



**San Mateo County Health System
Behavioral Health and Recovery Services Division**

MHSA Steering Committee

May 2nd, 2012 - 3 to 4:30 p.m.
Health System Building – 225 37th Avenue, Room 100
San Mateo

AGENDA

1. **Welcome and introductions** 3 to 3:10
Dave Pine, Supervisor District 1, Co-Chair
Sharon Roth, MHSARC Chair, Co-Chair

2. **Mental Health and Substance Abuse Recovery Commission (MHSARC)** 3:10 to 3:15
 - Call to order and action to release plan for public comment *Sharon Roth*

3. **MHSA 101 and progress report** 3:15 to 3:40
 - MHSA refresher – Report per component *Sandra Santana-Mora, BHRS*
 - Highlights:
 - FSP Children, Youth and TAY *Paul Sorbo, BHRS*
 - FSP Adults and Older Adults – Housing *Judy Davila, BHRS*

4. **FY 12/13 Annual Update** 3:40 to 4:00
 - Changes in the state level MHSA landscape, local implications *Stephen Kaplan,*
 - Revenue projections and MHSA Plan *BHRS*

5. **Group Discussion** 4:00 to 4:25
Stephen Kaplan (facilitator)
 - Anything missing?
 - Approval of priorities
 - Public comment

6. **Next steps and closing remarks** 4:25 to 4:30
 - Public comment period ends June 6, 2012 with a public hearing to be hosted by the MHSARC *Supervisor Pine*

PUBLIC COMMENT PERIOD: May 2nd, 2012 – June 6, 2012

PUBLIC HEARING: JUNE 6, 2012 – 3 to 5 p.m.
225 37th Avenue, Room 100, San Mateo, CA 94606

**MENTAL HEALTH SERVICES ACT
STEERING COMMITTEE MEETING**

May 2nd, 2012

PROGRESS REPORT and ANNUAL UPDATE FY 12/13

San Mateo County Health System
Behavioral Health and Recovery Services Division



TODAY'S PRESENTATION

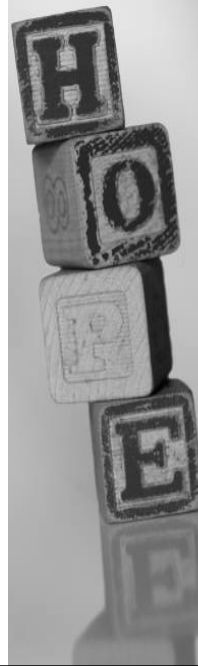
- MHSa REFRESHER
- PROGRESS REPORT (previous year)
- CURRENT CONTEXT
- FY 12/13

MENTAL HEALTH SERVICES ACT

REFRESHER

PROPOSITION 63

- Passed in November of 2004
- 1% tax on personal income > \$1M
- Funds MH services
 - Co-occurring services OK
- No supplant rule

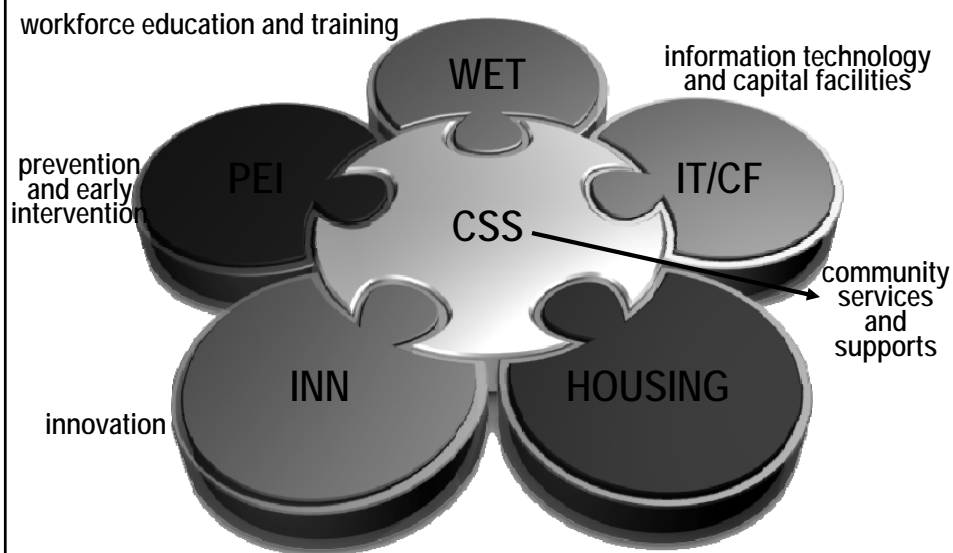


PRINCIPLES AND FUNDING BOUNDARIES

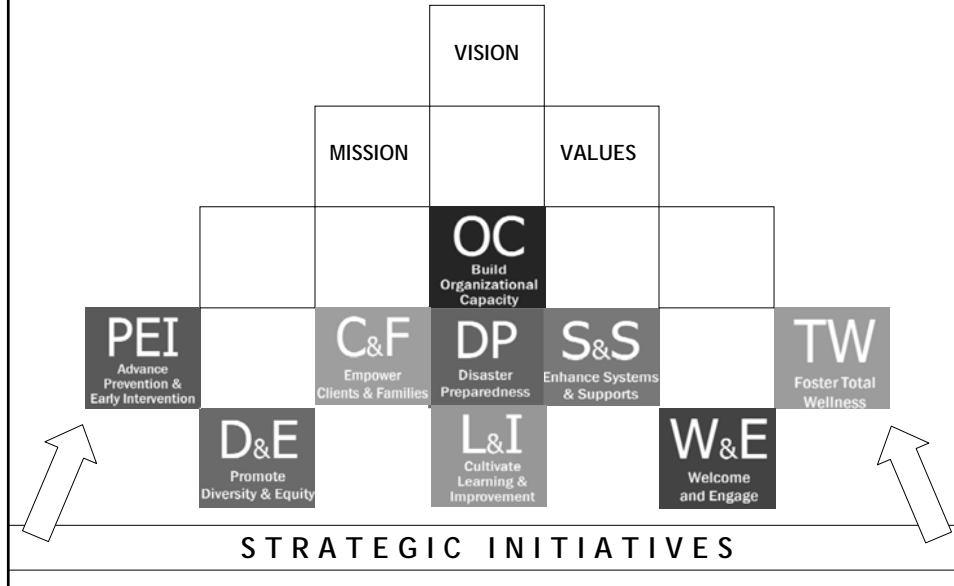
- Wellness, recovery and resilience
- Cultural competence
- Consumer/family driven services
- Integrated service experience
- Community collaboration

Fundable activities are grouped into 'components', each one with its own set of guidelines and rules.

FUNDING CATEGORIES



BEHAVIORAL HEALTH AND RECOVERY SERVICES



PROGRESS REPORT

MHSA AT A GLANCE – CLIENTS SERVED

outreach and engagement

06/07: 314
 07/08: 1,905
 08/09: 4,707
 09/10: 5,471
 10/11: 9,996

system development initiatives

06/07: 1,846
 07/08: 3,896
 08/09: 3,684
 09/10: 4,159
 10/11: 4,089

full service partnerships

06/07: 161
 07/08: 281
 08/09: 336
 09/10: 350
 10/11: 428



BEHIND THE HIGH LEVEL NUMBERS

INITIATION AND ENGAGEMENT CONSIDERABLY ABOVE TARGET

- Initiation: 2nd visit within 14 days
- Engagement: 3rd and 4th visit 30 days after initiation

PROGRAM	INITIATION	INITIATION BENCHMARK	ENGAGEMENT	ENGAGEMENT BENCHMARK
East Palo Alto Clinic (Adults)	90%	70%	79%	55%
MH Services for Seniors	79%		68%	
North County Clinic (Youth)	82%		68%	

BEHIND THE HIGH LEVEL NUMBERS

- 85 % penetration rate (best in the State) of any county in California for children in foster care. State average: 63%
- Our Pathways program saw a decrease in jail days of 73% for enrolled clients
- Through our partnership with Vocational Rehabilitation Services, we have created 13 jobs for mentally ill adults whose histories of hospitalization would not have predicted their insertion in the workforce



CLIENTS SERVED

PROGRAM	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11
Full Service Partnership (Adults/Older Adults)	41 A 33 OA	85 A 57 OA	125 A 103 OA	129 A 78 OA	169 A 81 OA
Full Service Partnership (Children/Youth/TAY)	87 C/Y/TAY	67 C/Y 55 TAY	60 C/Y 48 TAY	89 C/Y 54 TAY	135 C/Y 43 TAY
Primary Care-Based Behavioral Health Services	128	665	852	866	845
Outreach East Palo Alto	N/A	1,250	2,978	3,250	3,839
Outreach North County Collaborative	N/A	N/A	430	1,242	5,285
Older Adults System of Integrated Services	100	187	259	280	280

