MHSA Implementation Study:
Community Services and Supports Successes and Challenges

INTRODUCTION

This is the third report of a study that explores and documents the implementation of the Community Services and Supports (CSS) component of the Mental Health Services Act (MHSA).

The California State Department of Mental Health (DMH) contracted with a team of eight individuals including consumers, family members, and persons with mental health management, cultural competence and evaluation expertise to conduct this study. The first part of the study (MHSA *Implementation Study: CSS State Planning Process, June 2007*[1]) reported on the state's planning activities while the second (*MHSA Implementation Study*: *Planning and Early Implementation of CSS in Seven Counties, November, 2007)* reported on the planning and early implementation progress and challenges at the local level. The seven counties studied – El Dorado, Los Angeles, Madera, Monterey, Riverside, San Mateo, and Stanislaus – were all early implementers with all of their plans approved by DMH by June 2006. This third part of the study reports on the status, successes, and challenges faced by these seven counties in fiscal year 2007-2008, the second year of CSS implementation. As before, the study team focused on four specific program areas: forensic initiatives, physical health/mental health initiatives, ethnic oriented initiatives and consumer-driven centers.

The seven study counties reflect the diversity of California counties.

As can be seen in the table below, the counties vary in size, location, and ethnic diversity**.**

	El Dorado	*Los Angeles*	*Madera*	*Monterey*	*Riverside*	*San Mateo*	*Stanislaus*	*State*
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%	2.1%	1.9%
Total CSS Planning Estimates Thru 6/30/08**	$5.8M	$325.1M	$5.9M	$13.6M	$58.5M	$18.3M	$18.1M	$1,156M

*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.
**State Department of Mental Health.

[1] Both prior reports are available on the DMH website at: http://www.dmh.cahwnet.gov/Prop_63/MHSA

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In addition to the methodologies used in the second report, this report contains information from two staff surveys.

As in the last report, the information here is based on extensive interviews during one, two or three-day site visits to each county, a review of documents and an analysis of data submitted to the state as part of MHSA reporting. In an effort to expand the kinds of information used in the exploration of CSS implementation, we introduced two different surveys—a general staff survey and a special survey for consumer and family member employees of the county or contract programs.

The general staff survey was web-based and had two versions – one for staff working with TAY, adults, and older adults and one for staff working with children, families and youth. The web links to these surveys were provided to the MHSA Coordinators and in five of the counties the coordinators used various methods to inform staff in county and contract programs about the survey. Further details about the survey are found in Appendix A. The response rates were generally quite low, but we have in total 593 surveys from staff working with TAY, adults, and older adults and 281 surveys from staff working with children, youth, and families. Over 85% of the staff who responded to both these surveys said they worked in a program that was funded by MHSA, but a surprising roughly one-quarter of the responding staff to both surveys did not know if their program had MHSA funding.

The second survey was a paper and pencil questionnaire given to consumer and family member employees of the county or contract programs. The method for distributing the surveys was the responsibility of the MHSA Coordinator. The surveys were confidential and were placed in envelopes addressed to the Study Team. Further details about this survey are found in Appendix A. There were 128 surveys completed overall with some responses from all seven counties.

This report explores counties' progress on adopting the MHSA core elements.

The MHSA promotes the transformation of the public mental health system into a system which will better support the recovery of adult persons with mental illness and the enhanced resilience of children with behavioral and emotional problems. The desired transformation rests on the assumption that achieving changes in the organization and delivery of services will increase these desired outcomes for individuals and families served.

The desired changes in the system are reflected in five core elements which emerged from the state's stakeholder process as key values seen as necessary in a transformed system. These elements are a focus on wellness and resilience, cultural competence, client/family driven systems, community collaboration, and integrated service experiences for clients and families.

Our prior report dealt largely with how the counties were overcoming the

challenges of getting programs up and running. This year, we shifted the focus to explore the extent to which these five elements have been embraced by the counties. Our report on this area (Chapter 4) relies largely on interview data, but we also obtained some information through surveys. This latter effort was a preliminary strategy designed in part to assess the merits of obtaining this kind of data.

An additional focus is on how the CSS components relate to and interact with the rest of the county's mental health system.

The implementation of the MHSA has not occurred in a vacuum. As Chapter 1 describes, the context – particularly the fiscal situation – has created a special set of challenges for the counties. The MHSA was intended to fund new programs and expand successful innovative programs. The effort was to use these funds as a catalyst to transform the entire mental health system. In this year's study, we explored the counties' efforts to address the "dual systems of care" that some see as developing, as well as what strategies the counties have used – explicitly or implicitly – to spread the key MHSA principles to their overall system.

In addition to describing what is happening generally, selected "transformation efforts" are highlighted throughout the report.

The report contains the following chapters.

- ✓ Chapter 1: General CSS Implementation
- ✓ Chapter 2: Services and Supports
- ✓ Chapter 3: Special Program Areas
- ✓ Chapter 4: System Transformation and Core Elements

Throughout the report we have identified "transformation efforts", which in our view reflect the county's effort to do things differently and in a way that has the potential to lead to transformation. We do not believe that the evidence is sufficient to call these best practices, but they are worthy of note because they are attempts to implement the core elements of CSS, they might be helpful to others, and they should be the subject of further study to see the results. Identifying something as a "transformation effort" does not imply that the county's overall approach to a particular topic is exemplary or that the effort has been fully implemented as described – it simply indicates the county's intent and actions towards new and potentially transformative initiatives and programs.

CHAPTER 1: GENERAL CSS IMPLEMENTATION

A. CONTEXT

The major contextual factor affecting counties is the current fiscal situation.

Five of the seven counties are facing major budget problems for FY 08-09; a sixth may escape budget cuts by relying on a one-time Medi-Cal prior year settlement. This comes on top of significant cuts during the FY 07-08 year which resulted in hiring freezes in at least three of the counties and actual closure of clinics, reduction in services, and/or transfer of clients to lower levels of service in three of the counties. The magnitude of the shortfalls requires that Mental Health Directors and other key staff expend considerable time and effort addressing how to realign their service systems within their fiscal constraints.

Complicating the budget situation is the desire of some of the Boards of Supervisors and some county staff for more flexibility on the use of MHSA funds and the non-supplantation restriction. Some of the counties would like to use MHSA funds to backfill other revenue losses within mental health, utilize MHSA to pick up mental health-related functions which were performed by other departments (e.g. screening persons entering the forensic system), or pay for cost of living adjustments for all the mental health programs.

Workload demands are a major impediment to effective services according to program staff.

The financial situation is reflected in high caseloads which many program staff feel are an impediment to effective services. About half the staff on the web-based survey agreed with the statement that their "workload was too high to allow for effective treatment".

"Our workload is too large to allow for effective treatment."	Strongly Disagree	Disagree	Agree	Strongly Agree
Staff working in programs for TAY, adults, older adults (N=587)	10%	42%	31%	17%
Staff working with children, youth, families (N=277)	6%	43%	36%	15%

Despite this serious challenge as well as staff layoffs and budget uncertainties, staff morale was rated as good to excellent by about half the staff.

"How would you rate the staff morale in your program?"	Excellent	Good	OK	Poor
Staff working in programs for TAY, adults, older adults (N=586)	17%	38%	31%	14%
Staff working with children, youth, families (N=277)	23%	39%	26%	11%

The two items were related; among those who felt that workload was too high for effective treatment, only 32% rated staff morale as good or excellent compared to 65% of those who disagreed that workload was too high for effective treatment (staff working with TAY, adults, older adults).

The other common contextual theme is the complexity and workload resulting from the implementation of all the MHSA components.

During the first year of CSS implementation, attention could be directed almost exclusively to starting the new programs. During this second year, county leadership and MHSA coordinators have had additional MHSA related tasks: planning for Workforce Education and Training and for Prevention and Early Intervention and ensuring the collection of CSS utilization and financial information. While the planning and reporting requirements are seen as useful, the intensity and complexity of all the current requirements are seen as too burdensome to continue as is into the future.

B. IMPLEMENTATION PROGRESS AND CHALLENGES

Overall, implementation of CSS work plans is proceeding well.

The first year of implementation was a struggle for most of the counties because of the magnitude of the effort, the need to establish new procedures, and the lack of sufficient infrastructure to accomplish these tasks. This year staff expressed much more confidence and satisfaction with how things were going. Staffing for important infrastructure units such as human resources, contracting, finance, and Information Technology (IT) has increased (a need strongly expressed in Phase 2 of this study) although many of these functions are still feeling considerable pressure.

Almost all the programs are now operational, although not all are fully staffed and/or meeting their utilization targets.

The Table below presents data from the counties' Exhibit 6 (Three Year Plan-Quarterly Progress Goals and Report) submissions to the State Department of Mental Health. It indicates the actual number of participants and the percentage of the target which has been specified by the county for the second, third or fourth quarter of FY 07-08.[2] This table should be interpreted with the greatest caution as it displays the difficulty of tracking program utilization at the state level. The county sets its own targets and changes these targets and can alter the targets as circumstances evolve. This information is most useful to county stakeholders who, if given all the information, can assess the level of progress on implementation taking into consideration the original setting of targets and the validity of changes in these targets over time. Additionally, the instructions for

[2] Three of the counties have not yet submitted their fourth quarter reports.

completing the Exhibit 6 have been confusing to many counties, and some continue to have questions. With these caveats and by excluding information which we know to be the result of special circumstances (noted in footnotes to the table) we can make the following observations.

- ✓ All but one county have substantially surpassed their Outreach and Engagement targets. There has been the greatest confusion about how to count these contacts with a resulting uncertainty about the usefulness of the data.
- ✓ Achievement of System Development targets ranges from 82% – 87% in four of the counties. The other counties are above targets (except that Los Angeles information may not be accurate).
- ✓ FSP enrollments in relationship to targets vary by age group and by county.
  - o Children: Four of the counties are at or above 75% of their targets.
  - o TAY: Five of the counties are above two-thirds of their targets.
  - o Adults: Five of the counties are near or above 75% of their targets.
  - o Older Adults: Only three of the counties are at or above 75% of their targets.

Number & Percent of Target 3rd or 4th Quarter 07-08)	*El Dorado*	*LA*	*Madera*	*Monterey*	*Riverside*	*San Mateo*	*Stanislaus*
Outreach and Engagement							
Number	149	7,808	60	1,198	619	1,203	400
Percent of Target	324%	1300%	30%	692%	138%	164%	118%
System Development							
Number	175	37,957	412	500	7,885	1,247	825
Percent of Target	172%	239%*	85%	87%	182%	82%**	85%
FSP - Children							
Number	7	1,163	20	32	71	41	3
Percent of Total	58%	67%	91%	80%	44%	103%	75%
FSP - TAY							
Number	6	898	16	****	94	48	18
Percent of Total	67%	80%	70%		24%***	120%	113%
FSP –Adult							
Number	17	1,930	27	****	353	61	33
Percent of Total	155%	74%	108%		112%	122%**	57%
FSP – Older Adults							
Number		202	20	****	114	165	4
Percent of Total		75%	80%		114%	33%	22%

* There may have been a revision in the way in which these figures are counted since in Q1 the figure was 105% of the target.
** Second Quarter; 3rd Quarter may be an anomaly.
*** Targets were raised dramatically for Riverside TAY from 25 (Q1) to 388 (Q4) and for San Mateo OA from 35 in Q1 to 496 in Q3.
**** Due to challenges in setting up reporting units for each of the FSP programs, reporting an accurate number of FSP clients during the initial implementation period was not possible. And Monterey did not initially understand that it had the option of changing the target figures.

Significant implementation challenges remain.

The most critical challenge identified this year is the lack of appropriate space. This is noted throughout the county systems where space cannot be found for additional staff or programs. Interviewees also noted that finding sites for programs within the community remains problematic. This lack of space seems particularly daunting because, unlike some of the other challenges, no one can foresee readily apparent solutions.

The second most mentioned challenge is human resources. The transferring of staff resulting from layoffs and budget reductions sometimes results in staff that are not enthusiastic about their new assignments. Some counties are experiencing difficulties in hiring for particular staff classifications. A lack of bilingual and/or bicultural staff remains a major obstacle for all of the study counties.

Many of the contracting issues noted in the first year of this study have been addressed with new procedures having been established, but issues remain. In particular, there has been little progress on figuring out how to assist small organizations who have not done business before with the county to develop the capacity to become a government contractor. This is especially problematic if the organization believes it needs to become Medi-Cal certified to make the endeavor financially feasible.

Systems for tracking utilization and financial data for reporting to the state continue to be developed and refined. Some counties continue to feel stretched by the Full Service Partnership (FSP) reporting requirements and the MHSA revenue and expenditure reporting.

C. STAKEHOLDER INVOLVEMENT

A major task with regard to stakeholder involvement has been a shift to a monitoring role for CSS implementation while retaining planning responsibilities for other MHSA components.

The local CSS planning efforts were generally viewed as very successful (with some exceptions[3]) with most stakeholders feeling newly empowered and involved. We noted in Phase 2 site visits last year an initial let down feeling at the conclusion of the planning effort with some stakeholders not knowing what would come next and how they would be involved in implementation. This year the tension about insufficient involvement in implementation was muted, but the overall challenge of how to accomplish an appropriate oversight and monitoring role was more apparent. The effort is complicated by the fact that stakeholders

[3] The most notable exception was the lack of successful engagement of ethnic communities in many of the counties.

are concurrently involved in planning for Workforce Education and Training (WET) and Prevention and Early Intervention (PEI) as well as in dealing with system changes resulting from the ongoing budget challenges.

