Mental Health Services Act Implementation Study: Phase II

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

This report describes the planning and early implementation of the Community Services and Supports (CSS) component of the Mental Health Services Act (MHSA) in seven early implementing counties.

This is the second part of a study to explore and document the early stages of MHSA implementation with the intent of identifying aspects of the process that have worked well and those that have been challenging. Under contract with the California State Department of Mental Health (DMH), a team of eight individuals including consumers, family members, and persons with mental health management, cultural competence and evaluation expertise, explored local CSS planning and implementation activities in seven counties. The first part of the study (Mental Health Service Act Implementation Study: Community Services and Supports State Planning Process, June 2007) covered the state CSS planning process.

This report describes the planning and early implementation of CSS in El Dorado, Los Angeles, Madera, Monterey, Riverside, San Mateo and Stanislaus counties. These counties were selected for their diversity in geography and demographics and all were early implementers, with all of their plans having been approved by the state by June 2006. The study methods for this report include a review of county plans and subsequent documents as well as extensive interviews with a wide range of county staff and stakeholders conducted during two- to three-day site visits to the counties in the winter of 2006-07. The report thus covers a very early stage of implementation, since at that time the county plans had been approved for less than a year.

In addition to reviewing general planning and implementation activities, the site visits explored four special program areas in which most of the study counties had initiated programs/services: Ethnic-oriented initiatives, forensic initiatives, consumer-driven centers, and physical health/mental health initiatives.

The overall impression from the seven study counties is that enthusiasm and commitment to the CSS effort is extremely high.

The promise of the MHSA for not only additional funds but also as an impetus for system transformation has created excitement within the study counties. The huge investment of time and energy on the part of county staff, consumers, family members and a wide range of stakeholders speaks to the significant interest in mental health issues within these communities. The CSS planning processes were extensive in terms of breadth and depth, and the resulting CSS plans represented the priorities of a deeply involved set of stakeholders. Implementation has been challenging, but progress is being made in both getting programs and services up and running and in beginning the process of integrating the MHSA principles into the overall system of care. Good groundwork has been done through the CSS process for the remaining MHSA components.

While the information in this report is largely anecdotal, it reflects common themes across counties.

For the most part, the information gathered from the seven study counties was surprisingly consistent, both within each county and across all of them. While no formal methods for ascertaining agreement were used, the commonality of experiences provides a reasonable measure of validity to the findings.

Planning

The county planning processes were unique and rewarding experiences for those who participated, and participants generally expressed positive views about the process.

Virtually all interviewees who had participated actively in the planning processes indicated that those processes were empowering, exhilarating, and exhausting. Counties generally had age-based planning groups whose members spent numerous hours learning about the existing system of services, assessing needs, establishing priorities, and making recommendations about how the CSS funds should be used.

Decisions were generally made by a representative stakeholders' group with a transparent and formalized voting or consensus-building process. Most participants reported that their input was not only heard but included in the plan, or if not, then at least sufficiently discussed so that they knew why it was not included.

While the outreach efforts were the most extensive ever undertaken by the counties, they also see this as just a beginning step in an on-going process.

All the counties undertook a serious effort to reach out to all aspects of the community for input into the planning process. The outreach effort was designed not only to get large numbers of participants but also to hear new voices, particularly of those representing underserved communities. Counties learned in the process that traditional ways of obtaining input were less successful, particularly with ethnic communities. Outreach efforts that made use of personal contacts and/or targeted specific community organizations or occurred where people naturally gathered, were more successful than general meetings. Using a personal contact or partnering with a local community organization worked well in obtaining input in ethnic and other cultural communities.

Counties readily acknowledged that they consider this process to be a first step in their engagement with ethnic communities in order to eliminate service disparities. While new relationships were established, it's difficult to overcome existing distrust and suspicion with the public mental health system. Most of the study counties are building upon the relationships established with ethnic and other cultural groups during the planning process in various ways, including particularly their implementation of the outreach and engagement portions of the CSS effort.

The planning processes opened new areas of opportunity for consumers, family members and other stakeholders.

Consumers played a significant role in all the county planning processes. Most counties made arrangements for consumers to be paid for their time. Members of official consumer groups were the most active, but efforts were made in some counties to obtain input from a wider range of consumers by going to residential care facilities and locked facilities, and by trying to engage consumers who lived independently and those who were not involved in organized consumer groups.

Most consumers who were interviewed felt the planning experience was new and encouraging in that they played a more active role in decision making rather than just giving input. However, some indicated a concern that this new partnership was fragile and the outcome was still in doubt as to whether there had been a fundamental change in relationships between consumers and service providers. They emphasized a desire for continued roles in decision-making and for increasing opportunities for sharing power in determining the direction and in the operation of mental health services.