CLIENTS SERVED

PROGRAM	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11
Crisis Hotline	168	539	677	728	728
Pathways	56	181	185	123	143
Consumer/family partners	595	842	764	932	904
EBP expansion (youth/adults)	948	2,192	2,125	2,076	2,223
Puente DD clinic	N/A	N/A	69	117	144
Interns	135	131	224	368	350

FULL SERVICE PARTNERSHIPS OUTCOMES

OUTCOMES	CHILDREN & YOUTH	TAY
Decreased Homelessness	34%	47%
Decreased Hospitalization	38%	56%
Decreased Incarceration	37%	45%
Decreased Arrests	100%	83%
Decreased School Suspensions	90%	100%
Increased School Attendance	34%	34%
Decreased Out-of-Home Placement	66%	77%
Improved School Grades	51%	38%

FULL SERVICE PARTNERSHIPS OUTCOMES

ADULTS	
Decreased Homelessness	88%
Decreased Hospitalization	82%
Decreased Incarceration	96%
Decreased Arrests	100%

OLDER ADULTS	
Decreased Homelessness	100%
Decreased Hospitalization	50%
Decreased Incarceration	100%
Decreased Arrests	100%

HOUSING – KEY ELEMENTS

- Construct or acquire housing units for seriously mentally ill adults, older adults, families with severely emotionally disturbed children and transitional aged youth
- Funds for both construction and operation
- \$100,000 per unit not to exceed one third cost of unit; and up to \$100,000 per unit for unit operating costs
- BHRS responsible for services through Full Service Partnerships



HOUSING PROJECTS

Cedar Street Apartments
Approved in 2009 - 14 units



El Camino Apartments
Approved in 2010 - 20 units



Delaware Street Apartment - Approved in 2011 – 10 units

HOUSING – FUNDING BREAKDOWN

ONE-TIME ALLOCATION:	\$ 6,762,000
▪ Cedar Street \$ 524,150	
▪ S. El Camino \$ 2,163,200	
▪ Delaware Street <u>\$ 1,124,860</u>	
TOTAL COMMITTED \$ 3,812,210	
Remainder:	\$ 2,949,790 (+ interest)



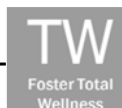
PREVENTION AND EARLY INTERVENTION

- Cautious approach to implementation
 - Approval of PEI plan coincided with beginning of financial recession
- Anti-Stigma initiative has reached 850 individuals in FY 10/11
- Early Childhood Community Team served 26 clients in 1 quarter of operation in FY 10/11.
 - Numbers have increased dramatically with program in full operation in 11/12, currently providing MH consultation services to 130 children and 25 staff, and parent groups in the Coast. Also serving 8 families in Daly City.



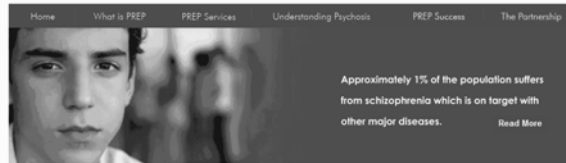
PREVENTION AND EARLY INTERVENTION

- Office of Diversity and Equity
- Community Interventions for School and Transition Age Youth:
 - Teaching Pro-social Skills served 40 students in 6 schools (January through June 2011)
 - Seeking Safety, served 91 clients in 6 months of programming
 - Project SUCCESS: 15 clients served in 1 quarter of programming
 - Middle school initiative served 53 students in FY 10/11



PREVENTION AND EARLY INTERVENTION

- PREP, Prevention and Recovery in Early Psychosis, targets individuals ages 14 to 35 with first onset schizophrenia and other psychotic disorders.



About PREP - San Mateo

PREP is an early-intervention treatment program for schizophrenia and early psychosis which uses a strength-based roster of services to create a 2-year plan designed specifically to put families back on track.

PREP referral line is 650.504.3374



WORKFORCE EDUCATION AND TRAINING

- BHRS Staff Mentoring Pilot (40 mentors and mentees)
- Mental Health Loan Assumption Awardees (9)
- Lived Experience Academy (10 graduates)
- *Can We Talk* Consumer & Family Member Employment Conference (150)
- Second Trauma Informed Care Conference (530)
- Ongoing implementation of evidence based practices including Seeking Safety, Motivational interviewing, WRAP, Strength-Based Case Management, trauma-informed care, mindfulness based cognitive therapies (600)
- Continued recruitment of interns and distribution of stipends with increased collaboration with ODE (20 stipends, 65 interns)



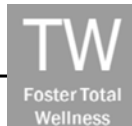
TECHNOLOGY

- First pilot clinic, East Palo Alto, went live on 12/8/09
- By the end of FY 09-10, there 450 Avatar users and we had full electronic medical record with electronic prescribing, assessments, treatment plans, progress notes, transfer/discharge record
- In FY 10/11 Avatar became the "system of record" as of July 1: fully operational and in use in all of our directly operated County Clinics; began working with contracted CBOs to submit data to us trough Avatar



INNOVATION

- The mission of Total Wellness is to ensure a coordinated and holistic, wellness-based approach for our clients with serious and persistent behavioral health issues
- Services include: nurse care coordination with primary care services; peer wellness coaching; peer led wellness groups such as smoking cessation and well body; health education; nutrition classes and physical activities; TW WRAP group, among others
- A total of 247 individuals have been enrolled and served since the program went live in February 2011



CURRENT CONTEXT

MHSA LANDSCAPE

- Great uncertainty regarding State budget and legislative processes
 - GOP budget proposal
 - S.B. 1136 (Steinberg)
 - A.B. 2228 (Hayashi)
 - TBL 601 (Governor's proposal):
 - OAC to "receive" plans to support evaluation
 - Repeals county performance contract
 - Designates County BOS to approve plans
 - Appropriates \$60M to DPH for the CA Reducing Disparities project



PLANNING FOR THE FUTURE

PRINCIPLES

- Follow existing MHA guidelines
- Maximize revenue (e.g., MAA, Medi-Cal) for MHA funded programs
- Prioritize direct services to clients over indirect services

PLANNING FOR THE FUTURE

PRINCIPLES

- Use reserves to mitigate impact to services (reserves decreasing)
- Evaluate potential scenarios against BHR's Mission, Vision and Values. When the economy improves, we want to be well positioned to carry-on our work
- Avoid impacting any geographic, ethnic, or linguistic group disproportionately

PRIORITIES IDENTIFIED BY STAKEHOLDERS

P R I O R I T I E S

- Maintenance of effort so as to avoid undermining progress made, thus positioning ourselves well for growth
- Expansion of FSP services
- Implementation of early onset project