A uniform challenge is how best to keep stakeholders informed about the status of CSS implementation.

While the overall goals of CSS work plans are fairly straightforward, the details of implementation can be very complex. Counties struggle with how to describe (sometimes slow) progress on these details in a way that is understandable to stakeholders. Too little information can lead to stakeholder frustration and too much to stakeholder fatigue or a feeling of being overwhelmed.

Efforts, which appear to be promising include:

- ✓ Updates (usually monthly) to established stakeholder groups such as consumer networks or centers and NAMI meetings
- ✓ A regular agenda item on Mental Health Board/Commission meetings
- ✓ Newsletters which highlight accomplishments and also publicize ways to get involved

The effort to keep everyone up to date can be frustrating. One county did an elaborate updating of all its work plans but then said “by the time it was done and on the website it was already old and it didn’t get much attention.”

The more challenging task is how to create a structure and process for real oversight.

There is an appreciation that stakeholders need to be more than passive recipients of information about the status of program implementation. Stakeholders want to become active participants in ongoing monitoring not just of the presence of programs but of what they are doing and what is being accomplished.

This task is made more difficult by the lack of any clear standards by which to judge how well the county is doing in its implementation efforts. Some interviewees (including county leadership) expressed an interest in having more structured and rigorous means by which to assess progress. They would like to have more performance and client outcome data upon which to make judgments but are not sure how to obtain and/or use such information in a productive fashion.

Counties are approaching the issue of structure in different ways and with varying levels of effort. One approach has been to encourage and support the Mental Health Boards/Commissions in their role as monitors of the county mental health system. These Boards/Commissions are created in statute with a required majority of consumers and family members. In some counties, the

MHSA planning effort was undertaken under the overall umbrella of the Mental Health Board or Commission. At least two of the study counties noted the increased role and capacity of their Boards as a consequence of their heightened MHSA activity. They note that some stakeholders have attained a sufficient level of knowledge and confidence to play a very active and influential role. "The consumer and family members have been nurtured so now they have heated discussions, with staff just hanging back."

Other counties have continued the special structures established for CSS planning and utilize some part of that structure for ongoing reporting on implementation. In this approach, the new planning tasks (for WET and PEI) have increased the numbers and types of people who need to be involved, therefore, making progress on CSS monitoring more difficult because not everyone has the same knowledge base. The use of special task forces and committees helps with the planning tasks, but doesn't resolve how to establish an effective monitoring process.

Transformation Effort: Los Angeles has made the most serious commitment to creating new structures and processes which will allow stakeholders to have a meaningful role in the monitoring of the mental health system and in decisions about that system. The task is especially difficult in Los Angeles because of the size of the county. Undaunted, Los Angeles has revised the structure established for CSS planning by expanding its Delegates group to 90+ representatives and creating a new System Leadership Team with 25+ representatives. It has worked through a new set of roles and responsibilities for each group which will extend beyond just MHSA. It is considering how it will balance its consensus model from the initial planning effort with a voting model necessary to operate more efficiently. The redesign effort has itself entailed a great deal of process work in an attempt to resolve longstanding issues of mistrust. Views on how well this will work are mixed, but the effort is clearly not "business as usual."

CHAPTER 2: SERVICES AND SUPPORTS

A. ACCESS

Improving effective access to the mental health system is one of the CSS goals as well as a desired goal that emerged from local planning efforts.

During the CSS planning process, counties discovered (or confirmed what they already knew) that stakeholders (both potential clients and other community agencies and organizations) are frustrated about a lack of access to mental health services and supports. While services will necessarily be limited by constrained funding, counties are learning that strategies can be implemented, which will make the system more open and welcoming both to those it can serve and to those who will need to be referred elsewhere.[4]

4 Strategies addressing barriers to services for the ethnic communities are discussed on pg. 24 Ethnic-Oriented Initiatives and pg. 49 Cultural Competence. Addressed here are efforts to change fundamental aspects of the system.

Stakeholder input highlighted more than just a closed door. Even when the door is open, the environment is not welcoming and results in rapid disengagement, or the path through the system to an appropriate service or support is so complicated that people drop out.

Counties have made significant efforts to improve access.

Counties are often framing their efforts as creating a more "welcoming" environment and attitude towards people trying to enter the system. This includes both making more effort to engage potential clients and being more helpful to persons who do not qualify for services.

- ✓ Riverside has charged each clinic with developing a welcoming plan. This has resulted in greater awareness and efforts to make the environment more acceptable to consumers of varying cultures.
- ✓ Stanislaus has restructured its central access number to be answered by a 90% consumer-staffed warm line. Crisis calls are passed along to an emergency response team.

Some counties have designated specific positions to ensure access, particularly to FSPs.

Los Angeles has created System Navigator positions for each age group within each of its service areas. As initially conceived they were to enhance entry into the mental health system, but they have focused most of their efforts on attempting to reach ethnic and priority population targets which Los Angeles set for each of its FSPs. While the county is reconsidering its targets, the efforts of the System Navigators were generally lauded by interviewees.

> *Transformation Effort:* The System Area Navigators (SANs) are responsible for providing the linkage to the FSPs. They accept referrals to FSPs and also seek out potential FSP clients through linkages to other systems, for example the jail. They can follow up on referrals in which the client fails to follow through. They also provide a point of contact for the FSP providers being available to answer questions and to provide assistance when needed: "providers are so grateful for a 'go to' person." They bring some flexibility to a system (driven by strict criteria) which is valuable to maintaining good relationships with both referral sources and providers. While reporting to the service area administrator the various age group SANs meet monthly and all meet together quarterly. An area of continual discussion (and variation by service area) is figuring out how the more individual client-focused SAN responsibility fits with the broader community relationship development activity of the outreach and engagement workers.

Two counties have implemented major restructuring in one geographical area in conjunction with an effort to improve access for an underserved population.

Monterey has approached altering its generally centralized access system in its smaller south region as part of its effort to reach out more to the Latino community. They have removed any payer or medical necessity criteria for being seen in the clinic. One can walk in and get an appointment within a week, and they are trying a same day/no appointment effort on one day each week. They have also done active outreach to schools and faith-based communities. The approach has led to a doubling of the case load. The county plans to gradually expand this kind of effort to other selected special populations.

San Mateo has also moved to open its system as part of its efforts to create more accessible and community-friendly services in East Palo Alto. The county refurbished an underutilized clinic, embraced a welcoming attitude, and began a same day access policy with all new clients getting a risk assessment within three days. Access has improved considerably, and while not yet at capacity they are moving to more group activity in anticipation of ongoing growth. The effort is enhanced by outreach workers connected with community-based organizations that, as a result of increased confidence in the services provided by the clinic, are making more referrals.

Contracting with non-mental health organizations has been another strategy for improving access.

This strategy will be discussed in greater depth in the Ethnic-Oriented Initiatives section of the report, but it is noted here as a more general strategy to extend the reach of the mental health system. So long as stigma about mental health issues remains, using more traditional human service organizations as contract providers opens the door to many persons who might not otherwise avail themselves of these services.

> *Transformation Effort:* El Dorado County has contracted with the Family Resource Center (FRC) in South Lake Tahoe which has been in operation for 15 years. The county has employed and outstationed a Latino clinician and also funds another position and supervisory support in a Latino Engagement Program designed to provide mental health services for the Latino population in SLT. Prior to this effort mental health did not serve this community well, but the agency is trusted and now with mental health workers on site there is a big demand for mental health services. "Once we got the right clinicians, people do come…if we had more time we would have more clients".

Roughly two-thirds of the staff report that their programs are easier to access than a year ago.

Two questions on the general staff survey asked about changes in accessibility over the last year.

"Compared to a year ago…"	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*
"We have a more welcoming attitude in our physical space and first contacts with our clients."				
Staff working with TAY, adults, older adults (N=482)	8%	20%	44%	28%
Staff working with children, youth, families (N=210)	5%	20%	42%	32%
"Our program is more accessible because we have increased hours, have provided transportation, have more bicultural-bilingual staff, or have an easier intake process."				
Staff working with TAY, adults, older adults (N=456)	9%	27%	46%	18%
Staff working with children, youth, families (N=212)	6%	21%	44%	29%

A high percentage of staff also report that they are "encouraged to reach out to clients who miss appointments" (87%) and that they are "expected to continue to serve clients even if they do not take their medications or attend recommended services" (85% for staff working with TAY, adults and older adults and 79% for staff working with children, youth, and families).

B. SERVICES AND SUPPORTS BY AGE GROUP[5]

Adults

The adult FSPs are largely modeled after AB 2034 and provide high intensity services for consumers who need a broad array of services and supports.

Counties generally use the AB 2034 and ACT-type model for providing intensive services for previously unserved or underserved persons in the priority populations of homelessness, involvement with criminal justice, high use of inpatient or emergency services, or institutionalization. Counties reported that programs with prior experience in the use of an AB 2034 or ACT model appear to do better at operating such a high service intensity FSP.

Some of the issues that counties are confronting with their adult FSPs include the following:

[5] The basic features of the counties' FSPs and System Development Programs for each age group are more fully described in last year's report. This discussion focuses more on the issues which have emerged as the programs have matured. Those wanting more detail on what the FSPs and other programs are like should consult the earlier report.

- ✓ Some of the consumers present very complex clinical and behavioral issues even for those accustomed to working with the AB 2034 population.
- ✓ The larger counties struggle with gaining consistency among regions in the application of criteria for entrance into an FSP.
- ✓ Some of the criteria, e.g. homelessness, do not fit for certain ethnic populations. For example, a Latino adult may lack her/his own stable housing situation, but not be officially homeless because of moving among relatives.
- ✓ Some of the requirements, for example, the 24-hour coverage and the use of flexible funds are difficult for county operated programs because of bureaucratic obstacles.
- ✓ Service design and billing is complicated and problematic when attempting to fit services within the Medi-Cal system in order to obtain the anticipated revenue for the programs.
- ✓ Finding suitable housing for consumers remains a challenge for almost all counties. Some have included housing specialists within their FSP staffing, some have separate housing specialists, and some have contracted separately for housing assistance.

Once implementation has been achieved, the biggest challenge is figuring out how FSPs should fit into a county's adult system of care.

As noted, almost all the adult FSPs were designed to provide "whatever it takes" to consumers who have a high intensity of need. As such, it can be thought of as both a level of care and as an approach to providing services. Two factors are leading counties to delve into the FSP concept more thoroughly.

- ✓ As budgets are constrained, counties are struggling with how to organize their service systems so that as many persons as possible can get a level of service that meets their needs.
- ✓ As consumers move along in their recovery process, some no longer need nor want as high a level of service as provided in the FSP as originally designed.

Both of these considerations raise the issue that these initial FSPs are considered a high level of care and that consumers might exit the program when they no longer need and want that level of care. Some counties have embraced this approach, believing that a formal "graduation" is a valuable and empowering experience for consumers.[6] Others stress the importance of maintaining continuity in the consumer-provider relationship and are more likely to informally reduce the intensity of services, but not exit the consumer from the FSP. They can accommodate the budget concern by adding consumers to the FSP, in effect, reducing the per consumer cost.

[6] It should be noted that those who advocate this position are clear about maintaining a very flexible policy of allowing consumers to re-enter the higher level of services whenever needed.

Stanislaus is perhaps the furthest along in adjusting its system to deal with this issue. The county has developed four levels of care – with its initial FSP programs as the highest level of care. The county is attempting to accommodate both of the above points of view. A lower level of care will be available either at the FSP site with the same providers or at a separate site with a new provider. Consumers will be officially exited from the FSP, even if they are receiving services at the same site from the same providers.[7] Eventually, the county would like to have all levels of care at every site so that a consumer can get what s/he needs and wants at any point in time. The complexity of tracking all this will be challenging.

Los Angeles is also moving towards a level of care organization of its adult system of care and is in the process of assessing clients on a recovery-oriented scale which suggests a level of care. The focus of attention in Los Angeles appears to be the movement of clients from outpatient clinics to Wellness Centers with the movement from FSPs not yet a center of attention.

All the counties with AB 2034 programs have used the funding cutoff as an opportunity to assess all of their 2034 clients to determine which individuals continue to need this level of care and can be served through an FSP and which can benefit from a movement to a lower level of care.

The disparity in funding between MHSA funded and non-MHSA funded programs and services is most apparent in the adult system of care.

An often heard concern about MHSA is the creation of dual systems of care – (a) between new and exciting and well funded MHSA programs and the old core system of care and (b) between the richly funded FSPs and the rest of the MHSA-funded programs. Budget cuts, which have led to an actual shrinkage of core services in some counties, have magnified this concern which has grown into a genuine fear about a backlash against the MHSA. This concern appears to be most prevalent within the adult system of care which is most reliant on the shrinking realignment and general fund dollars and is therefore experiencing the most cuts in core services.

Transition Age Youth (TAY)

Counties find the TAY population challenging, but are gradually learning how to engage and be helpful to this population.

The CSS funding has brought increased attention and services to the TAY population. For many counties, this is the first concerted effort to address the needs of this population and it has required gaining a better understanding of

[7] This is reportedly to avoid continuing the high level of data reporting required for consumers who are part of FSPs.

both the clinical characteristics of the population and of youth culture. Some of the challenges and learning that have emerged are briefly noted below.