The level of family member involvement differed across the counties. Counties that had active National Alliance on Mental Illness (NAMI) and/or other parent networks experienced greater success in engaging parents in on-going active roles.

It was challenging to sustain participation of other stakeholders due to the extensive time commitments involved. Counties tried various ways to do this and met with varying degrees of success. Most counties used a variety of committees and workgroups and some took advantage of structures used during prior planning efforts.

The state planning guidelines had a significant role in shaping the final plans.

The most significant impact of the state guidelines was the already mentioned extensiveness of the local planning process. Other important impacts were the focus on analyzing and reducing ethnic disparities in access to services, which encouraged the breadth and intensity of outreach efforts. The structure of age-based planning created more attention to the Transition Age Youth (TAY) and older adult populations than they have traditionally received. The requirement that more than half the funds be spent on Full Service Partnerships (FSPs) led to a greater emphasis on this conceptual model than would likely have occurred otherwise. The most controversial of the state planning guidelines was the limitation of funding for involuntary services, an issue about which stakeholders continue to be divided.

For some, the state planning guidelines conflicted with the attempt to have an open community planning process, but most interviewees felt that the structure was useful in developing their plans. Because the seven study counties were all early in the process, they faced some additional frustration because the state guidelines were not finalized until after they had already done substantial planning. In some cases, this necessitated some "back-tracking" in their planning efforts.

General Implementation

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

The major obstacle to quick and easy implementation has been the lack of adequate infrastructure to cope with the large volume of new programs to implement CSS plans. Program designs had to be further refined and then requests for proposals (RFPs) written and bids evaluated and/or new staff hired all while still running existing programs. Attention was generally not paid to infrastructure needs during the planning process, and county political pressures to fund services to meet most of the needs identified often made the use of funds for additional infrastructure considerably less compelling. Every aspect of support for programs from human resources to contracting to information systems to space is impacted when new programs are added but because mental health staff, managers and constituencies think first of services, the need for these vital supports often takes last place.

As a consequence, timelines have proven to be overly optimistic. While counties are making slow but steady implementation progress, there is frustration on the part of some stakeholders about how long it is taking new programs and services to become operational.

Contextual factors – such as concomitant budget cuts – made a large difference in the pace of CSS implementation.

Two of the counties faced significant budget cuts at the same time as the CSS funds became available. This greatly complicated implementation as attention and resources had to be devoted to transferring staff from programs that were closing to new CSS programs. It also limited the ability of the counties to hire staff that had specific expertise and interest in the new programs. Confusion was created for stakeholders about why some programs were being closed while new ones were being opened.

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

The general shortage of mental health professionals and paraprofessionals was repeatedly cited as the biggest obstacle to implementation. This was particularly the case with bilingual and bicultural staff. Additional issues included a shortage of experienced managers, and a lack of staff that have been trained within a wellness, recovery/resilience orientation. Bureaucratic and civil service issues were also identified as presenting barriers to efficient hiring processes.

Significant progress is being made in all the counties in the hiring of consumers and family members.

There is no established best practice for how to structure consumer and family member job classifications within an existing county bureaucracy. Two counties created separate position classifications while the other five used existing ones with the addition of added credit for personal experience with mental illness. The larger study counties are creating consumer and family member positions within their upper management structures. Recognizing that integrating consumer and family staff into the clinical structure can be challenging for all, some of the counties have undertaken major efforts to prepare their workforce and then to follow through with ongoing support and training for both existing staff and new consumer/family member staff.

The involvement of community organizations in the CSS planning efforts led to increases in services contracted to private organizations.

Both the planning processes themselves and the desire to reach out to unserved communities through community-based organizations resulted in new and expanded contract services in most of the study counties. This further stressed existing county infrastructure with the need to develop requests for proposals and review processes and ways to accommodate new kinds of contracting arrangements. In addition, finding space and sites for new programs has been challenging for both county programs and contract providers.

Counties are trying to delineate a new role for stakeholders in the implementation process.

The participation of stakeholders in the planning process was unprecedented, and those with the greatest participation and interest expected some level of similar involvement as implementation proceeded. Counties have struggled with how to continue a high level of stakeholder engagement while attempting to move as quickly as possible through the tasks that come with implementation. The counties have sometimes restructured their planning groups and/or have altered meeting schedules and/or redefined roles and responsibilities. There is a strong desire to maintain the partnership with stakeholders, and a realization that failing to do so could be perceived by stakeholders as simply a return to business as usual.

Full Service Partnerships (FSPs) and System Development Efforts

In general, counties have selected high-need populations for their initial FSPs and are providing high-intensity services.

For adults, five of the counties are utilizing an AB 2034-type program model. The model is based on providing intensive services to clients over an extended period of time. The other two counties are using different models. One has a model in which all the clients are residents of a particular housing site, while the other is using a more flexible definition of an FSP with clients moving in and out of an intensive level of services. FSPs for older adults are similar to what the county is providing for adults, except for accommodations for special needs of this population such as more intensive medical and nursing services and a greater degree of collaboration with other agencies that serve these clients.