FISCAL YEAR 12/13 PLAN

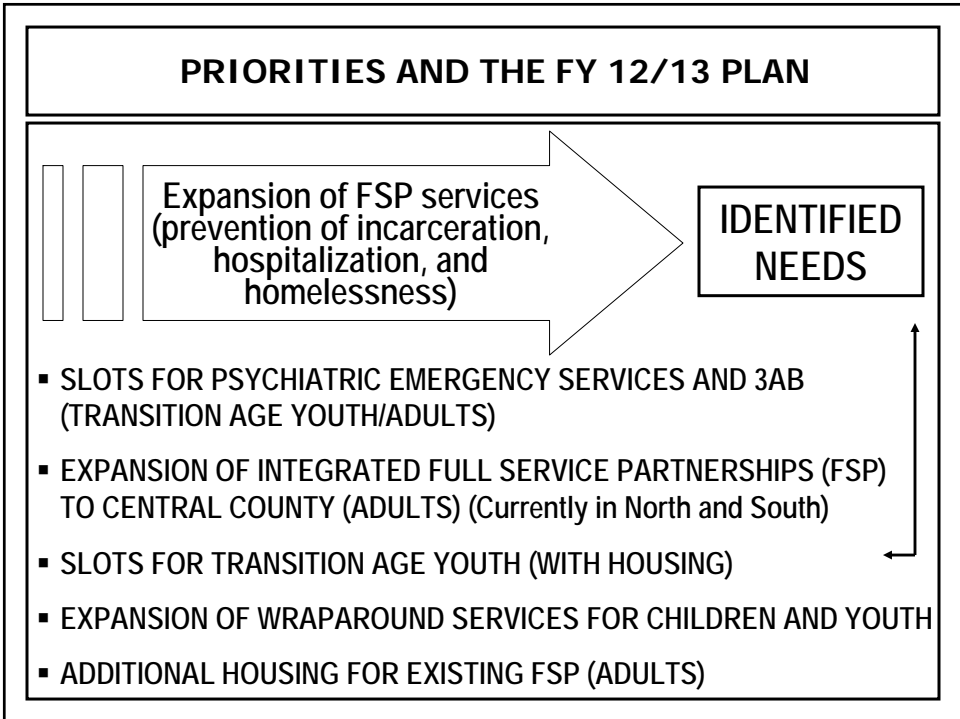
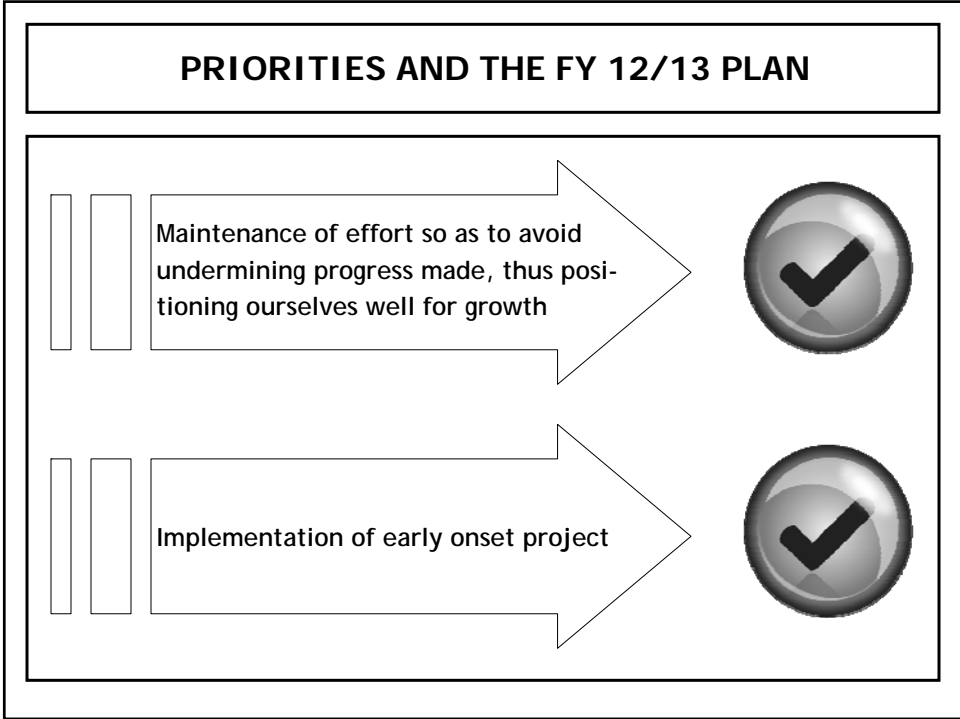
STATE REVENUE PROJECTIONS FY 12/13

	FISCAL YEAR									
	ACTUAL					ESTIMATED				
	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	
CSS	518	650	900	784	741	940	971	1,038	1,146	
PEI	115	233	330	216	185	235	243	259	287	
INN		71	71	120	49	5%	5%	5%	5%	
TOTAL	633	954	1,301	1,120	975	1,175	1,214	1,297	1,433	

PROPOSED EXPENDITURE LEVELS VS. PROJECTED REVENUE - FY 12/13

	PROJECTED MHSA COST FY11/12	PROJECTED ALLOCATION FY 12/13 (10%)	PROJECTED FY 12/13 (15%)	PROJECTED FY 12/13 (20%)
CSS	\$13,004,477?	\$13,174,150?	\$13,772,975?	\$14,371,800?
PEI	\$4,478,339	\$3,450,260?	\$3,607,090?	\$3,763,920?

San Mateo's strategy of using higher revenue years to carry us through lower revenue years has paid off: for FY 12/13, expenses will be equal to revenue for CSS; for PEI, rollover will allow to maintain program expenditure levels until the revenue fully stabilizes.



OTHER NEEDS IDENTIFIED

COMMUNITY SERVICES AND SUPPORTS

- PRE-CRISIS RESPONSE SERVICES
- EXPANSION OF ASSESSMENT, SUPPORTED EMPLOYMENT AND FINANCIAL EMPOWERMENT FOR CLIENTS
- EXPANSION OF SUPPORTS FOR YOUTH TRANSITIONING TO ADULTHOOD
- TRAUMA-INFORMED CARE SERVICES EXPANSION

PREVENTION AND EARLY INTERVENTION

- EXPANSION OF INTERVENTIONS FOR CHILDREN AND YOUTH AGES 0 TO 25
- EXPANSION OF PARENT PROJECT

DISCUSSION AND NEXT STEPS

- ANYTHING MISSING?
- APPROVAL OF PRIORITIES FOR FUTURE IMPLEMENTATION

DURING PUBLIC COMMENT PERIOD WE WILL:

- COST OUT PRIORITIES IDENTIFIED
- PRESENT AT JUNE 6 PUBLIC HEARING BEFORE MHSARC
- BOARD OF SUPERVISORS APPROVAL OF THE BUDGET OF THE HEALTH SYSTEM (SEPTEMBER)



San Mateo County

Health System

Behavioral Health and Recovery Services Division

Mental Health Services Act (MHSA)

FISCAL YEAR (FY) 2012/2013

UPDATE TO THE THREE-YEAR PROGRAM

AND EXPENDITURE PLAN

COUNTY CERTIFICATION

County: San Mateo

County Mental Health Director	Project Lead
Name: Stephen Kaplan, LCSW Telephone: (650) 573-3609 E-mail: skaplan@smcgov.org	Name: Sandra M. Santana-Mora, MA Telephone: (650) 573-2889 E-mail: ssantana-mora@smcgov.org
Mailing Address: San Mateo County Health System Behavioral Health and Recovery Services Division 225 37th Avenue, 3rd floor San Mateo, CA 94403	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes for this annual update/update, including all requirements for the Workforce Education and Training component. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

This annual update has been developed with the participation of stakeholders, in accordance with sections 3300, 3310, subdivision (d), and 3315, subdivision (a). The draft FY 2012/13 annual update was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget, 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three year plan and updates be approved by the Department of Mental Health after review and comment by the Mental Health Services Oversight and Accountability Commission. In light of this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

The costs of any Capital Facilities renovation projects, if any, in this annual update are reasonable and consistent with what a prudent buyer would incur.

The information provided for each work plan is true and correct. All documents in the attached FY 2012/13 annual update/update are true and correct.

STEPHEN KAPLAN, LCSW
Mental Health Director/Designee (PRINT)

Signature

June 15, 2012
Date

**COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS****County:** San Mateo**30-day Public Comment period dates:** May 2nd/June 6, 2012**Date of Public Hearing:** June 6, 2012

The Behavioral Health and Recovery Services Division of the San Mateo County Health System devised a local planning process and structure to seek input from the broad San Mateo stakeholder community for the initial component of the Mental Health Services Act (MHSA) to be implemented, namely Community Services and Supports. This planning structure has remained in place and had since framed all our planning activities related to any component of the MHSA, with adjustments as each component has called for.

The Mental Health and Substance Abuse Recovery Commission (MHSARC, formerly the Mental Health Board), as a whole and through its committees structure, is involved in all MHSA planning activities providing input and receiving regular updates. The meetings of the MHSARC are open to the public, and attendance is encouraged through various means: notice of meetings (flyers, emails) are sent to a broad, ever increasing network of contacts including community partners and County agencies as well as consumer and advocacy organizations, and the general public. In addition, notice of meetings and other opportunities for input are publicized at different internal and external meetings and venues; presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the different committees of the MHSARC (they meet monthly); at the monthly MHSARC meeting; at meetings with community partners and advocates; and internally with staff.

The MHSA Steering Committee created in 2005 is co-chaired by a member of the San Mateo County Board of Supervisors and by the chair of the Mental Health and Substance Abuse Recovery Commission. Comprised of over 40 community leaders representing the diverse San Mateo community including mental health constituencies (clients, advocates, family members, community partners, County and CBO staff), and non mental health constituencies (County leadership, Education, Criminal Justice, Probation, Courts, among others), the Steering Committee greenlights MHSA proposals and approves the programmatic direction of MHSA-funded activities. All members of

the Mental Health and Substance Abuse Recovery Commission are members of the MHSA Steering Committee.

A multiyear approach to planning underlies San Mateo County's MHSA strategy, which facilitates stable programming, ensures a balanced approach when considering programmatic changes, and utilizes higher revenue years to cushion lower revenue years.

In the summer of 2009, the Behavioral Health and Recovery Services Division engaged the BHRS stakeholder community in a series of meetings to develop the budget for FY 10/11, which encompassed all funding sources, including MHSA. That stakeholder group was informed of, and provided input into, the response to the local directive to address San Mateo County's structural deficit. This deficit has occurred because countywide revenues have not kept pace with expenses, and reflects the global economic and financial reality we've been facing in the last few years.