- ✓ There is a difference between the younger TAY group (16- 18 year olds) and those in their early twenties. There is also substantial variability among individuals based on their clinical situation, their history, and their level of maturity.
- ✓ Engagement is a challenge. Traditional service models are unlikely to lead to engagement. Activities relevant to a youth culture are essential to establish meaningful engagement, and the use of peers can help. "You have to have a broad definition of 'cultural.' If you are youth driven you have to be open to what youth are into. It takes youth to learn about their culture."
- ✓ Programs must deal with issues which have not been part of their usual scope, for example, promiscuous sex or involvement with gangs.
- ✓ Housing is a major issue; some estimated that more than half of their TAY population need assistance in securing housing.
- ✓ The needs of the individuals can fluctuate rather quickly, making an assignment to a program like a high need intensive service FSP problematic.

Counties have structured their TAY FSPs differently, but all struggle with the right configuration.

Without having more information about the characteristics of the FSP clients in the different counties, we do not know how much of the variation in service models reflects client characteristics and how much programmatic philosophy.

- ✓ The FSPs in some counties operate more in the model of the children's wrap-around programs, using children's providers as contractors. and/or using the structure of interagency gate keeping and oversight.
- ✓ Other counties use an adult AB 2034 model either with TAY individuals included in the caseload with adults or as a separate caseload with a different staff team.
- ✓ One county – Monterey – mixes its 12 TAY FSP clients into a larger TAY program which was started under their federal System of Care grant. This team provides a range of services including case management for about 70 youth. The program is youth driven; youth define their own goals and make their own service decisions in partnership with staff. The major distinction for those in FSP slots is that they have access to flexible funds. Having an ongoing connection for a crisis-prone and mobile population is seen as a benefit of this type of less traditional approach. Youth can just "hang out" or engage in more active recovery services and efforts as their needs/wants fluctuate. Monterey staff see the program as a "place for a soft landing."

The other service added with CSS funds has been TAY centers.

The approach to TAY centers has also differed by county in part depending on what existed before CSS and whether the new service is more connected to an adult consumer run center or to a TAY FSP. Some of these differences are noted below:

- ✓ Some centers require that the TAY be a current or past mental health client while others publicize the center as open to any TAY in the county. A middle ground is requiring a mental health diagnosis, but not that the person be receiving any current mental health services. This difference reflects varying tradeoffs between the potential stigmatizing of a program that is just for mental health clients and the value of having an environment that feels safe and supportive because it is specifically for mental health clients.
- ✓ Some centers focus almost exclusively on the provision of recovery and educational-vocational activities. Others view the centers as informal drop-in sites where youth can socialize with one another and get informal assistance from peer support staff.
- ✓ The centers in Los Angeles (pre-dated MHSA but have expanded their hours with CSS funds) are grass roots, community-based centers with some city funding and have a minimal level of mental health services. The Service Area Navigators and Housing Coordinators visit the sites to provide linkages and assistance as needed.

Within this variation of purpose and policies, there are two issues on which all interviewees agreed.

- ✓ A feeling of safety must be created. Congregating a group of young people within relatively small spaces can generate volatile situations. So centers either prohibit access to subgroups that may be more prone to aggression and/or they have very clear rules and procedures for how to deal with any verbal or physical abuse or aggression. "To ensure the feeling of safety there is "zero tolerance" environment and we will not tolerate violence or abuse or threats."
- ✓ Engagement remains the critical challenge. It is difficult but essential to understand the youth culture well enough to provide the population with something that is relevant to their needs and interests.

Transformation Effort: Josie's Place is a drop-in center in Stanislaus for TAY who have a mental health diagnosis. Within this requirement the center attempts to provide a safe environment for a wide variety of ethnicities and cultures. This includes youth from 16-24 years of age, some youth who are homeless, some young mothers with their children, some associated with Goth culture, youth from the Southeast Asian community, LGBT youth. The mix provides "a lot of mutual support sometimes overcoming differences that one wouldn't expect." There are two peer support employees. There are a variety of activities available, but no one is required to participate.

Engagement of youth in the running of the center has met with mixed results; an early Advisory Council had dwindled, but youth are involved in setting a monthly calendar of events. Efforts are underway to get more classes established and to get employment-related services on site, like offering a job within 5 days.

Older Adults

The major impact from CSS for older adults is the beginning development of a separate infrastructure and system of services and supports for this population.

Even more than with the TAY population, CSS has served as a catalyst for the development of a constituency for older adults. While the active participation of older adult consumers is not often present, the service providers from mental health and other agencies have been one of the most active ongoing stakeholder groups. As noted in last year's report, counties have established new positions and new units with a focus on the special needs of the older adult population. In some counties, the training that has accompanied the new services has been outstanding and added to the overall quality of the new services. Challenges continue 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. So far, most of the service attention has been focused on the young-older adult group, with counties defining the services as for those 60 and over. There is recognition that the older frail elderly group also has needs, but they have thus far received less attention. The major services developed to date are the FSPs, outreach services for assessments, and some treatment.

The concept of a long-term AB 2034 intensive service model FSP does not appear to fit neatly with the needs of the older adult population.

Riverside has structured its older adult FSP to be a 6-9 month program with extensions possible. They see the time limit as a way of empowering clients, and they work to establish community supports for when mental health services are no longer needed and provided. They also rely on the flex funds to assist with a wide variety of needs, including moving expenses and medications.

The older adult FSP in El Dorado is a six-person house with a maximum length of stay of two years. The goal of the program is to move clients to independent living.

Los Angeles has used System Development funds to implement a robust mobile outreach/assessment/service program for older adults while also establishing

slots for older adults in separate FSPs. Based on their experience to date, they question the distinction between the two services. The characteristics of the clients and their needs are not very different, with many of those receiving the outreach services almost meeting the criteria for the FSP services.

> *Transformation Effort:* Los Angeles has begun a Field Capable Clinical Service with 7 contracted and 10 directly-operated programs which provides wide county coverage. Eligibility criteria are adults 59 or older with a significant mental health diagnosis creating some functional disability that are not able to receive services at a clinic site. The teams spend some time co-located for a few hours a week in health care, senior centers, and housing – some through formal and other through informal arrangements. The connection to the USC health clinics is the most established of the sites. Most of the evaluations lead to short-term rather than ongoing mental health services.

Children and Families

There is more variation in FSPs for children and their families; counties are using evidence-based practices and wraparound models.

As noted last year, the addition of CSS funds allowed San Mateo to fold its SB 163 program into a new FSP with good results. Monterey assigns a few FSP slots into a range of its other programs and assigns the slots to children and their families with more intensive needs or to those who can most benefit from the flex funds. Riverside has selected two Evidence Based Practices – Multidimensional Family Therapy and Multidimensional Treatment with Foster Care for their FSPs – both of which are time-limited efforts.

The enrollment in FSPs in Los Angeles has been slower and has raised some concerns. Most of the programs are contracted, and some of the newer providers have had some difficulty providing a more intensive level of service. While the county was hoping to leverage EPSDT for children and their families, there has been a greater need for FSP slots for the indigent population than was budgeted. The availability of the flex funds has been crucial – 85% of the funds have gone to housing or housing-related needs – and the county would like this category of funds increased. The county cites the lack of reimbursement for transportation as a potential serious financial problem, and contractors complain about training time which is not reimbursed.

In El Dorado, outreach efforts resulted in contracts with two community organizations to provide FSPs. Getting the programs up and running and clarifying the program definition and billing have taken time and effort.

For the most part, counties used CSS funds for children and families to expand and strengthen their existing systems of care.

Many of the study counties believe that their systems of care reflect the vision and key elements of the MHSA and did so prior to the passage of the Act. For this reason, most chose to build upon and expand their existing systems, working with their child welfare, education, health and juvenile justice partners, as well as a variety of community based organizations. We found the implementation of evidence-based practices to be strongest in this age group. In addition to FSPs, several counties also used System Development funds to train child and family staff and contractors in a variety of different evidence-based practices.

Transformation Effort: Stanislaus County provided CSS System Development funding to an existing partnership center to create Families Together. The additional funding allowed for an expansion of services and activities. The site has become an active place which engages parents, caregivers, and various youth with activities such as a men's support group, tiny tot respite, mental health education for parents and caregivers, a Spanish language support group, and ample drop in space. An example of the ingenuity of the Center is a Beading Group which provides socialization with the product being sold to the community. "When you have children who cannot function in a social setting or you are raising grandchildren, you get so isolated – social settings are very important." "If I didn't have this center I would be in my bed most of the time. Staff follows up to encourage you to come. Phone calls are important."

CHAPTER 3: SPECIAL PROGRAM AREAS

Consistent with the thrust of emphasizing the local planning process, each county focused on different populations and programs within the general parameters set in the state planning guidelines. With the diversity of CSS services and supports, we decided to focus on four program areas that received some MHSA funding in most of the seven study counties, allowing us to draw some general program-focused observations.

Many of the details of the programs being implemented by the counties are in the prior year's report and are not repeated here. We highlight in this chapter some of the implementation progress and challenges, with particular attention to what appears to be important for efforts to be successful.

A. FORENSICS

The adult forensics initiatives are generally making progress.

Six of the seven counties have adult forensic-type programs as part of their CSS activity. Efforts have been augmented in all of these counties by the receipt of Mentally Ill Offender Crime Reduction (MIOCR) grants, which have, in some cases, been blended with CSS funds and in others, have been used for additional types of programs. Evidence of the success of the programs is that demand for participation in the programs is high with some programs nearing their capacity. Many of these initiatives were developed and implemented by stakeholders who were firmly committed to the programs and willing to work

through troublesome issues which arise because of the different cultures of mental health and forensics. As the programs have expanded beyond this initial core of stakeholders, it has been challenging to maintain the high levels of collaboration with new participants who were not involved in the initial planning and who may not begin with the same level of commitment.

The major program effort has been the establishment (or expansion) of adult Mental Health Courts.

While there are variations from county to county, the basic features of the court systems include the following:

- ✓ Referrals can come from any place in the system, i.e. from the jail, from probation, directly from the court, etc.
- ✓ The ranges of offenses are generally felonies and in some counties can include violent crimes.
- ✓ The program is voluntary and, in most (but not all) court programs, the person must plead guilty prior to entering the program. The program usually lasts for the duration of the probation period.
- ✓ The probation officer is responsible for tracking the conditions of probation with the power to recommend that the person be sent back to jail.
- ✓ There is an independent process by which the defendant is assured of counsel about the benefits and potential downsides of pleading guilty.

While the official court part of the programs is similar, the structure of the mental health services that constitute the treatment component varies considerably. Most counties have developed specific programs for the population, including a seven-day a week special day program or membership in an FSP that enrolls specifically the offender population. Others link the client to a general FSP, and in one county, the CSS addition consists of a linkage service which ensures that the person released on probation is connected to, and maintains contact with, an already existing service within the core system of care.

Certain key elements are found in the successful Mental Health Court programs.

Stakeholders in all the counties were consistent in the features of their programs that they felt made them successful:

- ✓ Everyone feels that his/her perspective is genuinely heard during the court process. The judge never acts as a rubber stamp ensuring that all parties feel they can get a fair hearing for their position on any particular case.
- ✓ The criteria for entry into the program are tightly monitored. Limiting the program to those types of individuals who all stakeholders have

agreed have the best chance of profiting from the efforts, increases the chances for success and keeps up everyone's enthusiasm.

- ✓ The mental health representative who interacts with the judge, the public defender, and the district attorney is respected and has credibility. The legal parts of the system must develop a level of trust in the mental health component and feel they can rely on the judgments of the mental health assessments.
- ✓ The judge is interested and committed to the model. Repeatedly, interviewees noted how important the judge is in setting the appropriate atmosphere in the court.

Transformation Effort: El Dorado's Behavioral Health Court in South Lake Tahoe has continued to operate successfully providing many consumers with their first positive experience with mental health services. The collaborative team of the district attorney, public defender, probation, jail staff, Public Guardian, and sometimes CPS work well together after an initial period of learning about each other's roles, perspectives, and responsibilities. The judge has been an active supporter of the program from the beginning and shows great talent in relating to those who come before her. "We have had some graduates – people that have been in and out of jail all of their lives. [The program] has improved the quality of life of a lot of our clients. A lot of them enjoy coming to court." "Judge has people stay through court so that they can see others' successes and failures." One difference with the El Dorado model is that the people do not have to plead guilty prior to entering the program. Program staff believe one reason the program is successful is that they have lengthened the assessment period which allows them to abide better by their criteria which requires a severe mental illness such as schizophrenia, major depression, PTSD, bipolar disorder, or severe anxiety.

Four of the counties have specific youth forensic initiatives.

Monterey County has a specific Behavioral Health Court for juveniles. The mental health program uses Brief Strategic Family Therapy, an evidence-based practice which begins while the juvenile is incarcerated and continues in one of the county's FSPs after release while s/he is on probation. In Riverside, mental health staff act as consultants to the court and to all the parties, including the district attorney, public defender, and probation officer. The county also receives direct referrals from the judge to one of its FSP programs. These same two counties also screen all the youth who enter the Juvenile Hall for mental health problems.

Los Angeles has structured mental health programs in their Youth Camps relying on evidence based practices and training of the camp staff. The development of relationships with mental health is seen as enhancing the chance that the youth (and family) will continue services after release.

Stanislaus has a 10-week Aggression Replacement Therapy (ART) program, an evidence based practice, as part of one of its FSPs, and a modified ART program

is being used in Juvenile Hall.