Four of the counties have designed specific FSPs for their TAY consumers, while the other three counties are including TAY consumers in their child/youth and/or adult FSPs.

Three counties have incorporated their CSS FSP funds for children/youth into existing SB 163 or other child and youth program models, while the other four have created new and separate programs for children and their families.

Early implementation efforts have identified a need to clarify the concept and definition of FSPs.

With the diversity in service models for FSPs has come some confusion about concepts such as duration of services, levels of service intensity, the "whatever it takes" concept and issues about flexible funding. In addition, the diversity in models, budgeting, and initial priority populations will make comparison of estimated average costs per FSP client and outcomes difficult.

The age-based planning guideline structure increased attention to the older adult and TAY systems of care.

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. Four of the counties are undertaking major planning efforts and staff increases to strengthen a separate older adult system of care. Peer counseling, assessment and mobile outreach are among the clinical services that are being added for older adults with System Development funds.

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. Unlike the older adults, there were few service advocates for the TAY group so that new services for the group were more often merged with those of either children and youth or adults

Common system-wide initiatives funded through System Development funds included expanded or reorganized crisis and emergency response systems and an emphasis on implementing evidence-based practices.

Three of the counties are using CSS funds to reorganize and enhance their emergency and crisis response systems. Five counties have highlighted specific evidence-based practices, which will be implemented with CSS funds. Some of these practices are directed at the entire mental health system, not just MHSA programs.

Special Program Areas

Ethnic-oriented Initiatives

All seven counties have undertaken some ethnic-oriented initiatives.

Reducing ethnic disparities is a central goal of state and local CSS efforts. The state planning guidelines were explicit in articulating this goal, in requiring extensive analysis of these disparities within each county, and requiring the county to indicate the specific ways in which their CSS plans would address outstanding disparities. The counties developed a variety of approaches to reduce disparities and increase access to services.

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

Four of the counties are contracting with a variety of community-based organizations to assist them in building the capacity to address mental health needs in their communities. This effort is in response to feedback from communities that the lack of understanding of the culture and the role as a community outsider make it difficult for public mental health systems to provide services that will be readily accessed and accepted by community members. This alternative strategy builds upon the existing positive reputations of the community-based organizations and attempts to build partnerships that will allow the organizations to build the capacity to offer mental health services themselves.

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

Efforts here are directed to building additional capacity within the county systems with the specific responsibility for outreach to ethnic communities to either assist in linkages to existing services or to provide new more culturally appropriate services. In two instances counties are piloting more decentralized access systems that are designed to allow for more access to community members of underserved groups. Training in ethnic issues continues to be a high priority in most of the counties.

While most counties are prioritizing ethnic populations for CSS services, only one of the study counties is setting specific numerical targets for FSPs by both ethnicity and priority population. This represents a strong commitment to address the ethnic disparity issue directly. The county is finding difficulty meeting its targets in some areas and has realized it did not consider the interplay between ethnicity and referral sources. Without additional outreach and engagement to address some of these issues, the ethnic disparities are unlikely to be altered.

Forensic Initiatives

Six of the study counties had a forensic program in their CSS plan.

Most study counties have some history of joint efforts with law enforcement, probation and the courts, allowing them to engage the major players in the CSS planning effort. Most of the counties also had prior experience of joint programs operated under previous Mentally Ill Offender Crime Reduction (MIOCR) grants.

The DMH requirements that CSS funds can be used within a jail or juvenile justice facility only for services that facilitate discharge and that in collaborative programs only the proportion of forensic costs associated with mental health activities are allowable created some initial confusion and dismay at the local level among law enforcement and mental health planners. Counties are still working through some of this, but are moving forward with forensic initiatives.

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.

Mental health courts, enhanced linkages with the mental health system for persons in the criminal justice system, and specific FSPs were the three major types of forensic initiatives.

Four of the counties are adding or expanding existing mental health courts with a range of accompanying supportive services. Mental health courts were discussed seriously in two other counties but were not sufficiently high on the priority list to be funded. Another major initiative in three of the counties is to increase the linkages between the jails and juvenile hall and mental health services to enhance continuity. Persons with criminal justice involvement are a priority FSP population for most of the counties, but three in particular have special FSP efforts for this population, including one that has a probation person as part of the FSP team.

Mental Health/Physical Health Initiatives

Four counties have specific physical health/mental health initiatives as part of their CSS plans.

The impetus for enhanced coordination between physical health and mental health emerged from the planning process as a high need, but often without any clear program design. The county with the greatest experience with this kind of collaborative effort is funding expansion of its existing programs, and another county has created a special FSP to serve selected persons with existing mental health and medical conditions. The strategy in two counties is to co-locate mental health staff in primary care settings.