The budget planning process, which was reinvigorated the following fiscal year, had tremendous engagement from more than 130 stakeholders per meeting on average who participated in six initial planning meetings chaired by Cameron Johnson of the Mental Health and Substance Abuse Recovery Commission (MHSARC), and George Torney, a retired Alcohol and Other Drug provider. The process that this group engaged in not only addressed the budget for that particular year, but also developed and reached consensus on a series of principles to guide future years' planning processes, as follows:

- Follow MHSA guidelines
- Maximize revenue (e.g., MAA, Medi-Cal) for all MHSA-funded programs
- Prioritize direct services to clients over indirect services
- Avoid impacting any geographic, ethnic, or linguistic group disproportionately if considering service reductions
- Use reserves to mitigate impact to services (reserves have decreased)
- Evaluate all potential budget scenarios against BHRS' Mission, Vision and Values and MHSA principles when making budgetary decisions in order to be well positioned to carry-on our work in any economic climate

MHSA-specific priorities identified included the intention to maintain the level of programming in all components, prioritize for implementation an early intervention treatment program for schizophrenia and early psychosis, and expand access to Full Service Partnerships. These principles continue to guide our MHSA planning processes.

THIS SECTION WILL BE FINALIZED AFTER THE PUBLIC COMMENT PERIOD IS CLOSED:

The MHSA Steering Committee heard the FY 12/13 Plan on May 2nd, 2012, when the MHSARC also released it for public comment. The public comment period will close on June 6, 2012; on that day, the MHSARC will hold a public hearing.

Outreach strategies used to circulate information and to seek public comment include: posters and flyers created and sent to/placed at county facilities, as well as other venues like family resource centers and community-based organizations; the numerous internal and external meetings mentioned above; e-mails disseminating information about the availability of plans open for public comment are sent to over 1,000 electronic addresses in our ever-expanding database; notices are published in the local paper of largest circulation; word of mouth on the part of our committed staff and active stakeholders, among other dissemination strategies. Proposals are also posted on our County's Network of Care and on our MHSA website.

Stakeholder entities involved in the Community Program Planning Process

The Mental Health Services Act implementation is very much a part of BHRS's day-to-day business. Information is shared with a diverse group of stakeholders on an ongoing basis through progress reports, and by sharing successes and challenges. In this way, input is provided and collected on a regular basis at various venues. All the MHSA information is made available to stakeholders on the Network of Care website, and on the San Mateo County Behavioral Health and Recovery Services website –which contains an MHSA webpage. The MHSA webpage is the hub of information for all-things MHSA. We recently incorporated a new feature that allows interested parties to sign up to receive an automated email every time the website is updated.

This is a convenient and hassle-free way for stakeholders to keep apprised of MHSA developments, and learn about meetings and opportunities for input. The current list of

subscribers to that page is 412. Hard copies of all our materials are made available upon request.

BHRS's e-journal, *Wellness Matters*, which is published the first Wednesday of each month and distributed electronically to over 700 stakeholders, is also utilized as an information dissemination and educational tool, with a standing column written by the County's MHSA Coordinator.

Substantive comments received during the stakeholder review and public hearing. To be completed after the public hearing.

Mental Health Services Act Steering Committee

Maya Altman Executive Director Health Plan of San Mateo	Debby Armstrong Executive Director First 5 San Mateo County	Dan Becker Representative for the Hospital Council Mills Peninsula Hospitals
Clarise Blanchard Director of Substance Abuse and Co-occurring Disorders, Star- Vista; Representative BHRS Contractors Association	Rodina Catalano Deputy Court Executive Officer of Operations, County of San Mateo	Susan Ehrlich, MD CEO San Mateo Medical Center
Patrick Field Consumer	Stuart Forrest Chief Probation Officer Probation Department	Carmen Lee Stamp Out Stigma
Don Mattei Belmont Police Chief	Sharon McAleavey AFSCME	Mary McMillan Deputy County Manager County of San Mateo
Raymond Mills Consumer, Voices of Recovery	Dave Pine Supervisor District 1 Board of Supervisors	Melissa Platte Executive Director Mental Health Association
Steve Robison NAMI	Louise Rogers Health System Deputy Chief San Mateo County	Joan Rosas Associate Superintendent, Student Services, San Mateo County Office of Education
Deborah Torres Director, Child Welfare Human Services Agency	Teresa Walker Family Member	Patricia Way NAMI
Laurie Wetzel Executive Director Women's Recovery Association	Greg Wild Executive Director, Heart and Soul	

**Mental Health and Substance Abuse Recovery Commission (MHSARC)
(Formerly Mental Health Board)**

Edmund Bridges Consumer	Rodney Clark Family Member	Michael Eipp Family Member
Valerie Gibbs Member of the Public	Cameron Johnson Family Member	Laura Martinez Consumer
Dave Pine Supervisor, District 1	Patrisha Ragins Consumer	Sharon Roth, Chair Family Member
Judy Schutzman Family Member	Maureen Sinnott Member of the Public	Katherine Sternbach Member of the Public
Wanda Thomas Consumer	Josephine Thompson Family Member	Nancy Wilson Consumer
Donald Livingston Youth Commission	Tatiana Quintanilla Youth Commission	
ALL MHSARC MEMBERS ARE MEMBERS OF THE MHSA STEERING COMMITTEE		

The following are highlights of our programmatic activities during FY 10/11, per program:

FULL SERVICES PARTNERSHIPS (FSPs)

Fred Finch Youth Center and Edgewood Center for Children and Families were awarded the contracts to expand the Children, Youth and Transition Age Youth FSPs. These programs started in March of 2010.

Fred Finch Youth Center focuses on San Mateo County youth ages 6 to 17 placed in foster care temporarily outside of the County. Most of these youth reside in the South Bay and in the East Bay. Services are designed to support and stabilize youth in the foster home, support the foster family, and facilitate the return of the youth to the family of origin in San Mateo County when feasible.

This FSP also supports older adolescents transitioning out of foster care (18 years old and above), while assisting them in their journey towards young adulthood. Twenty slots are available for this program. It is worth noting that this FSP builds upon the foundation of the "Visiting Therapist Program" provided to the same population by Fred Finch in the community setting. The expansion design has allowed us to serve more youth while providing a fuller array of intensive services

Edgewood Center was awarded the contract to provide integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well as the integrated FSP for our intensive school based services which are provided in the Therapeutic Day School (TDS) setting, school-based milieu services, and the Non-Public School setting. Youth served are 6 to 21 years old. Twenty slots are available for clinic based services and 20 for school-based services. These two integrated FSPs provide a full array of wraparound services to support our existing mental health teams. With this expansion of FSP slots, Edgewood began operating a drop-in center for children ages 6 to 15 in San Carlos, which complements the existing one in San Bruno for youth 16 to 24 years old. The drop-in centers provide a full array of social and therapeutic activities that support children and families.

“Turning Point” for Child/Youth/Transition Age Youth (TAY) FSP

The enrollees have a high level of acuity, a high incidence of co-occurring substance abuse problems (41% of TAY and 8% of CY) and developmental delays (10% of TAY and 8% of CY). The average age for TAY participants is 20 years old and the Child/Youth average is at 15 years old. Both groups have high intensity needs with many stepping down from out of home placements (8% of CY and 28% of TAY), coming out of juvenile justice (38% of CY), and emancipating from foster care (28% of TAY).

The cultural diversity of the staff is strong with 13% African American representation, 26% Latino, 7.5% Middle Eastern, 10.5% Asian and 26% are bi-lingual Spanish. There are three peer partners (within the same age range as our Transitional Age Youth) and five family partners on staff (caregivers who have raised special needs children). The age range of our staff goes from 20 (a peer partner) to 60.

The latest count of FY 10/11 showed that the enrollees were: 43% Caucasian, 18% African American, 29% Latino, 4% Asian Pacific and 6% mixed.

The new Drop-In Center (DIC) in San Bruno for TAY was successful in regaining high numbers of youth attendees aged 18 to 25 years old since re-opening in May, 2010. Additionally, the new DIC for younger youth, ages 15 to 17, also showed steady increases in attendance, including several youth from the local TDSs, as well as community youth from other local high schools.

Both Drop-In Centers continued to offer a multitude of services including: support groups; independent living skills; educational support; social skills building; recreational outings, peer to peer support, transportation assistance and a healthy meal.

Turning Point TAY FSP enrollees engaged in a variety of supported education activities including GED prep activities, high school completion, education readiness groups at the Drop-In Center and attending local community colleges.

In collaboration with the Mental Health Association, Turning Point had a wide spectrum of housing options for TAY including transitional age youth living in supported individual apartments, a clustered apartment site, board and care, SRO's and Shelters.

“ISIS” for Child/Youth FSP

The enrollees have a high level of acuity, a high incidence of coming out of multiple prior hospitalizations (45%) and coming out of extended juvenile justice stays (18%). There is also a high incidence of co-occurring substance abuse problems (21%) and developmental delays (21%). The average age for ISIS participants was 14 years old. Participants had high intensity needs, with some stepping down from out of home placements (9%).

