MHSA Implementation Study:
Community Services and Supports Successes and Challenges

Executive Summary

This is the third and final report of this study and covers the second year of implementation of the Community Services and Supports (CSS) component of the Mental Health Services Act (MHSA) in seven counties. [1]

The information in the report comes from site visits (one to three days in length) to each county, from surveys of consumer and family member employees in all seven counties and of MHSA and other mental health staff in six of the counties' mental health programs. The report contains examples of exciting endeavors which we have called "transformation efforts", as well as a number of quotes which illustrate county implementation efforts and challenges.

Implementation is generally going well, despite the fact that most counties are facing major financial constraints.

In contrast with last year, staff expressed much more confidence and satisfaction with how things were going. Almost all the programs are now operational, although not all are fully staffed and/or meeting their utilization targets. This is in spite of the fact that five of the seven counties are facing major budget problems for the fiscal year 2008-09 while a sixth may escape such problems this year by relying on a one-time Medi-Cal prior year settlement. The major remaining implementation issues are finding space for new staff and sites for new programs as well as continuing human resource challenges particularly with regard to the hiring of sufficient trained bilingual and bicultural staff. Contracting processes have improved, but there are sometimes still significant delays in negotiating and processing contracts as well as special issues in working with smaller organizations who have not before contracted with the county.

Stakeholder involvement has evolved from solely a planning function into a role that includes oversight and monitoring.

Stakeholders not only receive information about CSS implementation, but they participate in a more active process of oversight and monitoring. They are additionally involved in planning of other MHSA components as well as sometimes addressing issues for the broader mental health system such as the budget situation. The counties are using different methods to achieve sufficient stakeholder involvement. Some have continued with a variation of their initial CSS planning structures and processes; others are relying more on their Mental Health Board/Commission; and others are creating ad hoc groups to deal with specific tasks. All recognize that additional work needs to be done to provide

[1] The seven study counties are El Dorado, Los Angeles, Madera, Monterey, Riverside, San Mateo, and Stanislaus. Two prior study reports are available on the DMH website at www.DMH.CA.gov

information to stakeholders that is understandable, relevant, and sufficiently detailed to allow them to be productive without overwhelming the consumers.

Access is improving.

Improving access to services is one of the goals of the MHSA as well as one of the specific goals of community stakeholders in many counties. Achievement of this goal has been somewhat frustrated by the budget situation, but all the counties have included some specific effort directed at increasing either general access to the system or access to a particular part of the underserved or unserved population in their county. Roughly two-thirds of the staff on a web-based survey said that their programs are easier to access than a year ago.

Implementation of CSS programs differ by age group. With adults, the biggest challenge, particularly in the larger counties, is how to incorporate the current high intensity FSP model into their existing system of care.

The concern about a dual system of care is most evident when comparing the high level of service for a consumer in an adult FSP with the minimal services available to a consumer in the regular system of care. A few counties are addressing the issue by scaling down the intensity of services to original FSP consumers by either graduating them to a lower level of care or by reducing their service level within the FSP. [2]

Counties are learning how to engage and serve TAY in more meaningful and effective ways.

Engagement remains the biggest challenge to the TAY programs. There is a growing recognition of the differences between the younger and the older TAY populations which makes this an even bigger challenge. Besides the FSPs, the most common new service for the TAY population is drop-in centers, which vary in the extent to which they are connected to the mental health system as opposed to being a more generic site open to any TAY in the community.

For older adults, CSS has served as a catalyst for the development of a separate infrastructure and system of services.

A major challenge continues to be the ability to hire staff with relevant experience and interest in working with this population. As with the TAY population, there is a distinction between the younger and older groups within the population. The concept of a long term intensive service model FSP does not appear to fit neatly with the needs of the older adult population. Most of the counties are

[2] This can be accomplished by adding additional consumers to the FSP with no additional staff or expenditure. Some believe continued connection to a service provider assists recovery while others believe a more formal “graduation” to another program is more appropriate.

using shorter duration models of FSPs for older adults, which include an extensive assessment process, which is usually conducted in the community.

FSPs for children and families differ among the study counties.

Two approaches stood out in the implementation of child, youth and family CSS programs. More counties funded evidence-based practices for children and families than for the other age groups. Most counties also used CSS funds to strengthen and expand their systems of care for children and families, working together with other agencies and community-based organizations.

As in the last report, the study focused upon four areas in which counties are implementing special initiatives.

This report highlights some of the implementation progress and challenges in these areas, with particular attention to what appears to be important for efforts to be successful.

For the most part, forensic initiatives are going well.

Six of the seven counties have mental health programs for adults in conjunction with the criminal justice system. Enough experience has been gained to highlight factors which make Mental Health Courts for adults successful. These factors include an open exchange of views about individual cases, the use of jointly developed, tightly monitored criteria for program eligibility, a respected and credible leader of the mental health component, and an interested and committed judge.