B. PHYSICAL HEALTH/MENTAL HEALTH INITIATIVES

The collaborative initiatives with physical health remain the most challenging of the four special program areas.

One county – San Mateo – had a robust program already in place prior to MHSA. It included the co-location of mental health staff in primary care clinics and the co-location of nurse practitioners at mental health clinics. CSS funds have built on this foundation with expansions of services in Spanish and Mandarin. San Mateo county has made efforts to begin an IMPACT model, which is a behavioral health program for Medicaid- older adults who have complex behavioral needs in conjunction with a specialty geriatric healthcare issue. Also, San Mateo has an initiative to assist the local Federally Qualified Health Clinic (FQHC) in East Palo Alto to launch a behavioral health component to its services.

Another county – Monterey – has taken a successful first step in developing a collaborative program by having an MHSA-funded psychiatric nurse practitioner co-located in the county's primary care clinic.

The other counties who have collaborative physical health/mental health work plans have either had to rework them based on early experiences and/or are just in the early stages of piloting ideas.

Experience suggests core factors which help to make collaborative initiatives with physical health/primary care clinics successful.

Representatives of the long-standing successful San Mateo effort and the newly emerging Monterey program highlighted the challenges and keys to success:

- ✓ Mental health managers and staff must understand and respect the different culture and working environment of a medical practice. Monterey's psychiatric nurse practitioner had worked in a medical setting and the familiarity with policies and practices generated credibility.
- ✓ The structure of the mental health component must ensure that the medical staff making referrals receive prompt responses and feedback.
- ✓ There must be some advantage for the physical health site for having the co-located mental health staff. The most important benefit comes from getting timely access for patients into the regular mental health system. The medical facility is giving up valuable and limited space for a co-located mental health clinician and there must be some payoff.
- ✓ Physician(s) need to be involved in designing the collaboration. But it is also important to have policies and procedures established before the planning begins so that the physicians can see that this is a serious and well thought out endeavor.

As more Federally Qualified Health Centers (FQHCs) and primary care clinics develop and/or recognize the need for behavioral health services for populations that traditionally access services through these clinics, county mental health may have additional opportunities for establishing linkages and providing consultation. In addition, with the increasing awareness of the poor health status of so many persons with serious mental illness, the forging of such relationships becomes all the more important because it offers the potential for individuals with serious mental illness and their families, who are traditionally served in county mental health systems, to get appropriate health care.

Differences in the progress and success of forensic and physical health collaborative initiatives provide useful lessons about what is necessary for such community collaborations to work.

There are elements in common with both the justice and the health systems. They both "touch" mental health clients, i.e. most clients have some contact with the physical health system and some with the justice system. They both have cultures which are different from mental health, and both have funding streams outside mental health. They both express frustration with and some mistrust of mental health because of their inability to get access to mental health services for their clients. And both can use help with clients with mental health problems who require more effort and present different challenges than their usual clients.

Some differences in these two areas help to explain why efforts with the justice system are progressing more rapidly and successfully than with the physical health system. For one, the history of collaborative efforts is more extensive with the justice system. The civil commitment laws and procedures have brought mental health, the courts, and the police into contact for a couple of decades as they have had to develop practices to deal with their overlapping responsibilities. Most mental health departments have conducted trainings for law enforcement. The MIOCR grants allowed for the building of joint programs; the children's system of care involved juvenile justice. The forensic system – law enforcement, the courts, public defenders, the district attorney, probation – are all public entities and so share some of the same orientation and kinds of bureaucratic constraints as county mental health programs.

The health care system does not share these characteristics; in particular, the history of working together is just starting and does not have the wealth of background and prior development of working relationships. While some primary care clinics are county-run, many are not, and do not necessarily share the same knowledge about the county bureaucracy. The lesson here is that achieving success in physical/mental health collaborations will likely take more time and the building of bridges between the providers in both systems, just as the forensic relationships have developed.

C. ETHNIC-ORIENTED INITIATIVES

The reduction in ethnic disparities is one of the primary goals of the MHSA. As we have explored the ethnic specific initiatives of the seven study counties directed towards this overall goal, we have observed several different strategies that counties are using. Some counties use only one strategy; others use a combination of them.

- ✓ The first strategy includes efforts to make the county and contract service delivery programs more culturally competent. The purpose of these efforts is to ensure that when a person or family from an ethnic community interacts with the traditional mental health system, s/he/they receive(s) services which are sensitive to and appropriate for the cultural context that the person or family brings. These efforts should result in better services that should produce better outcomes.
- ✓ Another strategy encompasses efforts to increase contacts with the mental health system for more people of diverse ethnicities. This includes providing outreach to ethnic communities to inform them of the availability of services, co-locating county mental health services in ethnic organizations, and/or selectively loosening the gate-keeping into the mental health system for selected communities by seeking referrals or allowing walk-ins or being more flexible about eligibility criteria. These efforts should result in more new clients of underserved ethnicities entering the mental health system.
- ✓ A third strategy is contracting with ethnic service organizations that are not traditional mental health providers, to develop their capacity to provide some mental health services. This often involves the ethnic service organization's hiring of persons with a high degree of credibility within the culture, e.g. promoters within the Latino community, to provide services for problems which might not meet the more stringent medical necessity criteria for entry into county mental health.
- ✓ Ostensibly, there is nothing to keep such organizations from developing the additional capacity to serve persons with more serious mental health problems, but it is often well beyond the reach of small community organizations because of clinical and bureaucratic requirements. The result of these efforts is to provide more services to unserved and underserved communities, even if some clients do not ever appear as open cases in the mental health system.
- ✓ The fourth strategy is a more comprehensive collaboration with not just an ethnic service provider, but with a whole community to design a range of efforts that will address the needs of persons with emotional and behavioral problems in the community, including the broader issues of addressing stigma and discrimination. The result of this kind of effort is a full range of mental health services that are accessible and appropriate for the particular population and that address their self defined needs.

The study counties are all engaged in attempts to address ethnic disparities with a growing appreciation of what it takes to be successful.

This is the first major effort by most of the county mental health departments to engage some of the ethnic communities in their counties. The process has evolved from initial efforts to engage ethnic communities in the planning process to more extensive and detailed planning and/or program implementation. Those efforts that are showing great promise have taken a long term view based on the belief that the building of trusting and mutually beneficial partnerships must rest on a firm foundation of understanding and mutual respect.

Some of the features of the more successful partnerships include the following:

- ✓ The core county and contract mental health system has to be more open to referrals from ethnic organizations and community leaders who make referrals. Trust will quickly dissolve if partners do not feel openness from the mental health system when they have a person whom they feel needs services. "Being able to get around the 800 access line is critically important – literally saving lives"
- ✓ Once persons from an ethnic community enter the system, they have to receive culturally competent services. This includes not only awareness and respect for their culture, but also the capability to provide the kind of services which are appropriate to the issues and concerns of those seeking services.
- ✓ The county's contracting process is not easy to navigate for small community based organizations. Counties have to be willing to be flexible and have to provide substantial assistance (either directly or through a contract with another larger community resource) to these smaller ethnic organizations. At times, it may be just a few community leaders with an idea; the county has to have the patience and resources to nurture these individuals and their ideas into an organization with which it can eventually contract.
- ✓ Each ethnic community needs to be addressed separately – a one-size fits all outreach effort will not suffice. This is not only because of the differing cultures, but even more importantly because of the varying levels of community readiness to take on this kind of effort.
  - o One variable of difference is the kinds of community-based organizations that already exist. The task is different if there is a well respected solid community-based organization that already knows the mental health needs of the community or if there is community-based organization (usually small) that has little familiarity with mental health issues or if there is an ethnic community which has no appropriate community based organizations, but does have some community leaders who can be engaged in a dialogue about mental health needs.
  - o Another variable of difference is the nature of the mental health needs which will vary with other community characteristics, cultural issues, the nature and extent of stigma, and the nature of the

communities' immigration histories and the accompanying acculturation issues.

Important challenges are being slowly confronted.

The importance of a long-range planning horizon for these efforts cannot be stressed enough. Along the path, counties are facing the following kinds of challenges:

- ✓ There is a fear among management and staff that as access increases, all existing resources will be inundated. This fear is magnified currently with the stress of absorbing workload with reduced core staff. The major strategy being used to address this fear is to pilot efforts in a particular region or with a particular population and assess the impact. This helps to deal directly with staff concerns about overloads, but does not lead to rapid system-wide reform.
- ✓ With a restriction in core services, it can be hard to get a commitment of resources and focus to sustain these strategies over the sometimes lengthy period it takes to build trusting relationships.
- ✓ Working with people and organizations and communities who do not usually work with the county and do not understand or fit into the bureaucratic structures can be very frustrating for all involved. The frustration can lead to additional misunderstandings and slow the process down. Management may need to intervene occasionally to keep the process on track.
- ✓ Setting priorities among all the possible ethnic initiatives can be challenging. As one ethnic services manager noted "I have to strike a balance between what is feasible and realistic and where we want to go."

Transformation Effort: Monterey has launched three major initiatives to address ethnic (and cultural) populations.
(1) Latinos are the majority population in Monterey County. Behavioral Health contracted with two community-based organizations – one an organization that serves farm workers and another that focuses on citizenship issues. The former already had promotores (promotores are individuals who provide health education and support to community and outreach to farm workers). The CSS funds have been used to train the promotores about anxiety and depression, create a liaison position, and to develop smooth referral connections so that persons who need services from the mental health system are seen promptly and receive services that are appropriate. The promotores providing information to the workers about the signs of anxiety and depression and simple ways to deal with these has helped reduce stigma and been helpful to many. "This works because the referral process has been worked out and services they are getting once they get there are language and culturally appropriate." The citizenship project has a Marriage and Family Counselor intern who provides some direct counseling services in a way which feels safe to clients who are generally undocumented and uninsured and helps to reduce the stigma associated with mental health problems.
(2) The county has been working for an extended period with community leaders within the African

American community to establish a program that would provide direct mental health services for primarily the youth in their community. An initial plan to have the services offered through the NAACP was not successful so the effort has been supported by a group of community leaders who are trying to form a new organization to house the services.
(3) The county has a contract with a collaborative that consists of three community-based organizations. The lead agency is a local non-profit services agency that provides mental health and substance abuse services. They have subcontracted with two additional CBOs that provide outreach, advocacy, and services for persons living with, or who are at risk of developing, HIV/AIDS. This has resulted in over 2000 units of mental health services being provided in less than two years. Because the general community is conservative – especially the Latino culture around issues of homosexuality – special efforts were needed in the way in which services were structured and provided. Concern about confidentiality means that group sessions are used less even though contract maximums are being reached. The service providers noted that "there is a network within the LGBT community and a buzz is going around about this being a good service."

Transformation Effort: San Mateo has launched a variety of ethnic oriented initiatives; each specifically designed to address the nature of the community with which it wants to partner. This is an example of the variety of types of partnerships which may be necessary depending on where the energy within a community can be found and connections established.
(1) The most extensive effort is occurring in East Palo Alto – an historically underserved community including African Americans, Latinos, and other ethnic groups. The county has formed a partnership with One EPA which is a large collaborative of leading citizens and organizations within the community. A variety of initiatives are underway through this partnership including the addition of one FTE position in each of three community based organizations along with extensive training on mental health issues for all the promotores in these organizations; a Family Awareness Night, including material translated into four different languages, which drew over 100 people, which was hosted by the mayor and which addressed mental health issues; the addition of a half-time mental health worker at the local health clinic to provide short-term cognitive interventions and facilitate referrals to the mental health system; and the provision of mental health education to the faith community. These activities have been coordinated with the opening of a same day service component for the county mental health clinic located in East Palo Alto. Working with One EPA established and effective community collaboration – has made this effort particularly effective as the community leaders involved in this organization can navigate any local political issues.[8] The commitment of time and energy from both the representatives of the community and county mental health has built trust and led to very successful results.
(2) Last year's study reported that the county was in the process of issuing an RFP to help the county determine the mental health needs of the Filipino community in the northern part of the county. In response, a few community-based organizations along with consumers, and representatives from public health nursing and school-based health services formed a group which now meets quarterly to oversee the project. They have thus far conducted two large education sessions for providers about Filipino culture and values and why people might seek services, and they are developing a resource directory in Tagalog and English. The participants view the initiative

8 As an example, there were some hard feelings about the way in which some of the organizations responded to a county RFP. These were raised and dealt with within the collaborative resulting in a new process by which the community as a whole will respond to any future RFPs.

as developmental. They continue to work at attracting additional community representation now also having the faith community and law enforcement involved. They are learning by doing - a Filipino Family Night was not well attended and planning for a follow-up event will de-emphasize mental health language and include some "fun" events.
(3) The Asian Pacific Islander initiative is another effort that is in the formative stages. It began through a meeting of community leaders and a series of interviews with cultural brokers (individuals connected with and knowledgeable about these communities). Without any significant community-based organizations the county decided to hire a community program specialist who developed a one-hour curriculum about the culture, which is being piloted. She also is becoming the liaison for mental health issues; she attends meetings of the One EPA as a representative of the API community and assists public health when they have families with mental health issues.

D. CONSUMER-DRIVEN CENTERS

The concept and design of the consumer-driven centers in the study counties have continued to evolve as more have been implemented.