The cultural diversity of the staff was strong with 32% African American representation, 32% Latino, 15% Middle Eastern/Asian/American Indian, and 32% are bi-lingual Spanish. There were three peer partners serving the new San Carlos Youth Center, and three family partners on staff (caregivers who have raised special needs children). The age range of our staff ranged from 20 (a peer partner) to 65, with most being in their 30s and 40s.

The enrollees were: 30% Caucasian, 13% African American, 45% Latino, 6% Chinese, and 6% Filipino/American Indian/Tongan.

The San Carlos Youth Center, serving youth ages 6-14 years old, continued to be open to provide supports for youth M-F, 2:00-6:00 pm, and on Saturdays 11:30 am - 3:30 pm, every week. Attendance increased substantially, with the highest attended days serving as many as 12 youth from ISIS, Turning Point, and Kinship programs combined. The average age of attendees was 10 years old, and attendees currently enrolled in program are composed nearly equally of females and males. The cultural diversity of attendees was strong, as well, with 25% Caucasian, 45% Latino, 10% Asian/Pacific Islander, 15% Multiracial, and 5% African-American.

The center continued to offer a multitude of services including: youth groups; independent living skills; educational support; social skills building; recreational groups and outings, peer to peer support, transportation assistance and healthy meals. In addition to this programming, a weekly A.R.T. group was facilitated for youth ages 11 to 14 years old, with 6 youth enrolled and attending regularly.

The ISIS program continued to have some early successes with maintaining youth in their homes. There were the first two graduations for youth in the program at the beginning of 2011, both having been in the program between 6 to 8 months. Each of

these youth had several previous psych hospitalizations prior to intake, and neither has had any incidence of time spent out of the home, in either psych emergency or juvenile justice, since their entrance into the program.

Fred Finch FSP

Youth who are admitted to the Fred Finch Youth Center's Full Service Partnership with San Mateo County are placed out of county and have challenges in maintaining their placement. Youth may reside in FFA or relative homes. Some youth are attempting to reunify with biological family. Out-of-County placed youth face additional struggles accessing services and getting mental health needs met. The youth and their caregivers in the FFYC FSP are given wraparound services to help stabilize the placement and help form healthy connections. Services are community based and are typically conducted at the youth's home or school.

The FFYC treatment team is comprised of 2 Care Coordinators (one is native Spanish speaking), 1 Youth Partner and 1 Parent Partner. Both the Youth Partner and Parent Partner have lived experience as a consumer or family member. The average age of our current enrollee is 14.9

The program demographics included 31% African American; 37% Caucasian and 31% Latino. Fred Finch Youth Center continued to do outreach to encourage referrals to the program. The County adapted the enrollment process so that clients were screened and presented to IPRC concurrent to the FFYC assessment process.

All youth and their families participated in Child and Family Team Meetings. Clinicians, FFYC team members, county workers and other supports were invited to participate. Client and family members were encouraged to express their requests and all team members contribute to helping meet these needs. The needs were varied with some including financial assistance for housing, moving expenses, laptop purchase, funding tutors, and linking individuals with community resources

REACH FSP

Caminar's FSP, R.E.A.C.H. (Recovery, Empowerment and Community Housing) is a Full Service Partnership Program, for Adults and Older Adult/Medically Fragile clients.

The FSP saw an increase in clients stabilizing (well over 80%) and participating in a variety of program elements and recovery oriented activities. In addition to community activities such as the Client Drop-In Center, Friendship Centers and Recreational outings, the FSP offered groups such as Men's Seeking Safety, Stress Management, Clozaril Group, Healthy Business, Art Group, WRAP Group and a Harm Reduction Group.

Implementing the ACT Model interventions, the FSP nurse facilitated the progress of our medically fragile population to develop and use skills needed to improve their health, education of their medical issues and improve their quality of life. This resulted in decreased need for ER visits and medical hospitalizations. They continued to succeed in getting two home-bound, morbidly obese, medically fragile clients, into the community for activities, such as swimming with other clients. These activities served to increase community integration and alleviate medically related conditions such as arthritis, pain and circulatory conditions. One of these clients weighing over 400 lbs. made lifestyle changes and lost 25 lbs! They have witnessed increased quality of life, reductions in weight and improved metabolic issues for several clients.

The R.E.A.C.H. FSP continued to provide 7-days per week intensive case management services including full-service psychiatric services, injections (in-home when necessary), daily in-home medication monitoring and weekly medi-sets. Nurses provided in-home assistance with teaching skills to manage diabetes, assessment, coordination and communication with medical providers. On occasion psychiatrists saw clients in their homes/in the field. They transported clients to appointments, offered an after-hours Warm-line, and 24/7 emergency response. Fiscal and budgetary services were provided through a Sub-payee function in conjunction with personal services coordination.

We contracted a new Supportive Living Residence, where five of our most at-risk male members are successfully maintaining in the community. Five women in our other Supportive Living Residence had to be temporarily re-located and moved to a new Supportive Living home January 3rd 2011.

One challenge was a fire, just before Thanksgiving, in one of the apartment buildings where Caminar housed about 25 clients. One FSP client had to be re-located 4 times since then and stayed in a Shelter bed. This tragedy took significant resources, staff time and client resiliency to manage, with placement issues.

Further challenges were clients with no Medi-Cal or income. These clients could not obtain primary care appointments nor have their medical medications paid for. The

process for SSI and appeals is taking up to 5 years. Placement was a critical issue for these clients, where housing is already unaffordable and even shelter beds may be unavailable for these clients with histories of behavioral problems. The FSP was unable to bill Medi-Cal for these clients and none of the services provided were billable or go towards the FSP.

Ten percent of clients utilized Transitional Residential Programs, 80% of clients were in independent living situations, and 6% lived in Licensed Board and Care Homes, and 6% were opened from Cordilleras, the sub-acute setting and were being engaged to transition to the community.

Ethnic make-up of FSP enrollees was: 11% Filipino, 6% Latino/Hispanic, 43% Caucasian, 7% Middle Eastern, 14% African American, 4% Russian and 15% Other.

Telecare Adult and Older Adult/Medically Fragile FSP's

Telecare, Inc. was contracted for a total of 200 members 75 Adult, 75 Older Adult/Medically Fragile (an additional 10), 40 Community Case Management and 10 in a new Wellness category

In addition to psychiatric services, personal service coordination, fiscal and budgetary services, crisis management, etc, the FSP also provided WRAP groups at various locations, CBT groups, a DBT skills group, a Co-Occurring/Dual Diagnosis Recovery group, an active Consumer Advisory panel along with its monthly meeting for Family and Friends. The Telecare FSP provided between 22 and 30 clinical or social groups a week, depending on the week (some groups occur monthly).

The Recovery Center at the Industrial Hotel was really successful with numerous social and clinical groups on site as well as health related services there weekly.

Staffing was a challenge (lost another Team Leader) during this period although they continued to have direct service providers who've been with the program for many years. They hired a replacement psychiatrist for and felt fortunate to have found a physician with an empowering and recovery oriented attitude to community psychiatry. Also, they hired a vocational developer who worked met with FSP members, worked with them on resumes, setting up interviews and developing employment options.

Currently the program has language capacity in English, Spanish, Mandarin, Cantonese, Taiwanese, and Tagalog.

Housing (All ages) – Telecare contracted to provide the housing for the Adult and Older Adult/Medically Fragile FSP programs. The housing program has been very successful with more members in stable housing through the development of additional housing options that are either directly managed or supported by Telecare with onsite staff. This has enabled members who might otherwise be at risk of losing their housing to receive the additional oversight and support they need to stay consistently housed. Additionally Telecare is supplementing some residential care facilities in order to enable clients to live in the community who require this level of supervision and services.

The Housing program developed a complete and dynamic continuum of affordable housing options, and 98.5 % of our members were stably housed. One challenge was to identify a site to relocate one of the supported congregate housing options. The particular site in question (also their oldest) was on the VA campus in Menlo Park and was to be razed to make way for new construction. The program identified a suitable location back in but a last minute funding torpedoed this option. Another solution was to combine two large houses within close proximity to one another.

COMMUNITY OUTREACH AND ENGAGEMENT

The **North County Outreach Collaborative** was comprised of these community based organizations: Asian American Recovery Services, Daly City Peninsula Partnership Collaborative, Pacifica Collaborative, and Pyramid Alternatives.

The **East Palo Alto Outreach** was comprised of the following community based organizations: El Concilio, For Youth By Youth, Free at Last, and Pacific Maa Tonga.

The MHSA funds in part **SMART**, a program developed by the Health System and American Medical Response West in December 2005 in which a specially trained paramedic responds to law enforcement Code 2 EMS requests for individuals having a behavioral emergency. This SMART paramedic performs a mental assessment, places a 5150 hold if needed and transports the client to psychiatric emergency services, or, in consultation with County staff, arranges for other services to meet the individual's needs. Access to the SMART program is only through the County's 9-1-1 system.

