Transitional Programs is the contractor serving the Western and Mid-County programs. They have developed initially with more structure. Consumers are required to attend an orientation session and officially enroll in the center. They have developed a five-track developmental program for TAY with the intention of following more of a college than a clinic model. They are struggling some with the conflict between having a formal program and having a site more open to the community in which consumers, particularly TAY, feel comfortable. They currently allow anyone to make one visit before initiating the more formal enrollment process.

Oasis Rehabilitation is the contractor in the Desert Region, and has been evolving more slowly in response to consumer requests. They have had an open house and a job fair and are running a couple of groups including a Wellness Recovery Action Plan (WRAP) and a 12-step program. They have a TAY advisory group but have not yet decided on how to address the separate needs of the TAY group. They are continuing to work with the county on a more formalized referral process to enhance consumer access to the peer centers. The contractor is trying to maintain a more open orientation, envisioning an initial meeting with consumers to determine what they want and then offering a range of opportunities from merely dropping-in to enrolling in the program, to volunteering, to working as an employee at the center and/or to being on the board.

All three centers have consumer and family member advisory boards, and most of the staff members are consumers. Both contractors report having more difficulty engaging TAY consumers than adults.

San Mateo

A multicultural wellness center in San Mateo combines a consumer- and family-driven concept with its ethnic-oriented strategy.

The planning for a multi-cultural wellness center in San Mateo is in the early stages. The department is engaged in a broad effort to extend its assistance to the East Palo Alto community (see Ethnic-Oriented Initiatives section) through partnership with a network of community organizations. Selecting a site for a wellness center in this diverse ethnic community is part of that strategy.

The planning for the wellness center is being led by the director of the Office of Consumer and Family Affairs and is occurring in partnership with consumers, community organizations and leadership in East Palo Alto. The inclusion of family members in the design is in response to the family-focused culture of the community and to help in reducing stigma associated with mental health services.

Stanislaus

Stanislaus County's vision is for a consumer and family employment and empowerment center, which will be outside the mental health system of care.

Stanislaus has operated a Wellness Recovery Center for a number of years. That center has mental health services such as medications and case management along with a large paid peer support staff. Consumers who use the Wellness Recovery Center receive peer support to work on their own recovery. While having a strong consumer orientation, the center is part of the overall system of care and is run by county staff.

The new employment and empowerment center is designed to evolve into a totally consumer-run center over a three-year period. The county issued an RFP for a contractor to develop the center with the understanding that it was to build the capacity of the consumer employees to be able to take over the governance and management of the center. While recognizing that a commitment to consumer direction would lessen its role in determining the

nature of the center's programs, the county did express a vision for the center in the RFP. As reflected in the naming of the center, the county vision entailed a program to assist individuals with personal development goals including volunteerism, supported employment and competitive employment.

The client network has space at the center and is handling the social activities at the center but has no formal relationship to the center except for the role of its members on the oversight committee.

The actual design for the center will evolve over time, in response to the desires of the consumers.

All decisions affecting the center are to be made by an oversight committee, which has joint membership including the contractor and the client network. Ideas for what the center should be are being sought through consumer focus groups and forums.

A consumer has been hired to direct the center. Other consumer positions to be hired include an employment specialist, life skills staff and a career counselor. A vision and mission statement has been drafted and an initial calendar of events established based on the consumer input received thus far.

The contractor operates an employment program at the same site as the new center and is interested in creating a continuum of services. The center would do pre-employment activities and then refer consumers to their employment program, which has work contracts and a same-day employment model that guarantees an actual job placement the day someone applies for work.

Implementation has been a bit rocky.

As in Madera County, the drop-in nature of the space resulted in individuals who were homeless (with problems other than mental illness) using the site. The Oversight Committee passed a standard of conduct policy, which sets standards for behavior as a way of addressing this issue.

A leadership change slowed development, but the county reports that having leaders who embrace and champion the vision is critical to success.

In May 2007, about 20 consumers came on a regular basis. A sign-in sheet recorded participants, and staff members made plans for some more structured ways to gather information about new people who come to the center.