As noted in last year's report, six of the counties have embarked on some type of consumer-run center. We have defined such centers (for the purpose of this study) as centers which have either consumers playing a major role in the direction and design of center activities, or consumer leadership, or more than 50 percent consumer hires. [9]

This section focuses on adult centers. We include here three centers that also operate TAY programs because they have the same general orientation with the TAY population as with the adults even though they may have different staff and a different location (or the same location but TAY come on different days). The TAY centers which focus solely on the transition age group are described in the TAY section of the report.

This section includes detailed information about 10 centers in six of the counties.

A survey form was completed by each consumer-driven center which asked about staffing, activities, governance, policies, philosophy/orientation, and transportation. Interviews were held with staff from most of the centers. Interviews were also held with some consumer attendees of the centers, but these were not formal, nor were the consumers randomly selected.

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9 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.

Since this is a preliminary exploratory effort, there are some cautions about the information that follows:

- ✓ The material in the surveys was not verified independently and was not always complete. Interviewees wanted their centers to appear successful and so may have been overly positive.
- ✓ The centers are evolving – there are substantial alterations and changes over time. Some of the centers, particularly in Los Angeles, are barely started.
- ✓ There may be a difference between policies and practice. For example, a county policy may require that attendees be or have been part of the mental health system, but as one center in such a county said, “we don’t close the door on anyone.”

The following descriptions are based on nine of the centers which have enough commonality to be discussed together. One of the centers – Oasis in El Dorado County – is sufficiently unique to warrant a separate description.

All nine centers are operated by contract agencies.

The sponsoring agencies with which the county contracted all had prior relationships with the county. Seven are providers of mental health services who generally, but not always, have a reputation for and experience with consumer direction and empowerment in addition to traditional clinical services. One of the sponsors (with two programs) is a consumer-driven organization whose central focus has historically been empowerment and training of consumers.

Only one of the nine centers has a formally constituted board for just the center, while a few others have informal advisory committees. Most rely on the governance structure of the sponsoring agency. Only one of the centers currently foresees developing a plan to transition to its own non-profit organization. Because the programs are all units within larger organizations, there was variation in the scope of responsibility of the center director and the independence of the program from the sponsoring agency. In some instances, the center appeared to operate with considerable autonomy with the ability to make its own policies within the scope of the contract. In others, there was much oversight by the sponsoring agency, and it was clear that the center was just another program within the agency.

Seven of the centers had consumers as center directors. When consumers were the directors of the program and had a wide scope of independence, there was often a mentoring figure within the sponsoring organization that was available to support the director, particularly with financial, contractual and employee issues. It was problematic where this was not in place. The two centers led by non-consumers each had some one in that position who was a strong supporter of the idea that consumer empowerment was critical for the center to remain true to its mission.

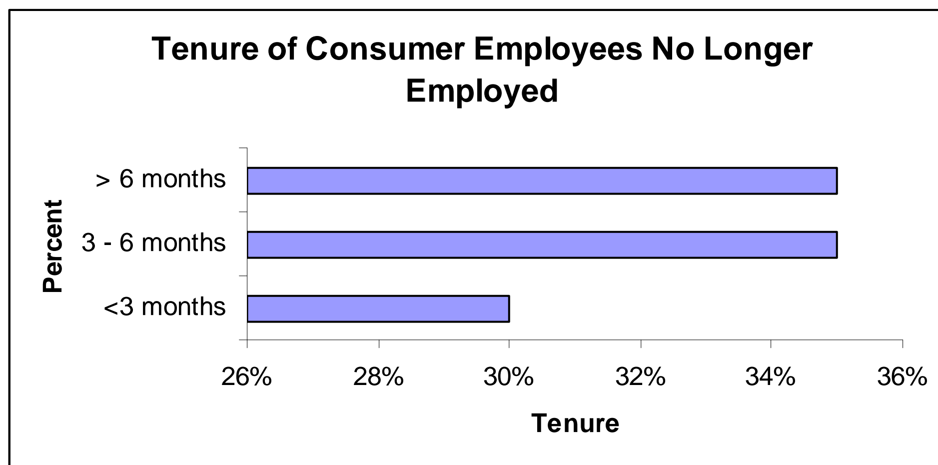
Over 80% of the staff is consumers and family members, largely consumers.

Full time staff range from one to eight; about half use a number of 20-hour a week positions. Just two of the centers rely on staff that largely works less than 20 hours a week. And while a number utilize volunteers, only one appears to have an organized volunteer program requiring a commitment to a special training program and a regular 10-hour a week assignment of specific tasks.

There is a range in the titles and responsibilities of the consumer staff. Most have specific titles and responsibilities, such as the housing coordinator, enrichment activities coordinator, ethnic engagement specialist, wellness trainer, information and referral specialist, self-help group leader, life coach. One program has a generalist category of program assistant for all consumer staff.

There was a wide range in the amount of consumer staff turnover.

The median hiring date of consumer staff members among the centers ranged from 11/06 to 7/07, and the forms were completed in early 2008, so the approximate time period covered ranged from about 6 – 12 months. Within that time period, turnover of consumer staff across the nine programs ranged from zero to almost 90%. The chart below indicates the tenure of those consumers who were no longer employed.



The reasons for leaving employment were 30% promotion, better job, pursue other interests; 13% stress or personal problems; 13% terminated or no show; 22% resigned (we couldn't determine the reason); and, 22% neutral reasons, e.g. health problem, moved, family problem.

The philosophy and orientation of the centers have much in common, but their roles in the county's system of care differ.

Four of the centers have their own mission statements, while two explicitly share that of the sponsoring agency, and three had no formal mission statement. The values expressed by all the centers focus on:

- ✓ A recovery philosophy ("We keep front and center that people can be well");
- ✓ Having consumers serve as role models of success and as peer supports;
- ✓ Providing a safe and secure environment; and
- ✓ Providing opportunities for growth and wellness.

Example: We provide a safe and friendly environment for consumers and family members. This is an environment where an individual can flourish emotionally while developing courage and confidence. We provide opportunities that promote self-determination, empowerment, lifelong learning, employment and training opportunities. (Done by initial group of consumers/family members)

In one county explicitly and another implicitly, the client-driven center is conceptualized as a level of care within the overall system of care. It is specifically designed "to support consumers who are in the later stages of recovery" or is seen "as the back end of the system to move people along into the community with natural supports." In the other counties, the vision for the center is more all encompassing and relevant to any consumer, e.g. "Our purpose is to express wellness and recovery by empowering people to change their own lives, by providing them with a safe, loving, non-judgmental place."

One question asked if the center followed any other model of consumer-driven center. Only the centers in Riverside County cited an example –Recovery Innovations[10] – while all others said they had developed their own approach. The significant involvement over many years of Recovery Innovations with JTP (the largely consumer run organization that contracts with the county to operate the Riverside County centers) provides these consumer run centers with a head start in designing and implementing an approach to these services.

Two of the counties (4 centers) require a current or prior connection with the mental health system.

Concerns about setting priorities for participation in the centers led two counties to require that the centers be open to only current or past recipients of county mental health services. One other county's center is open to anyone, but the employment services available at the center can be used only by persons receiving current mental health services.

As would be expected, the four centers with the requirement for some current or

[10] Known previously as META, based in Arizona, Recovery Innovations is a leading organization nationally in the development of consumer-run services and provides substantial training and education to other organizations like Riverside's JTP.

past connection to mental health services also have the most interaction with the mental health system. Mental health staff are either on site as a regular matter to engage their clients (one center) or receive periodic updates on referred clients and are invited to attend events at the center (3 centers). The other centers will interact only periodically with the mental health system making referrals or contacting mental health staff about specific consumers in case of incidents or crises.

The "drop-in" aspect of the centers differs and is not always clearly articulated.

All the centers stress the value of the scheduled recovery-oriented, skills-building, education-employment focused classes and activities. The desire is to have a center which engages consumers actively in their recovery with a variety of opportunities from which to choose. Less clear is the role of informal social interactions, particularly when these might be with employed or volunteer peers who can provide role models and useful interchange.

Three of the centers believe that these social interactions are one of the purposes and values offered by their centers. They believe it can overcome social isolation and that peer interaction happens best in informal situations. Four other centers are equally clear that the use of the center for drop-in purposes is outside their mission, desiring to create an environment in which attendees are more actively and formally engaged in recovery work. The remaining two centers are somewhere in the middle; they say that the center should be used for informal social interaction only if it will be useful in recovery, but this opportunity is not offered generally and they would like to move away from this drop-in use of the center.

> *Example:* We recognize the importance of peer support and that it can take place on many different levels. We encourage our peers to have the freedom to talk and interact at their leisure. Generally, we have programs offered simultaneously that we believe to be beneficial and supportive of recovery.
>
> *Example:* We are not a drop-in center – consumers are expected to participate in activities. They fill in an intake form that asks questions about short and long-term goals.

This issue is important to some consumers who would like a drop-in center. This is particularly the case when the current center has replaced a previous socialization or drop-in center.

Policies related to attendance and prohibited behaviors are generally similar.

The age range for the adult centers is usually 18 and older, but two do not include older adults. One county has a TAY component to its three consumer-driven centers. Hours are generally 9 to 5 or equivalent; one is open only 6 hours

a day; only three are open on Saturdays. All centers have people sign in – either at the door and/or for classes and activities.

All the centers have policies about prohibited behaviors. All prohibit violence, abusive or threatening language, and the use of substances on the premises. Most also have policies against using computers for pornography or sexual solicitation. There are a number of other policies about laundry use, telephone use, and smoking. Most have a formal policy about what happens if a person violates one of the prohibitions, which include how and for how long a suspension from the center might be used.

To handle grievances, the centers either have something specific to the center, or use a procedure from the sponsoring agency. There is a reliance on initial informal attempts to address grievances before moving to more formal procedures.

All the centers have formal schedules with group activities offered for the majority of the hours the center is open.

The selection of activities is generally the responsibility of a staff person. Ideas come from both staff and attendees about things that will promote recovery. To some extent, the schedule is the result of trial and error with considerable evolution over time – activities that have sufficient attendance continue and those that don't are dropped. The groups are generally led by consumer staff and/or consumer volunteers.

There is a continuum on the dimension of the formality and structure of the activities. Most structured are the two Riverside Juvenile Treatment Centers, which have five official curricula tracks, which lead to certificates upon completion (Intrapersonal Development, Interpersonal Development, Change/Adaptability, Employment Preparation and Wellness). Most of the centers have groups, which have open attendance and do not have a formal curriculum. There is a mix of social, health, educational/vocational, and mental health oriented activities and groups.

The table below includes the regularly scheduled activities at the centers. The figures in parentheses are the rough average of the attendance at the groups over the two weeks before the survey was completed.

One to Three Times a Week (Average Attendance Last Two Weeks)			
Center	Social or Health	Educational or Vocational	Mental Health Oriented
1	+ Jazzercise + Movie (10) + Bingo (24) + Let's Talk Coffee (daily) + Jump Start Your Health (15) + Health Educator Group (15) + Bingo (15) + Movie (8)	+ Academic Challenge (6) + Current Events (daily) + Career Development and Education (12) +Budgeting on the computer (6)	+ Approaching Conflict in a Better Way (8) + SMART Recovery 6 + 2008 Goal Setting + Well Traveled Paths (12) + Coping with Depression (8) + Healing the Past (9) + History of MH (7) + Anger Management (8) + How to be Assertive 6) + AOD Recovery Group (12) + Peer support group (15) + Women's support group (5) + Milestones peer group (10) + NAMI Family to Family Classes
2	+Mindfulness (1) +Music Studio (2) +Art Blooms (2)	+Emerging leaders (1) +Computer Tutorial (1) +Spanish (2) +Computer use (2) (every day)	+DBSA (4) Depression Bipolar Support Alliance +Peer support (5) (every day) +Women's group (3) +Men's Group (5)
3	+ Get Crafty + Talking Circle + Trip to Gym + Games +Morning Mingle (every day) +Lunch (every day)	+Trip to library +Project Return Group +Leadership Development +Job Skills	+ Double Trouble
4	+Movie and discussion (5) +Open discussion (8) +Social Saturdays (25) +Driving Class (9) +Pool (15) +Health and Wellness (15) +Guitar (3) +Arts anonymous (4) +Open Mike and Poetry Readings (10) +Relaxation (8) +Exercise walk (8) (daily)	+Basic computer lab (4) +Life skills/money management (10 per group) +Life skills (10) +Learning to work and benefits (15) +GED	+WRAP (8) +Recovery through Medication (7) +Relieving stigma through speech and drama (9) +Writing in Recovery (5) +Managing your emotions(7) + Consumer Awareness (8) (every day)
5	+Wellness Track Classes (12) +Interpersonal Development Track Classes (12)	+ Orientation (10) +Employment Preparation Track Classes (12)	+Intrapersonal Development Track Classes (12) +Change/Adaptivity Track Classes (12) +Healing the Wounded Heart Support Group (5) +Dual Diagnosis and NA (50)
6	Wellness Track Classes (12) +Interpersonal Development Tack Classes (12) +Gay lesbian support group	+Orientation (5) +Employment + Wellness Preparation Track Classes (12)	Intrapersonal Development Track Classes (12) +Change/Adaptivity Track Classes (12)

	(2) +Bingo (8)		+Recovery Planning Sessions – enrollments (9) (daily)
7	+Arts and Crafts +Movies (3)	+ Creative Writing (2) +Computer training (2)	+Anger Management – attendance good because mandated to come +Peer to Peer (4) + WRAP (4) + 12 Step (4) + Relapse Prevention (5) +Co-occurring ((4) +Positive Self Talk (4) + Diagnosis Discussion (6) + Stress Management (2) + Recovery Planning Sessions (7) (daily)

There are a range of less frequent activities, such as holiday celebrations and social events, which draw a significantly larger attendance (up to 75 or 100 individuals). A few have monthly town hall type meetings. And almost all have routine presentations by social security benefits staff and/or about health and/or other educational information.