StarVista (formerly Youth and Family Enrichment Services) is contracted to provide **Crisis Hotline** and Clinical Support Services. StarVista is contracted to provide a 1.0 FTE Spanish-speaking licensed clinician to staff StarVista's existing crisis hotline dedicated to adolescent callers and provide clinical services during peak hours of hotline usage. The clinician responds to requests from schools and provides crisis intervention services to youth, consultation to school staff, and provides appropriate referrals for youth and families to the BHRS through ACCESS.

CSS Outreach and Engagement provides funding to **Ravenswood Family Health Center**, a community-based FQHC that serves East Palo Alto, to provide outreach and engagement services and to identify individuals presenting for healthcare services that have significant needs for behavioral health services.

PEI Outreach and Engagement provides funding for **Health Equity Initiatives**. 489 people attended meetings of the Cultural Competence Council and seven Health equity Initiatives in FY 10-11. These initiatives are housed in the Office of Diversity and Equity (ODE). ODE also began providing Mental Health First Aid trainings in FY 10-11: four trainings that year were held in Daly City, EPA and Redwood City for 81 participants. Pacific Islander Parenting Project graduated their 2nd class, 22 Tongan and Samoan parents in November 2010. Also in November, 160 people attended the 4th Annual Family Awareness Night in EPA. We provided the 32-hour California Brief Multicultural Competence Scale Training Program to 19 participants. "Working Effectively with Interpreters in a Behavioral Health Setting" training: Six sessions were hosted and 242 persons attended.

SYSTEM DEVELOPMENT

Older Adult System of Care Development

The OASIS Program has continued to serve older adults who have multiple medical problems, cognitive impairment, and functional limitations in addition to their mental health issues. The complexity and severity of the medical conditions the clients face continues to increase resulting in greater challenges in putting sufficient services and resources in place for these clients to remain living in the community. Locating affordable housing with appropriate accommodations to handle the functional limitations of these older adult clients in San Mateo County is extremely challenging. We have also noticed an increase in older adults coming into our services who are homeless.

Some of these individuals have been on the streets for much of their life, but this situation has become a greater concern as they are aging and becoming more medically fragile. Others are finding themselves homeless for the first time as an older adult due to foreclosure and other financial hardships.

A major challenge early in FY 10-11 focused on the implementation of our electronic medical record. The OASIS program went live on Avatar on June 1, 2010 in our transition to the electronic chart from the paper chart. Although staff had received extensive training on the new system prior to implementation, there was no way to be fully prepared for what it would entail to actually use the new system in day-to-day work with clients. Staff found that it took longer to perform tasks on the computer than on paper as they were unfamiliar with the new system making the process more cumbersome. The nature of the team's field-based work created special needs that were not completely addressed in the planning and staff found themselves working longer hours to complete their documentation requirements in a timely manner. Procedures for handling client intakes and officer of the day responsibilities needed to be redesigned so that staff could still attend to the clients on their caseload and devote the extra time to the documentation. We were fortunate in receiving much support and assistance from our MIS team in resolving issues as they arose and adapting the system to meet the needs of the team. Although the effect of the extra hours and added stress on the staff began to be more evident as time went on, staff remained committed to providing high quality services to clients throughout these challenging months.

Another challenge that impacted our entire county system including OASIS was the gas explosion in San Bruno in September of 2010. Staff members from the OASIS team were part of a larger contingent of county staff that provided support and assistance to fire victims both on site and at the emergency centers. While the work was challenging, it was also very rewarding and gratifying to connect with the families in that way and to witness the strength they brought to the situation.

A major challenge was a fire in an apartment building in Redwood City that housed over 30 county clients a number of whom are older adults. All residents living in the building were displaced by the fire. Temporary housing arrangements needed to be made for all the clients and their belongings had to be packed and placed in storage. Additional supportive services also needed to be provided to these clients who suddenly found themselves displaced from their familiar environments and routines. This situation presented particular challenges for an OASIS client whose physical disabilities limited her housing options.

The OASIS program continued to successfully provide field-based mental health services to an older adult population who has complex co-occurring health issues including multiple medical diagnoses, cognitive impairments and substance use issues, in addition to social/environmental challenges and functional limitations. Caseload responsibilities needed to be restructured as our nurse practitioner intern and our two MSW graduate student trainees have all concluded their internship with the program. In addition, one of the part-time psychiatrists prepared to go on maternity leave in early July 2011. These changes are often especially difficult for older adults who are already dealing with multiple losses in their lives.

Referrals of monolingual Mandarin and Cantonese older adult clients have continued to increase with our ability to provide field based services to these clients by both a Chinese speaking psychiatrist and case manager. A particularly heart-warming situation involved a 95 year old monolingual Chinese speaking man who was hospitalized after a serious suicide attempt. Initial discharge plan involved placement at a locked facility out of county given the risk factor of another suicide attempt. This would have meant client being geographically isolated from family members who were very supportive of client which might have increased client's depression while working to keep him safe. However with the intensive field based services of the Chinese speaking OASIS psychiatrist and case manager and the extensive family support, client instead was able to be housed in one of our local board and care homes. He has been doing quite well ever since his return to the community.

A challenge in providing case management services to our monolingual Spanish or Chinese speaking clients is that the ability of these clients to communicate directly with the community providers is often limited by the fact that many agencies and providers do not have bilingual staff. Therefore the OASIS case manager frequently needs to serve as the communication link for these clients to other service providers which can be frustrating for clients and time-consuming for staff.

Senior Peer Counseling

The target population for these services include older adults experiencing mental health issues such as depression or anxiety which impact their functioning and overall quality of life. The focus of these services is serving clients from the following cultural backgrounds or groups: Chinese, Pacific Islander, Filipino, and other Asian, Latino/Spanish-speaking and Lesbian/Gay/Bisexual/Transgender (LGBT).

Senior Peer Counseling is provided in English, Spanish, Mandarin, and Tagalog. Counseling is also available to the Lesbian/Gay/Bisexual/Transgender (LGBT) community.

Pathways, Court Mental Health Program (Adults)

The Pathways staff participated in a team building retreat near the end of September 2010. This event was conducted by a professional trainer and was very successful in building more team cohesion.

Pathways men participated in social outings. Staff recall one particular memorable bowling outing, which was staffed by both Probation and Behavioral Health and Recovery Services staff. Everyone had a good time with the bowling, food and companionship.

Three Pathways clients graduated in the second quarter. Their graduations were celebrated in Court with each of them receiving Graduation Certificates and photos with the judge.

The month of November 2010 was full of successes for some of the Pathways clients. One of them was presented with a Consumer Hall of Fame award. Another member received the Hope Award. A third Pathways client was able to move in to his first apartment after receiving a Section 8 Certificate.

The week before Thanksgiving we held our Annual Holiday Dinner for the clients. This year we had VRS cater a turkey dinner with all of the trimmings. The afternoon was full of food and fun. We had a series of bingo games with prizes for the winners. There was a crafts table set up so people could make jewelry for themselves or as gifts. This was followed by our traditional kickball game. At the end of the event, clients were sent off smiling with extra food for later.

The Program wanted to bring on at least one intern, so marketing was done to get the word out to local universities. In addition, we wanted to start a Pathways Club House where clients would have a place to gather on the weekends. We formed a committee to design the program and to search for a site from which to operate.

There were six new Pathways Graduates in the last quarter of the year. Again, these graduations were celebrated in Court with each of them receiving Graduation Certificates and photos with the judge.

In May we had one of our yearly Pathways Picnics which was well attended by clients and staff. This was an excellent opportunity for bonding, having fun and celebrating successes. These successes included graduations from our program and from Project Ninety.

Our first intern with Pathways began in May 2011. She was a bilingual/bicultural clinical intern who has completed her masters and has community mental health experience in San Francisco. We expect to have her with us for the next two years.

June 4th marked the day of our Pathways Clubhouse Grand Opening. We were able to secure use of space from our local consumer run organization "Heart and Soul". Our clubhouse meets there every Saturday morning and starts off with a healthy breakfast for everyone. It is then followed by discussions and activities selected by the clients. We have 2 – 4 staff there every Saturday and have been averaging about 10 clients participating each week. It is a great way to build a sense of community and to provide additional structure and support over the weekend. After the Pathways Clubhouse meets each week Heart and Soul has their Saturday activities for which the Pathways clients are also able to enjoy.

Our Pathways Program was also one of the key components of a video we helped to create during this quarter. The title of the video is "Breaking The Cycle". It helps to illustrate the resources our county has to work with our seriously mentally ill that involve law enforcement, the courts and behavioral health services. The video has been distributed through out our county to law enforcement agencies and to the courts through out the state.

The enrollees continue to be diverse: 40% Caucasian, 20.5% African-American, 20.5% Latino, 14.5% Asian-American, 1.5% Pacific Islander, 1.5% Non-American Indian, and 1.5% Farsi.