Collaborative physical/mental health initiatives have presented challenges for most counties.

Counties have found it difficult to overcome the cultural differences between the physical and the mental health systems and to figure out how to address reimbursement, space and communication issues to make these efforts beneficial to both parties. Clearly such collaborations are possible judging by the one county (San Mateo), which has a history of successful joint programs and from the beginning efforts in another county (Monterey). But in other counties, the hopes of CSS collaborative programs with physical health are either slow to begin or being restructured based on early efforts.

Counties are using a variety of ethnic-oriented initiatives aimed at reducing disparities.

These efforts include heightening efforts to ensure culturally competent services at both county operated and contract provider services; reaching out to potential

new clients by co-locating services in ethnic community organizations; contracting with ethnic community organizations that do not traditionally provide any mental health services; and, forming long-term collaborative relationships with ethnic community leaders to work jointly towards reducing stigma and ensuring a wide range of appropriate mental health related services for the community. Implementing these strategies is challenging – finding the right cultural brokers and organizations with whom to work, overcoming issues of distrust and a prior history of disappointments, figuring out how to contract with small organizations that have never contracted with the county before, and overcoming county staff fears of being overwhelmed once the doors are open.

Approaches to consumer-driven centers differ among counties; maintaining engagement is a challenge for all.

Almost all the consumer-directed centers which have begun under CSS are operated by contract providers. Seven of ten centers that completed surveys about their centers had consumers as directors. Over 80% of the staff at the ten centers were consumers or family members. There are differences in how the centers are evolving within each county's system of care, which are detailed in this report. The biggest challenge for all the centers is how to maintain ongoing engagement in their activities. While large numbers of consumers have used the centers at some point, the regular daily attendance is often lower than expected or desired.

All of the study counties believe that the MHSA can and should be a catalyst for system transformation.

Counties are making varying progress on implementing and spreading throughout the system the five essential elements of the CSS requirements.

A focus on wellness with a recovery orientation is the most prominent of the five essential elements.

Many counties had already begun the shift to a recovery orientation before MHSA, but the CSS process has invigorated and broadened those efforts. Staff working with children and youth incorporate elements of a wellness orientation, e.g. stressing strengths and incorporating developmental concepts, but express uncertainty about the meaning and use of the concept of resilience.

Strategies to develop a client and family driven system are resulting in significant positive change.

An increase in the numbers of consumer and family member employees has been one of the most successful parts of the CSS component. Four of the counties have one or more management positions for consumers and/or family

members. On a special survey of consumer and family member employees, they expressed satisfaction with their jobs, except for wanting higher salaries and more training. Critical to the concept of consumer and family driven services is the enhancement of each person's and each family's role in making decisions about their own goals and services. In a web-based survey of all staff, over three-quarters of the respondents said they were involving consumers and family members more in decisions about their treatment goals and plans than they did a year ago.

The focus on reducing ethnic disparities has heightened attention to the cultural competence of existing programs and efforts to build bridges to ethnic communities.

One concrete effect has been a reinvigoration in many counties of the Cultural Competence Committee and an enhancement in the role of the Ethnic Services Manager. Counties are also moving to more contracting with trusted ethnic community organizations in an effort to ensure better access to services. The greatest challenge is how to balance the value of special cultural competence structures and systems with the need to incorporate cultural competence into everything the mental health system does.

Efforts for greater community collaboration, which were already underway in most counties, were enhanced by the emphasis of CSS on this core element.

As noted, community collaborations with the forensic system and with community based ethnic/cultural organizations have been some of the more important and most successful CSS initiatives. The concept has been pushed even further by a few counties which are turning more towards trying to build community ownership of mental health issues recognizing that the mental health department will never have sufficient funds to address all the mental health needs of the community.

In the study counties, there is less clarity about the concept of an integrated service experience than any of the other four core elements.

Some counties see an integrated service experience as the result of good community collaboration or as one end of a continuum of cooperation/integration in which services are combined in one location with one staff. Others have the broader concept of minimizing and easing the "handoffs" required either within the mental health system or between mental health and other systems. Depending on their particular orientation, a few of the counties have undertaken efforts to implement the concept, e.g. specifically working on the "handoffs" or implementing integrated services for co-occurring disorders.

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In general, stakeholders and staff in the seven counties are positive about what has been accomplished thus far.

Many of the individuals interviewed expressed the view that there has been a fundamental change particularly with regard to the acceptance of the recovery model, consumer and family involvement in the system, and a serious commitment to reducing ethnic disparities. Everyone is concerned about the integration of CSS and other MHSA components with the entire mental health system and counties are developing strategies, plans and creative approaches to make sure this will happen to the extent possible. The biggest area of concern is the difficult fiscal environment, and the creation of a dual system of care. Stakeholders and staff spoke to the importance of exploring and addressing this issue in the future.