Obtaining and sustaining participation in scheduled activities is problematic for most of the centers.

Except for one instance (an anger management class at one center), participation in scheduled activities is encouraged, but voluntary. Two centers use rewards – one, tokens, which can be exchanged for material things like food and another, certificates (and a graduation ceremony) for completion of a set of classes. One center requires some participation within 60 days, or the person loses membership in the center.

Without a more extensive study, it is hard to know how to interpret the fact that while the centers have had large numbers of consumers pass through their doors in the relatively brief time, all but a few cited engaging consumers on a regular basis in their activities as an ongoing challenge.

All centers are conveniently located near bus stops, but many still find transportation a challenge.

The centers are located on bus routes (often major routes or hubs) with a bus stop very near to the center. This works reasonably well for the centers located in urban areas, but even then the rides can be long. The centers located in rural areas report significant difficulty in getting consumers to the centers. In some, there are concentrations of population, but they are distant; for example, the center in Indio is 43 miles from Banning and 97 miles from Blythe (Riverside County). In others, the population is scattered in small communities around the city. Some clients report two-hour bus rides, one way, to get to a center (El Dorado County).

The centers make special efforts to overcome these transportation challenges. They occasionally use a van to pick people up at transportation hubs, they provide discounted public transportation tickets, and/or they use Dial-a-Ride. The center in Indio (through the use of growth funds) has begun to offer a mobile version of their center, setting up in Blythe once a month and going out to a rented community center site in Banning once a week. While the centers want to facilitate and ease the transportation obstacle, when the distances are not too great, they also see a tradeoff in not wanting to provide too much assistance, in order to promote consumer independence.

The consumer-driven centers are a work in progress.

We had the clear impression as we visited the centers, that staff was happy with what they had accomplished, but were continuing to struggle with translating their vision into reality. They want to be different from a traditional day program by offering activities which will actively promote recovery. Yet, engaging sizable numbers of consumers in this process has been a challenge with attendance being spotty and inconsistent.

The clearest benefit from the consumer-driven centers is seen with the consumer employees. Repeatedly, in our site visits to the centers, the consumer employees spoke glowingly about their experiences and how much they had benefited from the opportunity to work at the center and help others in their recovery.

Transformation Effort: Hope House in Madera County has achieved a consistently high participation of consumers in its center. It has a membership of around 300 and an average daily attendance of about 60. They have a full variety of scheduled activities with fairly good attendance and a wide variety of special events which attract a wide group of consumers. The Center views the drop-in component of the center as essential to its mission. Attendance at activities is voluntary but members get points which are redeemable for material things. The center's policies require that consumers become members and that all are currently receiving or have in the past received mental health services. There is a case manager on site who assists with transitions into services when appropriate. In response to members' request, the center is in the process of adding county resources for job development and vocational training. There is no formal board for the center; a committee of county mental health and Hope House administration meets regularly, and there is a monthly Town Hall meeting. Consumer employees describe the experience and expertise as well as the support that the non-consumer director brings to the Center as a critical factor in its success.

CHAPTER 4: SYSTEM TRANSFORMATION AND CORE ELEMENTS

Stakeholders hope and intend for the MHSA to be a catalyst to transform the entire public mental health system.

Proposition 63 held out the promise of providing sufficient funds to assist

California's mental health system to achieve full service for all those in need. Stakeholders in the original CSS planning process addressed the biggest areas in which they felt there needed to be change – increased access, reduced ethnic disparities, a recovery orientation to services, increased consumer and family member direction and more community involvement. The State Department of Mental Health repeatedly stressed that this "would not be business as usual."

While CSS is only the first of the MHSA components to be implemented and, while that implementation is still not complete, it seems timely to at least begin to look at what the study counties are doing to bring change to their whole system.

It needs to be remembered, however, that co-occurring budget cuts to the core system are having an impact on this overall change.

- ✓ *MH Director:* "Actual CSS dollars are small, but change processes are enormous. We were planting seeds (before CSS) and used the MHSA to take it to another level and weave them together, integrate (those changes) with the whole system."

The concept of "transformation" does not mean the same thing to everyone.

Transformation implies a large and significant change, but it does not in itself indicate the 'what' or 'how' of that change. As noted in prior reports, there is remarkable consensus around some of the central features of the MHSA vision, but these do not always translate into similar views of what and how change should occur. Here are some examples of how key players in the study counties are thinking about the big picture of transformation.

Mental Health Director "If you are optimistic you can see how in 10 years things will be different. The minute you have a big vision; you have in front of you all the things that don't work. We will no longer have a need for this kind of system this big because you have people getting the right help at the right time – that would be worth working for."
Director of Consumer and Family Affairs: "We see the goal of transformation but not the processes, we are trying to do things differently but do not see things being done differently."
Mental Health Director: "Transformation is not about the therapeutic process. It is a three-legged stool – peer support, therapy, medication."
*MHSA Co*ordinator: "Transformation is not change; if it is really transformed we don't now know what it will be and how it will turn out."
MHSA Coordinator: "Transformation gets messy when you try to operationalize the concepts. It takes time and is not easy – whenever you have change you get disequilibria."

We made an effort to assess county progress on achieving the underlying core elements of system transformation.

The CSS guidelines contained five essential elements of system transformation which were identified in the extensive statewide planning process. In this year's site visits we inquired with an initial open-ended question how the county felt it was doing on these elements. The response to this open-ended question allowed us to determine the salience of the elements to the counties. One county recited all five elements and appears to use these to frame all of their planning and implementation, while others named one or two which they appear to use as goals for their system. For others, the five elements did not appear to be in the forefront of their CSS implementation or thinking about their system.

We followed up with more specific questions to determine their understanding of the elements and how they assessed their progress on each. The element of greatest confusion was the integrated service experience. The concept with the greatest need for continued work was that of resilience.

What follows is a brief description of the counties' self assessments of progress and opinions of staff on the five core elements. This is followed by a summary of the strategies that counties are using to spread these core elements into the rest of their mental health system.

A. WELLNESS ORIENTATION: RECOVERY AND RESILIENCE

While believing they are making progress on instilling a recovery orientation, counties find it hard to know how successful they are in practice.

There is wide recognition that it is difficult to translate recovery concepts into everyday practices. Counties have done a substantial amount of training and introduced recovery language into staff meetings and department policies and materials. Interviewees noted that the staff language is changing. It is more common to hear staff talk about recovery concepts and to spontaneously raise an issue when someone uses older language. But how deep the change goes is difficult to tell.

> *MHSA Coordinator*: "Sometimes I will think we are doing great, and then I will overhear a conversation in the hall and I will get very discouraged."
> *Mental Health Director:* "No matter where you are working in our entire department at least recovery is something everyone is believing in and getting into."

Staff believes they are making progress with recovery. Seventy percent of the staff agreed or strongly agreed with the statement that, "Compared to a year ago we have more skills and tools to implement a 'recovery' orientation."

The most significant catalyst for change appears to be the use of consumer staff.

Having consumers work as peers in programs seems to be the most successful effort at instituting real change. Such staff are not only beneficial for consumers in the programs, but also just as importantly are living proof of the possibility of recovery. This kind of evidence can have a powerful effect on consumers and family members and on staff, particularly those who have been in the system for a long time seeing only consumers who are not doing well.

> MHSA Coordinator: "One program has a peer specialist who was chronically homeless who is amazing in de-escalating anger – before they wouldn't let this guy into the building because of his history – very powerful for staff to see this."

Staff responses to questions about their expectations for and the goals for their TAY, adult, and older adult clients reflect varying belief in and focus on recovery.

About three-quarters of the staff appear to hold hopeful expectations for most of the clients with serious mental illness whom they serve. Staff was asked how much they agreed with the statement that "Most of our clients with a serious mental illness will be able to …"

"Most of our clients with a serious mental illness will be able to…" (N=578)	Strongly Disagree	Disagree	Agree	Strongly Agree
"…lead meaningful, productive lives in the community"	2%	15%	53%	30%
"…manage their lives sufficiently to have only minimal support from the mental health system"	4%	25%	50%	21%
"…have a satisfying social support network outside of the mental health system"	3%	17%	54%	27%

Client goals appear to still be more focused on traditional treatment-related than recovery oriented goals. Staff was asked about "how many of your clients have personal goals related to each of the following…"

"How many of your clients have personal goals related to each of the following…"	Most	Some	Very few or None
"…intimate relationships" (N=519)	17%	50%	33%
"…spirituality" (N=524)	11%	45%	44%
"…being compliant with medications" (N=548)	49%	38%	13%
"…reconnecting with their families" (N=541)	17%	59%	24%
"…having greater insight into their disorder" (N=546)	24%	50%	26%
"…education or employment" (N=542)	34%	47%	19%

Staff working with children and their families are using some of the components of a wellness orientation but interviewees express uncertainty about the concept of resilience.

The table below shows respondents from the web-based survey of staff who work with children and their families and indicates that at least two-thirds agreed with statements about their programs that indicate various elements in a wellness-oriented approach that is built on strengths and understanding developmental needs.

	Strongly Disagree	Disagree	Agree	Strongly Agree
We share stories about children/youth and/or families who have successfully achieved growth and accomplished their goals. (N=269)	4%	26%	32%	38%
We provide consistent transition support for children/youth whose situation undergoes significant change, e.g. youth leaving foster system or children returning to their families. (N=242)	4%	19%	36%	41%
Services are flexible and allow children/youth and their families to integrate them into their daily routines. (N=272)	2%	15%	31%	52%
We attend carefully to developmental needs in establishing treatment goals and assisting our children/youth and their families to achieve these goals. (N=278)	1%	7%	36%	56%
We use a strengths-based approach to assessment and services. (N=280)	1%	5%	25%	69%

Both staff and family members that we interviewed seemed less clear about operationalizing the concept of resilience for children and families as compared to the concept of recovery for adults. Some interviewees talked about positive youth development as a more easily understood concept and most counties emphasize a framework that incorporates system of care principles along with the concepts of resilience and youth development.

Staff believe they have made progress in implementing the concepts of recovery and resilience.

Staff working with TAY, adults and older adults and staff working with children and families were asked to rate the following: “Compared to a year ago

	Strongly Disagree	Disagree	Agree	Strongly Agree
Staff working with TAY, adults, and older adults: “…we have more skills and tools for implementing a ‘recovery’ orientation” (N=502)	5%	21%	49%	25%
Staff working with children and families: “…we have more skills and tools for implementing a ‘resilience/youth development’ orientation” (N=204)	6%	28%	39%	27%

Perhaps the best judge of the recovery concepts' implementation into programs is consumer employees. Ninety-four percent of the consumer employees agreed with the statement that "Our program offers clients hope about their future".

A large number of consumer and family member employees report there remains stigma against mental illness in their programs.

Parent employees report more stigma than do consumer employees; three-quarters agree with the statement that "there is still stigma in this program about mental illness".

"There is still stigma in this program about mental illness."	Strongly Disagree	Disagree	Agree	Strongly Agree
Consumer employees (N=83)	18%	35%	34%	13%
Family member employees (N=38)	8%	18%	38%	35%

> *MHSA Coordinator:* "Stigma is still a huge challenge within the system."

Another potential indicator of this is revealed in a question in the survey for staff working with TAY, adults, and older adults about whether "bathrooms, lounges, telephones, and eating areas in your program are separated for clients and staff." Sixty percent said "yes" and 40% said "no".

B. CONSUMER AND FAMILY-DRIVEN SERVICES

The core element of consumer and family-driven services has multiple dimensions.

In addition to focusing on consumer-directed centers in the study, we also explored three other ways in which the idea of consumer and family driven services are manifested within a county's public mental health system:

- ✓ Consumer and family member involvement in planning, policy, and management of the county's service system
- ✓ Consumer and family member employees
- ✓ Consumer and family member involvement in decisions about their own services.

B1. CONSUMER AND FAMILY MEMBER INVOLVEMENT IN PLANNING, POLICY, AND MANAGEMENT

All of the counties continue to involve consumers and family members in planning, but sustaining participation is a challenge.

After the initial enthusiasm for the first round of CSS planning diminished, counties are finding it more difficult to maintain continued involvement, particularly as the task turns more to monitoring than planning for new programs.

As noted in an earlier section, in a few counties the Mental Health Board, comprised of a majority of consumers and family members, has become a more forceful and meaningful part of the planning and oversight process. Some noted the difficulty of engaging clients and also, particularly parents and caretakers of children, because of the multiple claims on their time and energy.

> *Consumer in Management:* "Consumers have been empowered by MHSA. Their indignation is a huge factor in moving the system forward. Once they stop being indignant the system won't move at all. Some of this frustration is positive for the system."
>
> *MHSA Coordinator:* "There is a small core of consumers and family members who track along with what is happening – they are developing and becoming more sophisticated about what it all means and what their role can be and what they want to do – they have grown and developed very well."
>
> *Consumer in Management:* "The part I am most worried about is that clients and family members are not a regular part of meetings."

More than half the staff in the web-based survey indicate involvement of consumers and families in decisions about the operation of their programs.