County staff, the contractor and the involved consumers all expressed great hopes for the center.

Stanislaus has been a leader in consumer-oriented services and provides strong county leadership for this center. The contractor also has experience with recovery-oriented and non-traditional mental health services and also seems committed to the development of a consumer-run center. The consumers are excited about the prospect of creating an environment and set of activities.

The county also initiated a transition age young adult (TAYA) drop-in center.

The Young Adult Advisory Council took an active role in guiding the early implementation and ongoing development of the drop-in center. The Young Adult Advisory Council was central in naming the drop-in center "Josie's Place" after a well-liked staff person who was tragically killed in an automobile accident. Young Adult Advisory Council members made the name change recommendation to the Stanislaus County Mental Health Board who, in turn, presented the recommendation to the Board of Supervisors.

While the center is county operated, two TAYA consumers, who were part of the Advisory Council, have been hired as part-time peer support staff at the drop-in center. Additionally, the youth are playing an active role in the design of the programming at the center.

Learning From Consumer-Driven Center Initiatives

The counties and contractors are moving toward consumer control of centers at different speeds.

The goal of a completely consumer-run center has been stated explicitly in four of the counties. In all instances, consumer input is being widely sought and listened to with regard to the design of the program and the kinds of services and groups offered. But there are differences in the amount of immediate consumer administrative control. The contractors in Stanislaus and Monterey moved promptly to hiring consumer directors who were given broad authority over program decisions. In Madera the director of the programs are not consumers and are staff members of the contract agencies. In Riverside, a consumer is the director at two of the peer centers, although the executive director is not a consumer. Los Angeles is currently involved in discussions with consumers about this same issue.

There is no consensus yet among counties, or even within counties as to how the centers should be designed and what services should be provided in a consumer-driven center.

The design of what the consumer-driven center should be continues to evolve in each county. This should be expected, particularly if each one is to be responsive to the desires of the consumers. But there are structural features and expectations that influence design decisions, and these often reflect the particular circumstances of the county. Examples of a few of the key issues follow. While these are discussed separately, they are all clearly inter-related.

- Should the center be a drop-in site open to the whole community? While this is appealing and promotes community integration it has its downsides. Madera and Stanislaus both had to resolve how to handle the use of the center by homeless individuals with an array of problems. Some consumers feel strongly that a drop-in site lacks the desired recovery and empowerment focus and will become another socialization center. A few are trying a membership approach.
- How closely tied should the center be to the mental health system? The concept in some counties is for these programs to be step-downs from more intensive traditional mental health services, i.e., part of a continuum of care. Some also see these as sites in which to engage persons who can then be referred for more traditional mental health services. These decisions are impacted in part by how constrained county capacity is and how much the county thinks it must use its resources for its own clients.
- Should there be professional services at the center? Depending on the circumstances in the county some have plans to provide medication services and educational and employment services.
- How formal and structured should the program be? A tension exists between wanting to provide and encourage the use of recovery-oriented programs such as WRAP and not wanting this to be just another set of programs.

A revisit to these programs in a year should yield valuable information.

The discussions and early implementation of these efforts are intriguing. Four counties have programs up and running and have managed their way through significant challenges. The effort in Los Angeles is just getting underway, and San Mateo is still in a planning phase. It is clearly too early to reach any conclusions.

PART FIVE: SYSTEM OF CARE IMPACTS

Counties are using CSS funding to change and/or augment their existing systems of care

In addition to the general implementation of the CSS component of the MHSA, and the focused initiatives selected for the study, this section looks at other impacts that the CSS component has had on systems of care. While it is too early to see a major effect, counties hope that both the planning processes undertaken in the counties and their early implementation efforts will change existing systems of care.

The study did not explore systems of care in depth, but focused instead on impacts particularly for the two age groups that have received appreciably more attention and targeted funding under CSS than at any prior time. The older adult system appears to be developing a clear separate identity with discrete services, while the TAY services have been more often merged with children and youth and/or adults.

The other focus was on major systems of care changes across age groups which at least a few of the study counties undertook.