The implementation of these programs has been challenging.

Integrating physical health and mental health is complex because of different cultures, ways of operating, methods of computing costs, reimbursement mechanisms, and rules and regulations. In some instances, the appropriate persons from the medical care system were not sufficiently involved in the planning to verify assumptions about how and where persons seek medical care or to be able to commit resources or space to intended co-location plans. As a result, implementation has been slow because program design elements have had to be re-thought and redesigned.

Consumer-driven Centers

Six of the seven counties are embarked on efforts to establish consumer-driven centers.

Consumer involvement in all aspects of the mental health system is a core value of the CSS component. One of the four program areas for the study was consumer-driven center initiatives, which have as a key component consumers as the major force in determining what happens and how it happens at the particular center. This concept is evolving as it is being developed and implemented in the various counties. While most of the centers are beginning with at least some degree of professional management, four of the counties are envisioning transfer to complete consumer control in the near future. Two of these counties have started with consumers in the executive director positions with professionals as advisors and assistants.

The design, intent, and service array of the centers differ by center with no one model emerging as a consensus choice.

A number of issues have arisen as these centers have begun to evolve.

- Should they be drop-in centers or have a more formalized structure?
- Should they be open to the whole community?
- How closely tied should they be to the mental health system?
- Should they be viewed as "step-down" sites from other services and/or should participation be limited to current or prior mental health clients?
- Should there be professional services offered at the site and what other kinds of services should be offered (e.g., vocational, educational)?

These issues are being actively discussed and deliberated with various models being attempted. The decisions are being driven by consumers and by the needs of the counties as they attempt to fit this emerging concept into their vision of a comprehensive consumer-oriented mental health system. Following the development of these centers over time should provide a particularly rich source of information.

Hopes, Concerns and Achievements

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. Interviewees also expressed hope for a system of services that is more accessible and appropriate for persons from diverse cultures.

The greatest concerns expressed were that MHSA would create a dual system of care and that expectations of stakeholders may have been raised too high.

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 programs are being implemented. Counties also 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.

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 by providing information about what is achievable in the short term, but acknowledge that they may have limited power to affect these expectations.

All of the study counties have considerable pride about achievements to date.

All of the counties believe the local planning process was an outstanding achievement that has created positive feelings and excitement, and has developed a foundation for future stronger collaborations with community stakeholders. The growing partnership with consumers and the increased interest and involvement of all county staff and contract providers in the transformation of the system were cited by a few as particularly noteworthy accomplishments. Having successfully implemented most of their CSS plan was cited by several counties as another source of pride, given their enormous bureaucratic challenges.

Ideas for Consideration

As stated previously, the intention of this study and this report is to inform the broad range of stakeholders about the progress in the early stages of CSS activity in seven study counties. In the course of the study the following ideas emerged as important for consideration in the further evolution of both the CSS and the other components of the MHSA.

- State planning guidelines and program and funding requirements should be made known as soon as possible to avoid confusion and frustration on the part of counties and their stakeholders.
- Future planning efforts should build upon this initial process, rather than trying to duplicate its breadth and depth.
- Meaningful outreach to underserved ethnic communities will require the counties to engage in a set of focused long-term strategies.
- Counties need to create a more welcoming and helpful environment and take a more proactive role in addressing the community concerns even when they cannot accommodate all the demands for services.
- Planning for future CSS funds and other MHSA components should include appropriate attention to infrastructure needs.
- Implementation timeliness should take into consideration the complexities and bureaucratic realities of implementing new programs and services.
- Consumers and family members feel positively about planning efforts, but they also expressed a strong desire to be true partners in a wellness-centered system. This necessitates a fundamental change in relationships among consumers, family members, service providers and system leadership.
- Attention should be paid to defining and sharing ways of maintaining involvement of stakeholders during implementation.
- The concept of an FSP and implications for program design and accountability need to be clarified.
- Ethnic disparity initiatives must be viewed within a framework of a long-term effort to build

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relationships with community partners and to address underlying issues responsible for the disparities – there is no quick fix.

- Physical health/mental health collaborations need to be built upon sufficient knowledge of both systems, and planning must include appropriate representation from both sectors if efforts are to be successful.
- The development of the consumer-driven center concept as it is implemented in the counties should be carefully studied and shared as a source of helpful information.
- Care needs to be taken to not overload counties (particularly small counties) with too many complex and detailed administrative requirements.
- Attention must be paid to continually addressing expectations in order to avoid disillusionment.
- It should always be remembered that the goal is system transformation, not just new or expanded services.

This is a stand-alone Executive Summary of a report by the same name. The full report, *Mental Health Services Act Implementation Study: Planning and Early Implementation of Community Services and Supports in Seven Counties* and/or additional copies of this document can be obtained from:

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