The general staff web-based surveys asked about the involvement of consumers and family members in "the making of decisions about how this program operates." Seventy-two percent of the staff working with children and families agreed that parents were involved in these decisions, while 61% of the staff working with TAY, adults, and older adults agreed with the statement.

Four of the counties have consumer or family member management positions.

The location within management and the scope of responsibility of consumer and family member positions differ by county. Three counties have an Office of Consumer and Family Affairs (or Advocates) with a consumer manager. The fourth county has three consumer and family management positions, each in charge of separate units.

The position in Los Angeles has the broadest potential scope; the consumer manager is a member of senior management, has a substantial staff, and will develop into having responsibility for the contracted consumer centers. In Riverside, the Consumer Advocate, the Family Advocate, and the Central Support Unit for Parent Partners all provide a training and support function for the clinics and for consumer and family member employees; these administrative positions all report directly to the director and have a role on all policy development and decisions. In San Mateo, the manager serves a clear advocacy role, being used in numerous situations to bring the consumer and family perspective.

> *Consumer in Management:* "The intent is to create a management level position whose charge is to be sure that anything that the county does has the consumer and family members' position included – not necessarily in charge of any programs but bring the perspective to everything."

> *Consumer in Management*: "Having the clout of management makes it easier. The County started with people at management level, top down which is nice and gives us credibility"

The introduction of consumers and family members in management is not without its challenges.

The most critical challenge is not having sufficient resources to make a difference in the transformation of the whole system. While having the clout of management behind the effort is helpful, it is not in itself sufficient for the size of the task.

> *Consumer in Management:*" We are one of the pivotal points of transformation. Scope of responsibility is the entire system, not just MHSA programs."

There is a clear need to have consumers and family members throughout the system, not just at the top management levels.

> *Consumer in Management:* "There are many levels of hierarchy that have to be gone through even if the Executive Management is behind it. There should be more consumers and family members at all management levels."

> *Consumer in Management:* "The biggest challenge is the bureaucracy--having to do everything multiple times."

Some of the individuals we interviewed, who were the most knowledgeable and committed to client and family direction, see their counties as not yet fully embracing this concept.

> *Consumer in Management:* "Consumer driven services are not really happening; it is more like in collaboration with consumers…. We have inclusion but not direction."

> *Consumer in Management:* "We are pretty far from consumer and family directed – failing to meet that standard. We are limping along."

B2. CONSUMER AND FAMILY MEMBER EMPLOYMENT

An increase in the numbers of consumer and family member employees has been one of the most successful parts of the CSS component.

The various approaches to consumer and family member employment, as well as the special efforts made by counties in undertaking these endeavors, are described in last year's report. Some factors have now emerged more clearly about what it takes for this effort to be implemented smoothly and effectively:

- ✓ Special attention to the recruitment, application, and selection process is necessary. The most successful recruitments have gone beyond the usual sources for applicants; such an effort can increase the diversity of the applicant field. There are special barriers (e.g. criminal justice background checks, identifying mental health issues in the routine health screening) in the application process which must be managed and facilitated if the process is to go smoothly. Being sure that applicants can meet the minimal requirements of the job (e.g. reading and writing levels or having a driver's license) is necessary in order to avoid unnecessary failures.
- ✓ The Human Resources divisions have to be willing to be flexible with the handling of certain of their requirements. The attitude of this department/division can be crucial to the success of the effort.
- ✓ Providing ongoing support to the consumer and family member employees is helpful, particularly where employees may find themselves as the only consumer or family member at a program site.
- ✓ Clarity in expectations and roles is important. Consumer and family member employees are being used differently by different counties and by program managers within the same county. What is important is not so much the role, as the communication of that role to both the consumer and family member employees and the rest of the staff, so that expectations are clear and misunderstandings can be avoided.
- ✓ Preparation of the workforce is also important. Staff need an opportunity to openly raise their concerns within a safe environment. This is not being done by all of the counties. In the all staff survey, 38% disagreed with the statement that "we had the opportunity to raise and discuss issues related to employing consumers in our program."

Counties continue to have different approaches to the use of consumer and family employees. For example, some counties expressed the view that flexibility is needed in the application of usual employment rules in order to accommodate these employees, while others felt just as strongly that they should not be treated any differently from any other employee.

Consumer and family member employees report the basic requirements of their jobs are acceptable, except for the salaries.

The majority of consumer and family member employees reported on the survey that the application process went smoothly (86%) and that they got a lot of training before starting their jobs (62%).

A majority also reported no major problems arranging transportation to their jobs (74%) and 87% agreed with the statement that "the schedule of when I work is convenient for me."

Salary was another matter. Eighty-eight percent agreed with the statement "I think I should be getting a higher salary" – 39% agreed and 49% strongly agreed.

The programs appear to welcome the assistance of consumer and family member employees.

The great majority of the consumer and family member employees feel welcomed and respected by their co-workers.

	Strongly Disagree	Disagree	Agree	Strongly Agree
I feel a part of the program where I work (N=127)	2%	2%	38%	58%
Other staff treat me with respect (N-130)	2%	7%	34%	57%
Some other staff members don't treat me like a full member of the treatment team (N=128)	39%	33%	16%	13%
Other staff were very welcoming from the very start (N=130)	6%	9%	36%	49%
I feel comfortable sharing my story and experiences as a consumer or family member with other staff members (N=128)	2%	12%	34%	52%

One sign of the acceptance of consumer and family member employees by other staff is the fact that they would like more of them. Nearly two-thirds (64%) of the staff working with TAY, adults, and older adults in the general staff surveys disagreed with the statement that "we have as many consumer employees as we need".

Roles and responsibilities are clear to a majority of the consumer and family member employees, but a significant minority believes they could be doing more than they are being asked to do.

As indicated in the table below, roles and responsibilities, who to go to with problems and getting enough information about clients to do their jobs, all seem generally satisfactory. One concern is that a small minority of employees (20%) feel they are asked to do things they don't feel capable of doing.

The most striking finding is that more than two-thirds of the employees feel they could be doing more than they are being asked to do.

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am sometimes asked to do things I don't feel capable of doing. (N=126)	32%	48%	16%	4%
My role and responsibilities are clearly defined (N=127)	7%	13%	51%	28%
I get as much information about clients as I think I need (N=127)	4%	13%	43%	40%
I could do more than I am asked to do (N=125)	7%	25%	38%	30%
I know who to go to if I am having problems with my work. (N=128)	5%	7%	35%	53%

This belief is reinforced by the general staff survey in which 47% agreed with the statement that “consumers in our program could be doing more than they are currently being asked to do in helping our clients.”

There appears to be a learning curve in how consumers are used in programs, with additional responsibilities being added over time. In the general staff survey, 71% of the staff working with TAY, adults, and older adults agreed with the statement that “Compared to a year ago we are making better use of our consumer employees.” The corresponding figure for staff working with children and families was 69% with regard to the use of family member employees.

Many consumer and family member employees would like more training and more opportunities for advancement.

A high 74% of the consumer and family member employees express a desire for more training about how to do their jobs. Given the fact that the vast majority (92%) of the consumer and family member employees say they “plan to stay at their jobs for at least another few years”, it would seem to be in the interests of the counties and programs to provide additional training opportunities. Even if such training does not benefit the particular agency, it could benefit the field, since only 16% of the employees said they would like to get a job outside the mental health field.

Consideration should also be given to providing more opportunities for advancement within the county or programs.

- ✓ Twenty-seven percent do not believe there are opportunities for advancement within their program or agency.
- ✓ Thirty-three percent say they cannot get financial support from the program or county to get more formal education.

Consumer Employee: “Great experience but higher pay or opportunities to grow (learn more) would be beneficial.”
Consumer Employee: “I appreciate the opportunity. Now I need information on advancement opportunities.”

Overall, the consumer and family member employees feel they offer something special and have benefited from the employment experience.

Ninety-seven percent of consumer and family member employees feel they bring something special to their jobs, and the experience of working has made 94% of the consumers and family members feel better about themselves.

	Strongly Disagree	Disagree	Agree	Strongly Agree
I think I bring something special to this job because of my experience as a consumer or family member (N=128)	1.5%	1.5%	20%	77%
This job has made me feel better about myself and my future (N=127)	2%	4%	36%	58%

Here is what some consumer and family members said about what was the most valuable or helpful thing they do in their job:

> Consumer Employee: "I feel I bring a lot of caring and compassion to the mental health consumers I interact with."
> Family Member Employee: "(I can) support parents as someone who has been there."
> Consumer Employee: "I provide a hopeful outlook on the future by modeling recovery."
> Consumer Employee: (I can) be there to help support and advocate, be responsible, share my opinion when asked, be a living testimony that recovery is possible."

The following general comments on the survey reflect consumer and employee views on how the jobs have helped them:

> Consumer Employee: "Helped me feel like I belong and am valuable."
> Consumer Employee: "It has given me a starting point and a comfortable place to work and learn."
> Consumer Employee: "This program gives me a healthy outlook on life. With the money earned I am able to contribute to others. I really appreciate this opportunity."
> Parent Partner: "I love my job. It is so rewarding to be able to help families, give hope, and be there for them."
> Parent Partner: "My position in this job is helping me to be a stronger person and to save my own family."

Only 12% of the consumer and family members said that they have "missed a lot of work because of personal problems and issues".

B3. CONSUMER AND FAMILY MEMBER INVOLVEMENT IN DECISIONS ABOUT THEIR OWN SERVICES

Critical to the concept of consumer and family driven services is the enhancement of their role in making decisions about their own goals and services.

A question on the MHSIP for adults and older adults is "I, not staff, decided my treatment goals." While the scores on this item reflect general satisfaction, the scores are the lowest of all the items on the MHSIP.[11] Similarly, the scores for items on the Youth Services Survey for Families (YSS-F) and Youth Services

[11] California's Community Mental health Performance Outcome Report, Fiscal Year 2006-07, California Department of Mental health, March 2007.

Survey for Youth (YSS) regarding their involvement in decisions about goals and services were among the lowest items on the surveys. Increasing the role of consumers and family members in the setting of goals and in the deciding of treatment services is one of the fundamental system transformation goals of the CSS.

Hopefully, scores on the MHSIP and YSS and YSS-F will show higher satisfaction on these items in CSS programs over time. For this report, we have results from the general staff's perspective through the web-based survey and from the consumer and family member's perspective from the survey of those who are employed in the system.

Staff in the web-based surveys indicate they involve consumers and families in decisions about their treatment goals and plans, with over three-quarters saying they are doing so now more than a year ago.

More than three-quarters report that their "clients' treatment goals and plans reflect their choices" often (40%) or almost always/always (41%). Almost three-quarters of the staff working with TAY, adults, and older adults report that the psychiatrists in their program "effectively involve consumers in decisions about their medications" often (31%) or almost always/always (42%).

Ninety-four percent of the staff working with children and families say that "service goals and plans are clearly related to the child, youth, and family beliefs, opinions, and preferences" either often (24%) or almost always/always (70%). Ninety percent agreed that "families are treated as partners with us in designing services that meet their needs" either often (24%) or almost always/always (66%).

The trend lines are also hopefully on the upswing, with over three-quarters of the staff working with TAY, adults, and older adults either agreeing (54%) or strongly agreeing (28%) with the statement that "Compared with a year ago we are involving clients more in decisions about their treatment goals and plans." Over 80% of staff working with children and families either agree (44%) or strongly agree (42%) that they are involving their families and youth, as appropriate, in such decisions more than one year ago.

Consumer and family member employees agree with staff that consumers and families are involved in setting their own goals.

Overall, 87% of the consumer and family member employees agreed (50%) or strongly agreed (37%) that "clients in our program are able to choose their goals".

Another question on the survey for staff working with TAY, adults and older adults dealt with whether "the clients with a severe mental illness in their program had advance directives covering potential crises and inpatient care".

Of those who knew, 45% said "yes" and 55% said "no." Thirty-six percent did not know.

C. CULTURAL COMPETENCE

This section focuses on the efforts made by the counties to improve the quality of their care by making their services culturally competent.

As noted in the Ethnic-Oriented Initiatives Section, counties have employed numerous strategies to increase the cultural competence of their mental health systems. In this section, we discuss cultural competence in terms of all of the efforts to improve the quality of the services provided by the county and its traditional mental health contractors. The new outreach efforts and broadening the network of providers to include more cultural groups have been discussed in the section on Ethnic-Oriented Initiatives (see pages 24-28).

The counties have clearly focused on improving their cultural competence as part of their CSS work.

As one county noted "Cultural competence is broader than MHSA, but MHSA is a validation of cultural competence." Briefly described here are the various strategies used by the counties:

- ✓ Four of the counties undertook a reinvigoration of their Cultural Competence Committees through the addition of outside ethnic groups, reorganization of activities, or heightened leadership. These efforts have led to more vigorous and engaged committees.
- ✓ Two of the counties upgraded the position of the Ethnic Services Manager either through giving the position more authority, including it as part of upper management, or attending more to finding the right person to do the job.
- ✓ Two counties have provided additional funds to extend the translation of materials.
- ✓ One county has expanded the use within its own programs of non-traditional culturally-specific treatment modalities.
- ✓ Two counties have embarked on cultural competence assessments of all or significant parts of their system.

Mental Health Director: "You cannot talk about the county's mental health system without talking about cultural competence because of the diversity in the county."

The counties express the challenge of how to obtain sufficient focus without isolating the cultural competence activity.