Older Adults and TAY

For older adults, one of the major results from the planning process was the awareness of the need to develop a separate older adult system of care and infrastructure.

The requirement for older adult services resulted in a substantial boost in attention to the needs of this population. All the counties had older adult work groups which became advocates for services for the population. One outgrowth of the planning process was recognition of some of the specific characteristics of the older adult population. Advocates for older adults stress the importance of making adjustments in CSS to be more relevant to older adults. This was most apparent in three areas: the importance of

families in the lives of older adults and the need for their inclusion in any services; the inappropriateness of many of the specific adult goals for recovery and the need to make adaptations for older adults within a recovery framework; and the difference in the needs between the young-older adult and the older frail adult subpopulations.

For many counties a beginning activity was to establish an older adult identity within the system and to develop a plan for how to build a system of care.

It became apparent that because there had not been many resources before, there was not an infrastructure nor a plan for how to proceed. As a consequence a first task for System Development funds was the development of an infrastructure.

- El Dorado is using CSS to fund staff positions to initiate the formal establishment of an older adult system of care (SOC) and to work with the community to promote program development in the area of outreach and engagement, systems development and peer support.
- Los Angeles has hired staff and initiated an older adult transformation design team to work on activities to support all of the older adult program areas to be funded by MHSA.
- Monterey has convened a collaborative to do strategic planning for a countywide older adult system of care, and they have developed a draft plan of goals, strategies and desired outcomes.
- Riverside has centralized their older adult CSS programs and has created a centralized unit which will provide overall management of older adult staff and programs county-wide. The older adult service manager is also working with other community agencies and organizations to build collaborative relationships and coordinate services.
- In Stanislaus, the addition of an older adult FSP allowed for the beginning of reconstituting a prior older adult infrastructure, which had been funded through a SAMHSA grant.

Peer counseling, assessment and mobile outreach are among the clinical services that are being added for older adults with System Development funds.

While the counties are undertaking more formal planning processes, they are beginning with some services that are either expansions of activities already in place or entirely new ones. Consistent themes among these services are the use of peers, often using formal training and supervision modules; provision of services in the community, either at home or at other community sites such as senior centers; and the importance of multidisciplinary teams to assure accurate and comprehensive assessments.

Riverside: "One of the main issues was getting an identity and infrastructure so we are not just part of adult services."
El Dorado: "The older adult SOC is new with MHSA. We came up with more needs than we can fund. We plan to take the first year or two to evaluate needs. We will have three staff: a coordinator, mental health clinician and a mental health worker."
San Mateo: "Not a huge amount of money but created a manager position which has meant leadership, best practices, which has been very positive so we are seeing a real change as a result of this."

Another feature of service development has been the need for greater formal and informal coordination with other organizations serving older adults, e.g., medical care providers, public health nursing and adult protective services.

Implementation has been slowed because of workforce issues. Riverside, Los Angeles and San Mateo cited the lack of specialized trained staff as major impediments to implementation. Los Angeles is relying significantly on contractors who have more experience with segments of the older adult population.

There are very few CSS services designed strictly for the TAY population.

For the most part, a separate identity for a TAY system of care has not developed as with older adults. In their planning processes, five of the counties had separate workgroups for TAY. They acknowledged the importance of the new voices even though consistent ongoing involvement was difficult to attain (see Planning section). Unlike the older adults, the TAY group had few service advocates so that new services for the group were more often merged with those of either children and youth or adults.

As noted in the FSP section, four of the counties will operate distinct TAY FSPs with either a separate staff person or a whole separate team.

Counties with specific programs for TAY are as follows:

- Riverside: specific tracks and activities for TAY within the consumer-driven centers.
- Monterey: a drop-in center that will provide housing, vocational services and life skills assistance.
- Los Angeles: expansion of drop-in center hours, increasing assistance on housing issues, services in juvenile probation camps.
- Stanislaus is implementing a drop-in center for TAY which will also serve as the program site for the TAY AB 2034 staff.