SYSTEM TRANSFORMATION AND EFFECTIVENESS STRATEGIES

The following initiatives substantially support capacity development within the existing county-operated and contracted public mental health system.

Consumer and Family Partner (All Ages)

San Mateo's consumer and family member initiative has been identified as a best practice by the Bay Area Mental Health Workforce Collaborative. Family and Peer Partners continue to serve over 900 clients every year, solidifying their presence in our system.

Puente Clinic

This specialty clinic sponsored by Behavioral Health & Recovery Services, Golden Gate Regional Center and Health Plan of San Mateo serves the special mental health needs of clients with developmental disabilities. The Puente Clinic served 144 clients in FY 10-11.

Neighborhood-based Multi-cultural peer run self-help center

In April 2008, BHRS released an RFP to select a provider of multicultural center (MCC) services for consumers of mental health services. One East Palo Alto (OEPA) submitted the only proposal and was awarded the contract in November 2008. OEPA was contacted to locate a facility to provide MCC services to support wellness and recovery through educational and leisure activities. MCC services are provided in an environment that is welcoming to adult consumers and their families who are multi-racial, multi-cultural and multi-generational, with a particular focus on clients who are African-American, Latino or Pacific Islander.

Evidence based practice expansion (All Ages)

Clinicians served 2,223 in FY 10-11. MHSA funding supports staffing specialized in the provision of evidence based services throughout our system, for youth and adult clients.

Trainees (All Ages)

MHSA funds supported cultural competence stipends for 10 mental health clinical trainees (MFT & MSW) representing bilingual and bicultural Spanish and African American populations. This effort has been successful since inception, with no difficulties finding culturally diverse clinical trainees.

The 10/11 Intern/Trainee group started their academic year in August and September 2010. Trainees served 350 clients in FY 10-11.

PREVENTION AND EARLY INTERVENTION ACTIVITIES

Primary Care/Behavioral Health Care Integration

This program aims at providing behavioral health services in the primary care setting, building on our Primary Care Interface program activities. The service philosophy of the program can be described as “assess, consult, treat, or refer.” In addition, the program facilitates communication between primary care and the regional mental health clinics. The staffing is quite diverse, with adult and youth clinicians with diverse language capacity (Spanish, Chinese). Psychiatric services are also provided when appropriate.

Total Wellness for Adults and Older Adults

PEI funds training of primary care providers for Total Wellness. These activities are blended into the Total Wellness which is funded through additional sources such as MHSA Innovation and a grant from the Substance Abuse and Mental Health Administration.

The **Anti-Stigma initiative** has reached 850 individuals in FY 10/11

Our Anti-Stigma initiative, centered around seven theatrical presentations that address stigma in different cultural/identity groups (African America, Chinese, Filipino, Latino, Pacific Islander, Mental Health Consumers, and Transition Age Youth) has struggled with the conversion of those initiatives into final DVD products.

Several unexpected obstacles delayed the project:

- Poor sound quality in the masters. While working on the editing process we came to the realization that the master had numerous sound problems. For example, the persons who performed in these presentations had lapel microphones attached to their clothing. Gesturing and movement during the presentations made cause the microphones to either dislodge from the right placement, or rub against clothing, making it very hard to understand what each performer was saying. Through a partnership with Peninsula TV we were able to improve the sound using various

tools at their disposal. While the final result is not perfect, it is the best we can do. This process took 6 months of the fiscal year.

- Once we had put the sound problem behind us, we encountered a host of difficulties with the subtitling process. These are: different length of translated portions of dialog from English into other languages (Samoan, Tongan, Spanish, Chinese –both Mandarin and Cantonese and Tagalog). This caused the subtitling company to have to manipulate the length of individual screens, as well as the background music in order to accommodate larger portions of on-screen text.

By the end of FY 10/11 we were still working on solving these difficulties, which did not keep us from outreaching to 850 persons through numerous presentations. In addition, we have collected over 500 “stigma pledges”, signed by individuals committing to help end the stigma surrounding mental illness and substance use. All five members of the Board of Supervisors have signed the pledge. Moreover, we continue to assess our county baseline in terms of perceptions regarding stigma using tools developed by a national authority on the subject, Dr. Patrick Corrigan. These tools, administered at two year intervals, will help us assess if our stigma work is actually improving perceptions about stigma.

Early Childhood Community Team served 26 clients in 1 quarter of operation in FY 10/11.

As it is always the case with start ups, there is an initial period when the right community relationships have to be established, staff have to be hired and trained, program locations have to be identified, secured, and conditioned. The program is currently fully operational. Numbers served have increased dramatically in 11/12. We continue to hear from the community that these services are in high need.

Community Interventions for School Age and Transition Age Youth

There are four programs under this category: Teaching Prosocial Skills, Project SUCCESS, Seeking Safety, and the Middle School Initiative (please see detailed descriptions for each in the project description below). Like with the previous project, start up of the program resulted in only one quarter of operation. That said, the programs have all stabilized in FY 11/12 and are valued assets in the different communities.

DESCRIPTION OF PROGRAMMATIC ACTIVITIES THAT WILL CONTINUE IN FY 12/12

State-developed guidelines for the creation of MHSA plans in the past have been centered around a presentation style with several tables and different fields of information that, in the view of our stakeholders, made those documents hard to navigate. We concur. A.B. 100, signed into law by the Governor last year, has introduced more flexibility in the way in which annual plans are developed.

We would like to take advantage of that newly gained flexibility to provide a big picture overview of all MHSA funded programs slated for continuation in FY 12/13.

COMMUNITY SERVICES AND SUPPORTS

Program: Full Service Partnership for Children, Youth and Transition Age Youth

Description:

Priority populations to be served by the program are: Seriously emotionally disturbed children, youth and their families, who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement; seriously emotionally disturbed and dually diagnosed transition age youth at risk of or returning from residential placement or emancipating, with juvenile justice or child welfare involvement; seriously emotionally disturbed children, youth and transition age youth with multiple psychiatric emergency services episodes and/or frequent hospitalizations and extended stays are also eligible, including homeless youth and youth exiting school-based, IEP-driven services. In addition to these children and youth that are known to one or more of the systems, the program also serves newly identified transition age youth that are experiencing a "first break". The programs are open to all youth meeting the criteria described above, but targeted to Asian/Pacific Islander, Latino and African American children/youth /transition age youth as they are over-represented within school drop out, child welfare and juvenile justice populations. Asian/Pacific Islander and Latino populations are under-represented in the mental health system.

This program helps our highest risk children and youth with serious emotional disorders (SED) remain in their communities, with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. Specialized services to transition age youth (TAY) aged 16 to 25 with serious emotional disorders are

also provided to assist them to remain in or return to their communities in safe environments, support positive emancipation including transition from foster care and juvenile justice, secure safe and stable housing and achieve education and employment goals. The program helps reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system. The 80 initial slots were divided between two 40-slot teams, one for children/youth and one for transition age youth. The expansion added a total of 50 new slots. Supervision of both teams by a single person assures consistent vision across both teams and collaboration between them, which intends to create a more seamless relationship between services for children and services for adults. Enrollees do not experience multiple transitions between programs as they age; they have access to the expertise across teams and the entire continuum of resources for children, youth and transition age youth as their needs change over time. Enrollees benefit from the shared resources across the program including the cultural and linguistic diversity of staff, parent partners, existing collaborative relationships with Juvenile Justice, Child Welfare, Education, Housing and Employment Services, and the expertise of individual clinicians in co-occurring disorders as well as on other evidence based practices. The program reflects the core values of the Wrap Around model: to partner with families and other key people in the life of clients in developing service strategies and plans; to assess family, child/youth and community strengths rather than weaknesses; to assist children/youth and families in becoming the authors of their own service plans; to encourage and support a shift from professionally-centered to family-centered practice and resources; and to also assess child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family's cultural values as a strength, a source of resilience, and an integral component of service delivery. It is worth noting that the transition age youth team emphasizes the individual consumer's role in developing their own wellness and recovery plan.

This FSP also offers drop-in center services and supported education services to engage TAY; these serve the FSP participants as well as other SED transition age youth in the community that are receiving mental health services. The focus is to provide self-help supports, social activities, and skill building, as well as support for those seeking to enter the college system, all aimed at enhancing ability to manage independence. Emphasis is placed in outreaching to LGBTQQI SED youth.

An expansion in FY 09/10 allowed for a new focus on San Mateo County youth ages 6 to 17 placed in foster care temporarily outside of the County. Services are designed to support and stabilize youth in the foster home, support the foster family, and facilitate the return of the youth to the family of origin in San Mateo County when feasible. This

FSP also supports older adolescents transitioning out of foster care (18 years old and above), while assisting them in their journey towards young adulthood. The program design allows BHRS to serve more youth while providing a fuller array of intensive services.