There has been tension at all levels of CSS planning and implementation about how to deal with cultural competence issues. Without a special focus, the issue does not have the prominence and attention it needs. Yet the ultimate goal is to

have the principles and practices of cultural competence embedded within all aspects of all programs. The most frequent approach has been to do both – to have separate focused cultural competence committees and plan components and to also develop specific strategies for ensuring that the efforts of the special committee are translated into general practice.

While each county is different, we found some commonalities in how successful counties approach the ethnic services manager position.

This is a big job and requires sufficient focus and resources. In medium and large counties, this generally means at least one full-time position devoted exclusively to this activity. Having a person in this position that is from the community and/or is known among the ethnic communities is helpful. Also, it is critical that the ethnic services manager be part of the management team in order to have sufficient authority behind the effort.

Staff is generally positive about the sensitivity of their programs to cultural and ethnic populations.

Seventy percent of the staff working with children and families say that the "service goals and plans are clearly related to the child, youth, and family beliefs, opinions, and preferences" almost always, or always. Another 24% say this is the "often" the case.

About three-quarters of both the staff working with children and families (77%) and the staff working with TAY, adults, and older adults (73%) agree that "compared to a year age our program is better prepared to offer culturally competent services."

Consumer and family member employees generally agree, with 90% either agreeing or strongly agreeing with the statement that, "This program respects the cultural and ethnic characteristics of its clients."

D. COMMUNITY COLLABORATION

Most counties believe they were doing reasonably well with this core element before MHSA.

While noting opportunities for improvement, most counties had already made strides in working more closely with other agencies and organizations in their communities. This was particularly the case within the children's system of care where joint efforts are part of the philosophical orientation. The emphasis on this element within CSS had pushed the effort forward and has been consistent with the direction in which some, but not all counties were already headed.

> *Mental Health Director:* "We are thinking about what other people we need to involve in our work and that did not happen in our past."

As noted in last year's report, Los Angeles and Stanislaus are evolving their view of how to ensure the mental health of the county's citizens by placing greater emphasis on community ownership of the issue. The development of community relationships to assist other organizations to take on some of this responsibility is seen as essential to ease the strain on the mental health system, which these counties believe will never have sufficient resources to meet all of the community's mental health needs on their own.

> *Mental Health Director:* "This department really belongs to the community."

> *Mental Health Director:* "We hope that a year from now…we would be in tune with our community, we really have branched out beyond the traditional providers in our area, out of that new partnerships might emerge, with synergistic ideas that create openings."

Staff working with children, youth, and families report good relationships with the agencies with which they often work.

As might be expected, the responses of staff working with children, youth, and families are positive about their relationships with the other agencies with which they have developed relationships over the years. Ninety-five percent agree "we work closely with the schools when appropriate for our clients". Similarly 93% agree that "our relationships with social services, the courts, and probation are good when we work with families who are involved with these agencies."

Staff indicated variable, but generally low, ability to obtain non-mental health services for their clients.

Staff working on the staff web-based survey indicated how often they "have (or have access to) adequate services to assist your clients in dealing with the following needs." Access to these other services generally involves interactions with other agencies or organizations, even if that access is provided through mental health. The results are not encouraging, particularly with some services such as housing for families. The only service which is cited by at least one third of the staff as available "almost always" or "always" is substance abuse services for TAY, adults, and older adults (37%).

How often do you have (or have access to) adequate services to assist your clients with the following needs:	Never/Rarely	Sometimes	Often	Almost Always/Always
STAFF WORKING WITH TAY, ADULTS, OLDER ADULTS				
Housing (N=569)	9%	37%	25%	29%
Education and employment (N=558)	6%	30%	36%	27%
Substance abuse (N=563)	5%	24%	34%	37%
Physical health problems (N=564)	7%	30%	36%	27%
STAFF WORKING WITH CHILDREN, YOUTH, AND FAMILIES				
Housing (N=258)	34%	35%	19%	13%
Education and employment (N=265)	11%	35%	34%	21%
Substance abuse (N=264)	8%	31%	38%	23%
Physical health problems (N=266)	9%	37%	33%	21%

The staff is about equally divided about whether access to non-mental health services has improved over the last year. For staff working with TAY, adults, and older adults, 52% agree with the statement that “compared to a year ago it is easier to get services for our clients from other agencies and organizations” and 48% disagree. For staff working with children, youth, and families, 58% agree and 42% disagree. The same is true for the statement that “We have more options for non-mental heath community services and activities for our clients”; 52% of staff working with TAY, adults, and older adults agreed and 48% disagreed; with staff working with children, youth, and families, 57% agreed and 43% disagreed.

E. INTEGRATED SERVICE EXPERIENCE

There is less clarity about this concept than the other core elements.

This core element arose from the concern expressed by consumers and family members that from their perspective, services are often fragmented. They have to go to multiple places to receive services, and at each place they have to repeat their story and history because different programs had not and did not share information or communicate. The concept refers thus to consumers and families having a seamless experience of their services and supports, not to any objective feature of the service system.

Clearly, a service system which displays the fourth element – community collaboration – is more likely to yield an integrated service experience for clients. But there is more to the concept than that. Services within the mental health system can be or appear to the client as disconnected, for example, between inpatient and outpatient care.

> *MHSA Coordinator:* "Integrated service experience can be the result of integrated services or collaboration of many services…. Integrated service experience is a result of good community collaboration. It is the one that is the most challenging, it is hard to have one team do everything, we need to collaborate to get all the needs met."

The concept is understood by most of the counties as an integration of different services into a single program at one site offered by one organization. The models of this that are most familiar to counties are integrated services for persons with co-occurring substance abuse and mental health problems..

Depending on their understanding of the concept, at least three of the counties are addressing it specifically.

Three of the counties spoke specifically of initiatives that they felt addressed this core element. The activities are different because their understanding of the concept was not the same.

- ✓ Los Angeles spoke about the concept more as it was initially identified in the state stakeholder process. The initiative they discussed related to focusing specifically on reducing the number of hand-offs made within the mental health system and specifically facilitating for the clients those handoffs that remained.

  > "Welcoming and triage are trying to create a better hand off to the ongoing service."

- ✓ San Mateo focused on how to make substance abuse and mental health services seamless for clients by creating a fully integrated program for those with co-occurring disorders. Staff work for and identify with the program, not with separate entities, which would be the case if the program was a coordination between two agencies in which staff would retain their loyalty to their home agency.

  > "When you are integrated you identify with the client you are serving. When you are collaborating you are more identified with your agency. "

- ✓ Stanislaus views the concept as referring to both the connection between services within mental health and those between mental health and outside agencies. The MHSA Coordinator sees "the integrated services experience as one of the products of good community collaboration."

F. EXTENDING CORE PRINCIPLES TO THE REST OF THE MENTAL HEALTH SYSTEM

Counties utilized a mix of four different strategies to move CSS core elements into their overall mental health system.

Counties relied to a greater or lesser extent on each of these strategies – some explicitly and some implicitly.

The first strategy is conducting training for the staff of all the mental health programs in some of the core MHSA elements. In most cases, contract staff has been included in this training, sometimes for the first time. Some of the training predated MHSA, but the CSS funds allowed for an expansion and a focus particularly on the elements of recovery and cultural competence. This is seen as a way to bring the "rest of the staff" along with those working in the newer CSS programs.

A second strategy is reframing the whole mental health system to encompass the core principles.

This strategy has been directed from the top down. While all the counties indicated that MHSA thinking has affected their whole system, Stanislaus has been the most explicit in rethinking everything – programs, structures, management, administration – in terms of the five essential CSS elements.

> *Mental Health Director:* "It has made us very conscious about what we are doing, does this line up with the essential elements, where are consumers, how are families involved – some of this is very intentional."
>
> *MHSA Coordinator:* "CSS is a reference point - it affects everything. It will be two years this month that our CSS plan was approved. At that time I could have never predicted how much CSS thinking and values would have gotten into the system. It is the future. Whether we realize it or not, it affects everything. Part of that is (our Director's) leadership allows us to act as if this is reality."

Another major whole system direction from the top is occurring in Los Angeles, where the top management is reworking its vision and strategic plan to incorporate the fundamental concepts in the MHSA.

> *Mental Health Director*– "We need one system not a rich one and a regular one. What will the system of care look like for the four age groups; what will be the roles of the county operated and the contract providers. This is the basic strategic planning work including thinking about how PEI will work to the benefit of the whole system and not just as a separate thing."

The third strategy is using a countywide initiative based on CSS principles to awaken interest and change.

Three of the counties have used a specific countywide initiative to implement particular core concepts.

- ✓ San Mateo has a major countywide Co-occurring Initiative which includes technical assistance and training utilizing outside consultants.

Mental Health Board: "Staff are embracing the change because of the co-occurring initiative and the possibility of change; there are staff that feel taxed but underneath that is a sense of excitement."

- ✓ Los Angeles has a Clinic Transformation Project which is an effort to involve all the staff in the transformation of the clinics. The clinics develop their own projects within a framework of four different domains: staff transformation, staff-consumer interactions, organizational structures and processes, and available services and capacities. Outside consultants were used to set up the effort and a combination of external and internal people continue with the monitoring of the effort.

Manager: "We have compliance of all the District Chiefs but not necessarily support but some embrace the change even if they don't necessarily agree with it. We do have enough champions who are informal leaders to make it happen – since last July there has been a lot of movement with process speeding up so we think we are past the tipping point."

- ✓ Riverside has embarked on a Welcoming Campaign which extends to all its clinics. Each one is to design and implement a welcoming plan. The regional managers have the responsibility for monitoring compliance.

MHSA Coordinator: "Just doing it [the welcoming plan] made a difference."

The fourth strategy is based on the theory that the changes implemented in CSS will "trickle out" into the rest of the system.

The most common example of this strategy is the use of consumer employees who bring with them the recovery and consumer empowerment aspects of the CSS vision. Their mere presence in the system brings change to the way staff and clients perceive the system.

There were numerous other examples, some highlighting a specific event and others just noting how the MHSA concepts and practices are having an effect on other programs in the system.

- ✓ *Program Manager:* "Karaoke in the lobby by a peer specialist was an amazing event for all the staff. The peer specialist had the idea and it was a huge success, others joined in and it was a big morale booster for everyone."
- ✓ *MH Director:* "One of the things that is wonderful for old traditional programs is the infusion of the philosophy and principles of CSS into our old programs."
- ✓ *MHSA Coordinator:* "What we are learning is how MHSA is impacting other programs, seeping into all the other programs."

G. STAFF SUMMARY

Roughly 60% of the staff overall feel that the MHSA has had a positive impact in their county, but more progress is needed in fully integrating MHSA programs and concepts throughout the systems.

The following table shows the percentages or respondents in the all staff surveys who held varying opinions about the MHSA within their county.

- ✓ In both surveys, a significant percentage of respondents answered "don't know" or "no opinion", suggesting either unfamiliarity with the MHSA and/or the particular question.
- ✓ About one-quarter of the respondents agreed that there is little connection between the MHSA and the other programs and another quarter stated that they "did not know".
- ✓ Less than half agreed that they were well informed about the MHSA planning, implementation, and oversight.
- ✓ About one-third agreed that staff in non-MHSA programs feel some resentment about the better funded MHSA programs.

	Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*	*Don't Know*
STAFF WORKING WITH TAY, ADULTS, OLDER ADULTS (N=581)					
There is little connection between new MHSA programs and the regular mental health system	12%	38%	20%	5%	24%
I am well informed about what is happening with MHSA planning, implementation, and oversight in our county.	11%	28%	36%	10%	15%
The impact of MHSA has been very positive in our county.	3%	11%	44%	19%	24%
Staff in non-MHSA programs feel some resentment about better-funded MHSA programs.	5%	12%	24%	11%	48%
MHSA has brought a positive change to the way we think about and deal with mental illness in our county.	3%	12%	41%	23%	21%
STAFF WORKING WITH CHILDREN, YOUTH, AND FAMILIES (N=277)	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*	*Don't Know*
There is little connection between new MHSA programs and the regular mental health system.	12%	33%	21%	5%	29%
I am well informed about what is happening with MHSA planning, implementation, and oversight in our county.	12%	35%	35%	7%	11%
The impact of MHSA has been very positive in our county	1%	10%	49%	22%	28%

Staff in non-MHSA programs feel some resentment about better-funded MHSA programs.	4%	16%	27%	9%	44%
MHSA has brought a positive change to the way we think about and deal with mental illness in our county.	2%	12%	42%	22%	23%

Conclusion

MHSA implementation for CSS is well under way in these seven diverse counties. Current funding problems in other parts of the system, ongoing workload, and planning and implementation of the other MHSA components are significant challenges in continuing substantial progress. Despite these challenges, CSS programs are being implemented as intended, stakeholders remain involved and counties have used diverse strategies to improve access for the unserved and underserved. All counties are concerned about the integration of CSS and other MHSA components with the entire mental health system and are developing strategies, plans and creative approaches to make sure this will happen to the extent possible. Collaborative initiatives have done best when there has been a strong history of working together (forensics and children's systems of care), but new collaborations are promising and have shown some early encouraging results (physical health/mental health and ethnic community based organizations). The five core elements are used in varying degrees in the counties and have not yet been consistently operationalized by counties or the state, but remain central to the focus of CSS programs. Consumer driven centers struggle with bringing their vision to reality and striking the right balance between structured classes and social, informal activities. Consumer employees have been significant in decreasing stigma and providing consumer role models for clients and staff. Transformation is yet to be fully defined, but these counties are working on changing their entire systems in ways that will bring MHSA concepts to life.