Although San Mateo's FSPs for TAYs are combined with their child and youth FSPs, as previously noted, the funding includes a drop-in center specifically for TAY.

This is not to say that TAY will not be receiving a wide array of either children and youth or adult services, depending on their particular age and needs. It means that the development of a system of care for that age group has not emerged from the CSS activity to date.

Major System Wide Initiatives

Three of the counties are using CSS funds to reorganize or enhance their crisis and emergency response systems.

Los Angeles included an Alternative Crisis Services component in its CSS Plan in response to the countywide emergency room crisis. The component includes four elements – all designed to build a more coordinated and comprehensive system to accommodate consumers in immediate crisis and as they progress through the 24-hour intensive service part of the system.

- Urgent care centers, which are being piloted in two different regions. They will have a 23-hour intensive services focus on the co-occurring population to reduce the use of Psychiatric Emergency Services (PES) and 72-hour holds.
- Expansion of the centralized Countywide Resource Management unit, which directs the use of all the 24-hour intensive services.
- Residential and bridging services which are county mental health program liaisons and peer advocates, ensuring connections between intensive 24-hour and community services.
- Enriched residential services will include a 48-bed augmented adult residential facility.

Stanislaus County is redesigning its emergency response system as a result of hearing from the community during the planning process a strong desire for a more mobile emergency response capability. A 6-month redesign process involving 28 people and 20 meetings led to a 13-person Community Emergency Response Team, of which at least three will ride with law enforcement. A contract has been awarded to implement a peer support and warm line component to the service. While only two of the positions will be funded with CSS dollars, the impetus for the change resulted from the CSS planning process. A crisis residential center for those who are homeless and mentally ill is another component of the Stanislaus crisis system being added with CSS funds.

Riverside included two crisis residential programs in its plan, but has had difficulty finding contractors and locations for the facilities.

Several counties are implementing Evidence-Based Practices (EBPs) with CSS funds, either in new CSS funded programs or within existing systems of care.

Below are some examples of the Evidence-Based Practices (EBP) initiatives within the study counties.

- Riverside has placed the greatest emphasis on using CSS funding to implement EBPs, using them as the primary treatment approach for their child/youth FSPs and also using System Development funds to train existing staff in several different models
- El Dorado has used one-time funding for EBP training and has also entered into a three-year training effort with CiMH for Functional Family Therapy training.
- Monterey is using EBPs in its parenting program, elementary school-based counseling program, adoption preservation program, adult forensic and homeless programs, and its Transition to Independence Program (TIP) for TAY.

- San Mateo is using EBPs in four middle schools that currently have no mental health resources. The county has initiated a major training effort to incorporate Integrated Dual Diagnosis Treatment (IDDT) training in all programs. The county is also using CSS funds to expand its existing EBP initiative countywide.
- Stanislaus is using EBPs in both its adult (IDDT) and youth FSPs (Aggression Replacement Therapy).

Learning From SOC Impacts

The requirement for age-based planning resulted in increased attention to older adults and TAY.

The focus on these populations in the CSS planning highlighted the lack of information about the needs of the populations, the lack of infrastructure to support new programs, the need to develop new and/or stronger relationships with other community organizations and the need for developing a plan for addressing needs comprehensively and effectively. This effort was addressed more concretely by the study counties with regard to older adults who will be developing older adult systems of care. While a few services are being developed specifically for TAY, some new initiatives for this age group are being incorporated in programs designed for children and youth or adults.

Counties are using at least some of their System Development money to address system wide needs.

Most counties expressed the concern that they did not want MHSA to create a dual system of care. So, in addition to creating new programs with System Development dollars, they are also using some of this funding to serve as a catalyst to change their existing systems. Two counties are addressing major redesigns of their crisis and emergency systems, a number are expanding EBPs within their systems, and most are funding training efforts for staff and some stakeholders in critical areas such as recovery and cultural competence.

PART SIX: HOPES, CONCERNS AND ACHIEVEMENTS

The passage of the MHSA brought with it a great many hopes and expectations, as well as the daunting challenge for the counties of a range of new programs and initiatives As noted previously, this report looks at seven counties at a point in time when they were just beginning implementation of the first of five MHSA components. During the site visits, we asked interviewees to share their hopes for the MHSA as well as their concerns about the future. We also asked county mental health leaders approximately four to six months following the site visits, what they thought their greatest achievements had been to date. This section describes some of the responses to these questions.

All of the counties hope that the MHSA funds will act as a catalyst for system transformation.

All of the interviewees expressed the desire and hope for a fundamental change in the ways in which the mental health system operates. While emphasis varies, the most consistent expression of hope is not just that there be more services, but that the ways in which the services are structured and operated will be changed. The most consistently expressed hopes are for a more recovery/resilience-oriented system and one that will be more inclusive of consumers and family members as true partners. And most interviewees hope for a system of services that is more accessible and more appropriate to persons from diverse cultures.

The seven study counties are in different stages of this change and, because of their particular immediate challenges, tend to be more focused on one or another aspect of the transformation. But both county mental health leadership and all the other stakeholders appear to hold a fairly consistent view of the direction in which they want the system to move. Cited below are some of the specifics of what various stakeholders expressed in their vision for change.

The county mental health leadership in the two counties facing the most severe immediate budget issues expressed a vision of altered roles for the community and for consumer-driven services.

The most dramatic vision of system change was expressed by the mental health leadership in the two counties that have faced the most immediate and significant budget reductions. Leadership in Los Angeles and Stanislaus counties articulated clearly and forcefully their need to forge a new relationship with the community as a way to get additional

resources for mental health clients. Both counties believe they need to be more reliant on community organizations since they cannot provide all the needed mental health services in their counties. In other words, the change is driven both by a value that partnership with the community is a goal of a recovery-oriented community-based system as well as the reality that only a community effort can provide all the services needed in a comprehensive community "wellness" system.

While all the counties hope that wellness centers and consumer-driven services will move their systems toward being more consumer-driven and recovery-oriented, these two counties in particular also hope that these centers will provide services that are effective alternatives to some of the existing clinical services that will continue to be at risk due to the fact that realignment and other revenues cannot keep up with rising service costs.

Stanislaus: "We need to turn our organization around to the community in a way we never have. Our role will be more to develop capacity in the community. The outreach and engagement and the consumer and employment centers are key; they are critical programs to change what we are doing. It is only because we have had this awful year that we have gotten there so quickly." "Transformation is our relationship with our community."
Los Angeles "We need a community response to deal with all the folks who will be losing services… the money and programs are a distraction from building of a community will to take care of these folks which is beyond county mental health's ability…there are 100,000 people who won't get services unless we build community will." "The mental health system can't change peoples' lives by themselves – there are other parts of the community to help people's lives get better."

Counties also are hoping that the MHSA will improve access through a combination of redesigned and increased services.

Monterey and San Mateo counties in particular received forceful input in their planning processes about the lack of accessibility of their service systems. Leadership in these counties expect MHSA funding and programs to result in increased access to mental health services, particularly for underserved ethnic communities. They are both addressing this issue through a combination of increased openness and through working with community organizations that can address the specific needs of underserved communities. As noted in earlier sections, both counties have pilot efforts in specific regions of the county to have more of an open door to referrals. And both have instituted major efforts with community-based organizations to develop their capacity to provide mental health services that might be more acceptable to particular ethnic communities.

Monterey: "We hope that we can respond to demands for greater access…no wrong door. We need greater involvement with community organizations. How to get places where people talk about their lives to be more constructive. We will know we have gotten transformation when people will know where they need to go, access is more open, we are culturally respectful, and when consumers are true consumers and have choice, can shop around"
San Mateo: "Biggest new things are the ethnic disparities and working with other organizations." "Access issues raise issue of being more open to community and less focused on target population." "Biggest issue which came up through all the input process was access problems – not being consumer friendly – doing a pilot in one region with less centralized access, no wrong door and everyone gets something."

Another focus for some counties is the change in clinical practices.

El Dorado is an example of a county that is embarking on the beginning stages of a major change in the way it views its clinical services. The leadership envisions MHSA as an opportunity to alter the basic ways in which clinical services are delivered. In the past, the county has had a very traditional medical model system, largely driven by Medi-Cal funding. Now it sees an opportunity to adopt a more recovery-oriented, consumer-directed system of services. County staff members are getting out of their offices, doing more contracting with community agencies, getting more involved with the community and looking at making all of their services more welcoming and accessible.

As noted previously, Riverside and Monterey are examples of counties that are using the CSS funds to emphasize evidence-based practices in some of their new service-delivery models.

El Dorado: "The department is changing its culture. The practice of autonomous clinicians doing their own thing is evolving quickly into a recovery-oriented team-based approach."
Monterey: "We are getting better at partnering and bringing in evidence-based practices."
Riverside: "We took the CiMH matrix of evidence-based practices to our planning committee; they selected the components they wanted, the department selected the actual practices."

Trying to infuse the whole system of services with the underlying principles of recovery-resilience and consumer-family involvement is the biggest task for some counties.

As noted, some counties have already implemented elements of these principles in their existing programs. For them, the next task is to extend those principles more thoroughly through their whole system. They hope the MHSA can be a vehicle for making these changes viable throughout their systems.

Stanislaus is initiating a Community Integration and Change Team (CICT) to move the entire Behavioral Health and Recovery Services (BHRS) toward "recovery in the community." The overall goal of the CICT plan will be to implement actions designed to integrate MHSA values throughout all BHRS programs, and to involve and partner with the community on program development and service delivery. A specific plan with action steps and outcomes will be developed.

"We were already on the road with recovery and wellness centers for a number of years – not so advanced with resilience."
"Been part of a regional recovery group for many years but still need a culture shift for whole system particularly psychiatrists."
"I can't feel the transformation. I see some new programs. That's not the same. How does the system change to serve the clients better rather than just what new services can we provide?"
"Resistance to change from line staff."
"System has not evolved evenly yet. Recovery model is more in place in some parts of system than others."

Some expressed a hope that stigma would be reduced by the MHSA.

One county – El Dorado – actually undertook a brief anti-stigma campaign during its planning process. A number of stakeholders hoped that the attention to mental health issues from MHSA would lead to a reduction in stigma.

Stanislaus leadership anticipates "MHSA changing the culture." An interviewee recounted a meeting on documentation of services in which a staff person opined on the stigmatizing language that the staff sometimes use about consumers and how hurtful that is. This led to an increase in awareness.

Contract provider: "There will be less and less stigma over time so that it's easier to reach people of different cultures."
Consumer: "Elimination of stigma needs to be a priority – particularly in ethnic communities."
Staff: "MHSA has made a shift for us including listening to our own language. That little thing in the documentation dialogue caused us to start pushing down on the words we use. The manager for Consumer and Family Services contributes to this change also."

The greatest concern expressed was that MHSA would create a dual system of care.

The difference between the richness of resources devoted to FSPs and new programs for previously unserved clients and the paucity of services for others currently being served in the system creates tensions, particularly in counties that are experiencing cutbacks in services at the same time CSS is being implemented.

On a more routine basis, counties are experiencing difficulty in maintaining sufficient attention to the rest of their services because of the huge investment of time and energy required to implement the new CSS initiatives.

Riverside: "At the client level will be differences – those in FSPs will get really good services and then others won't. Some of these others will feel very left out. This is a reality of not enough money. Will be looking at a two-tiered system."
Stanislaus: "Like children and step-children – differences in caseloads of 10 to 70 – had been working to get everyone to 40 but now that has stopped."
Los Angeles. "Contractors are concerned about a two-tiered system. The issue is starting to emerge in county clinics as well."
San Mateo: "A major challenge is keeping our attention and energy focused on the rest of the system. We are now in a labor/management discussion about staff not feeling supported in their clinical day-to-day work."
Madera: "Trying to get FSPs up and running meant it was hard to focus on ongoing services – hospital days went up because we were not focusing on it. [It is a challenge] to keep minding the store while we are trying to do something new. The other programs were starting to suffer."

Many expressed concern that the expectations of stakeholders may have been raised too high.

A fear about not being able to meet high expectations was expressed not only by county mental health leadership but by other stakeholders as well. Some counties have tried explicitly to manage these expectations, but acknowledge that they may have limited power to affect this.

San Mateo: "Community expectations – needs expressed went so far beyond what mental health services could address."
Monterey: "Won't be able to deal with high expectations." "Worst fear is that won't be able to deal with the expectations." "Raise expectations – giving false promises if we cannot carry through."
Los Angeles: "Stakeholders gone wild – created too many expectations which we can't meet." "Expectation about MHSA way too high."
Stanislaus: "Tried to deal with expectations from the start by explaining how mental health funding and changes to the system occur."
Riverside: "Tried to manage expectations around what the money could and couldn't be used for – need to continue to manage this."

While all counties are concerned about the complexity of the state administrative requirements that have already been instituted and those that are to come, small counties are particularly worried.

Both El Dorado and Madera counties indicated that, based on their experience to date with CSS, they are worried about their ability to meet all the requirements of all the MHSA components. For example, Madera finds the restrictions on the amount of unspent funds that a county can carry over is problematic, given the slower pace of some of their implementation. All counties are worried about the amount of work that state Department of Mental Health will require for the other MHSA components.

"This is now exploding with new components, which is exciting but anxiety provoking. Every week have to rethink, 'is this the best use of staff resources'…. Many small counties struggling more. Scale of what we need to do to apply and maintain funding is too much."
"We cannot do what we did for CSS plan for future funding streams."

Counties differed in what they felt their greatest achievements were as of spring 2007.

All of the counties reported that they were making slow but steady progress. They were finding some programs more difficult to implement than others due to workforce shortages and recruitment problems, finding appropriate space and dealing with political issues within their counties. The following represent their sense of their greatest accomplishments to date.

- El Dorado reported positive feedback from consumers and a greater connection among staff throughout the system who are now working more closely with one another.
- Los Angeles was particularly proud of the Service Area Navigators and the communities' happiness with them. The Mental Health Director also stated that he "thought they had turned the corner" with their workforce and were moving toward a more recovery-oriented model. Staff in general were more involved and engaged than they had been at the time of the site visit.
- Madera is particularly pleased with its consumer-driven center, Hope House, which has more than

200 members and an average daily attendance of 40. The town hall meetings provide clients with a forum to express concerns and ask questions. Consumers have a computer lab available to search for jobs, they have received job training, and many have participated in certificate classes such as CPR training and victim witness training

- Monterey cited its progress on implementing 20 of its 28 work plans. In addition, county representatives are proud of their community information and feedback process and the increase in non-traditional providers with whom they have entered into contracts and agreements.
- Riverside thought its greatest achievements were in working with consumers, both in terms of adding them to the county's workforce and in the opening of two peer centers.
- San Mateo has furthered its co-occurring disorders initiative; through EBP training the county has created 80 or 90 change agents who are involved in how they can become "more co-occurring capable."
- Stanislaus feels it set high expectations for the CSS implementation and in spite of budget cuts and other problems, as of the update interview, the programs were up and running and the clients are enrolled.

Learning from Hopes, Concerns and Achievements

Stakeholders expect major changes in the mental health system, not just more services.

While stakeholders are excited about the opportunity for additional resources, the consistent theme was that the hopes for MHSA go beyond just more services. County mental health leadership, consumers and family members and other interested stakeholders envision in particular a system that more fully embraces recovery-resilience and a partnership with consumers and families. Stakeholders will be tracking changes in these underlying system concepts – not just the addition of services.

Keeping expectations realistic can be on an ongoing challenge.

The promise of an infusion of dollars, a planning process that asked stakeholders what they wanted, and a set of principles that promise to alter the way in which services are delivered sets the stage for unrealistic hopes and expectations. County leadership is generally attuned to this potential problem and it provides added impetus to efforts to make changes that are visible to stakeholders.

A major concern is the development of a dual system of care.

Inherent in the approach taken by the state in the CSS guidelines was the creation of a hoped-for only temporary division between those consumers and families who would be fully served and those who would not. The strategy is to utilize funds saved through the successful outcomes of fully served persons to gradually increase the percentage of consumers who can be fully served. The interim period creates a duality of care which is extremely difficult for consumers and families and also frustrating for staff. Staff members who are working in new programs are able to provide clients with a full array of services, while other staff members continue to struggle with high caseloads and the knowledge that some of their clients and families need more or different kinds of services that are not available to them at this time.

PART SEVEN: NEXT STEPS

This report completes the first, or baseline, segment of this study.

The California Department of Mental Health contracted with the authors for a study of the early implementation of the Community Services and Supports (CSS) component of the MHSA. A first report "Mental Health Services Act Implementation Study: Community Services and Supports State Planning Process" was released in August 2007, and reported on the statewide planning process including the creation of the CSS Plan and Expenditure Requirements and the plan review process. This report covers the planning and early implementation of the CSS plans in seven study counties.

The site visits to the seven counties occurred in the winter of 2006-2007, during the first year of implementation of their approved CSS plans. The information reported here therefore represents the very first stages of implementation.

The study counties and their communities report feeling positive about their local CSS planning processes, and resulting expectations are high.

While not perfect, all of the study counties and their stakeholders agreed that the CSS planning process was a step in the right direction, and resulted in some important learning and exciting new initiatives. The promise of an infusion of dollars, a planning process that asked stakeholders what they wanted, and a set of principles that promise to alter the way in which services are delivered set the stage for extremely high hopes and expectations. In addition, counties are under pressure to demonstrate success, due to the high visibility of the MHSA.

Some letdown was experienced by counties and stakeholders as they began the arduous task of implementation.

Excitement was high at the end of the planning process. The first frustration counties and their stakeholders encountered was a generally longer than expected delay in the time period between plan submission (when the formal role of stakeholders ended) and the start up of new programs and services. This was due to several factors including the state review process, hiring freezes in some counties and the myriad of activities that have to occur around starting new programs – recruitment and hiring, lengthy contracting processes and all the challenges as described earlier in this report. Keeping stakeholders involved and informed during this period was a major challenge, and interviews with key stakeholders, particularly consumers and family members, reflected their concerns that counties might not follow through with their promises for a more collaborative and open relationship.

Counties have struggled with this issue of how to keep stakeholders, particularly consumers and family members and staff not directly involved in CSS programs, informed and feeling a part of the process. Change such as is being undertaken here brings with it concerns, discomfort and a level of apprehension that was clearly felt in the study counties during this period. Although it is extremely stressful and can engender resistance and distrust, these feelings also can be seen as positive signs that counties are clearly not doing business as usual and real changes are beginning to take place.

"We are on the dawn of great things."

The next phase of this study will provide interesting and important information about how implementation is progressing, and whether or not counties are moving toward the goals of the MHSA and embodying key elements of the CSS component throughout their systems.

All stakeholders want and expect change in the system, not merely new services. While everyone is hopeful, they also acknowledge that change is likely to be gradual and incremental. The next phase of the study will focus on the progress these counties have made over the next year of implementation.

Another series of site visits will be made to each county approximately one year after the first site visits occurred. Attention will be paid to the following:

- The progress of implementation of work plans, including the extent to which and how the challenges noted in the first year have been overcome.

- A more detailed description of the initiatives in the four focus areas –ethnic-focused, forensic, health-mental health, and consumer-driven centers – as they have developed, including the identification of elements that seem to be most effective.
- Views of consumers and families about the extent to which not only new programs but the general culture of the public mental health system has changed to include them as partners.
- The extent to which concerns about a dual system have been addressed.
- A self assessment by each county's mental health leadership of how well the county is doing in accomplishing the major transformation goals of CSS – community collaboration, cultural competence, a client/family driven mental health system, and a wellness focus which includes the concepts of recovery and resilience and integrated service experiences for clients and their families.

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