The expansion has also allowed for the provision of integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well as the integrated FSP for our intensive school based services, which are provided in the Therapeutic Day School (TDS) setting, school-based milieu services, and the Non-Public School setting. Youth served are 6 to 21 years old. These two integrated FSPs provide a full array of Wrap Around services to support our existing mental health teams. In addition, with the expanded FSPs, a second drop-in center for children ages 6 to 15 is currently operating in San Carlos, supplementing the one in San Bruno for youth 16 to 24 years old. As mentioned above, the drop-in centers provide a full array of social and therapeutic activities that support children and families.

Program: Full Service Partnership for Adults

Description:

Seriously mentally ill adults who may also have co-occurring disorders to be served by the FSP include: those eligible for diversion from criminal justice incarceration if adequate multi-agency community supports can be provided; currently incarcerated individuals for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization; individuals placed in locked mental health facilities who can succeed in the community with intensive supports; and individuals whose mental illness results in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of criminal justice or institutional placement. The program focuses on engagement of Latino, African American and Pacific Islander populations that are over-represented in the criminal justice system and underrepresented in the mental health system.

The Full Service Partnership for Adults offers “whatever it takes” to engage seriously mentally ill adults, including those who are dually diagnosed, in a partnership to achieve their individual wellness and recovery goals. Services are focused on engaging people on their terms, in the field and in institutions. While services provided through this program address the individual’s underlying mental health and behavioral health problems that

may have led or contributed to involvement in the criminal justice system and institutionalization, a wide range of strategies and supports beyond mental health services are essential. The overall goal of the program is to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed in the community with sufficient structure and support. The program is grounded in research and evaluation findings that demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal behaviors. The program also follows the model and philosophies of California's AB2034 Homeless Mentally Ill Adult programs and the assertive community treatment approach, aiming to use community-based services and a wide range of supports to enable seriously mentally ill and dually diagnosed adults to remain in the community and to reduce incarceration, homelessness, and institutionalization.

The Full Service Partnership provides the full range of mental health services including medication support with a focus on co-occurring mental health and drug and alcohol problems. Staff are trained in motivational interviewing and develop dually focused programming, including groups. Medication services include psychiatry and nursing support for ongoing dialogues with consumers about their psychiatric medication choices, symptoms, limiting side effects, and individualizing dosage schedules. Staff is available to consumers 24/7, and service plans are designed to utilize exceptional community relationships. Peer partners play a critical role, modeling personal recovery, helping consumers establish a network of peer, family, and cultural supports and, in particular, helping consumers connect with a non-profit network of peer-run self-help centers.

The FY 09/10 approved expansion allowed for the introduction of the concept of integrated FSPs, in response to the need to be flexible in our step-up/step-down processes in order to create a more seamless service delivery experience for our clients. The word "integrated" reflects the FSP staff from community based organizations in our County-operated South/Central and North County clinics. Three levels of care are included in our redesigned FSP: an intensive level "1 to 10" (1 staff per 10 consumers/clients), a community case management level "1 to 27" (1 staff per 27 consumers/clients), and a wellness level of care.

Program: Full Service Partnership for Older Adults and Medically Fragile Individuals

Description:

This Full Service Partnership serves seriously mentally ill older adults and medically fragile individuals who are either at risk of institutionalization or currently institutionalized and who, with more intensive supports, could live in a community setting. In many instances these individuals have co-occurring medical conditions that significantly impact their ability to remain at home or in a community-based setting. The program outreaches especially to Asian, Pacific Islander and Latino individuals, as these populations are under-represented in the current service population.

Similar to the FSP for Adults, the goal of this program is to facilitate or offer “whatever it takes” to ensure that consumers remain in the least restrictive setting possible through the provision of a range of community-based services and supports delivered by a multidisciplinary team. The program targets seriously mentally ill older adults and medically fragile individuals who either would be at risk of placement in a more restrictive setting without intensive supports or who could be moved to a less restrictive setting with these additional supports. The program works with board and care facilities and with consumers living in the community to prevent them from being placed in locked or skilled nursing facilities, and with residents of skilled nursing and locked facilities to facilitate their returning to a less restrictive setting. Referrals to the program are received from locked facilities, skilled nursing facilities, acute care facilities, board and care facilities, primary care clinics, Aging and Adult Services, community agencies, and from individuals/family members themselves. Services are available around the clock. For many of the consumers targeted by this Full Service Partnership, their mental illness impedes their ability to adhere to essential medical protocols, and their multiple medical problems exacerbate their psychiatric symptoms. As a result, these individuals need support and assistance in following up on medical appointments, medical tests/treatments, and close day-to-day supervision of medications. Difficulties managing these issues as well as shopping, meal preparation and other routine chores often lead to institutional placements so that these basic needs can be met. The goal of the FSP is to make it possible for the consumer’s care to be managed and his/her needs to be met in a community setting. A full-time nurse enables the treatment team to more effectively collaborate with primary care providers and assist consumers in both their communications with their primary care doctors and in their follow-up on medical

procedures and treatments. The licensed clinicians in the team oversee the completion of the multidisciplinary assessment and the development and implementation of a comprehensive service plan that involves all members of the team, the consumer and the family, contingent on the consumer's wishes. Peer Partners provide support, information and practical assistance with routine tasks, and cultivate a system of volunteer support to supplement what the Peer Partner can provide. Similarly, when a family is involved and the consumer is supportive of their involvement, a Family/Caregiver Partner works with the family to build their capacity to support the consumer. With these strategies, the Full Service Partnership helps to mobilize natural supports in the consumer's system and contributes to building those natural strengths to maintain the consumer in the least restrictive setting. In addition to the FSP staff, each FSP member receives the supports of their "virtual team" that includes the individuals/family members in their lives as well as any other needed health or social services supports for which they are qualified such as In-home Supportive Services, Meals on Wheels, senior centers/day programs, etc. These formal and natural supports are identified and integrated into the consumer's individual service plan.

Similar considerations apply as with the previous program regarding integrated services.

Program: Outreach and Engagement

Description:

Targeted populations include African-American, Asian, Filipino, Pacific Islander, and Latino individuals. Strategies include population-based community needs assessment, planning and development of materials to identify and engage diverse populations in services. Special emphasis is given to building relationships with neighborhood and cultural leaders to ensure that un-served and underserved communities are more aware of the availability of behavioral health services, and so that these leaders and their communities can have more consistent input about how their communities are served.

This program strategy identifies and engages individuals by building bridges with ethnic and linguistic populations that experience health disparities and may experience behavioral health services as unresponsive to their needs. Strategies include population-based community needs assessments, planning and materials development as well as hiring of community based "navigators", and primary care-based behavioral health services to identify and engage diverse populations.

Initially fully funded through the Community Services and Supports (CSS) component of the MHSA, in FY 09/10 we commenced a redirection of the services within this program that are fundable under the Prevention and Early Intervention component.

Program: Pathways, a Mental Health Court Program

Description:

The Pathways Program serves seriously mentally ill (SMI) nonviolent offenders with co-occurring disorders -mental health and substance use/abuse. The program was designed to be appropriate to the issues and needs of Latino, African Americans and Pacific Islander populations, as they are over-represented in the criminal justice system.

The Pathways Mental Health Treatment Court Program is a partnership of San Mateo County Courts, the Probation Department, the District Attorney, the Private (Public) Defender, the Sheriff's Department, Correctional Health, and the Behavioral Health and Recovery Services Division. Through criminal justice sanctions/approaches, and treatment and recovery supports addressing individuals' underlying behavioral health issues, offenders are diverted from incarceration into community-based services.

The program aims at:

- Reducing recidivism and incarceration
- Stabilizing housing
- Reducing acute care utilization
- Engaging and maintaining active participation in personal recovery

Anyone can refer someone to Pathways, including self-referrals. Eligibility criteria are:

- San Mateo County residency
- A diagnosis of a serious mental illness (Axis I), with functional impairments
- Statutory eligibility for probation
- Agreement to participate in the program voluntarily

The referrals are sent to a centralized location in the Probation Department. They are then forwarded to the client's lawyer, at which point the client and the lawyer decide on whether they are interested in the Pathway services. If they are, the lawyer has the case directed to the Pathways Court calendar. Many people get screened out for not meeting

the criteria for admission specified above or choose not to be considered for some of the following reasons:

- The lawyer presents the client with a “better deal” involving less jail/probation time
- The person referred does not identify with being seriously mentally ill
- The person referred has no desire to work towards recovery

Program: Older Adult System of Care Development

Description:

Population served: Older adults at risk of becoming or seriously mentally ill (SMI), including those served by specialty field-based outpatient mental health team, County clinics, community-based mental health providers, mental health managed care network providers (private practitioners and agencies), primary care providers, Aging and Adult Services, and community agencies that provide other senior services. There is an emphasis on specific ethnic/linguistic populations for different regions of the County. For example, in the Coast region the focus is on Latino populations, while in North County the focus is on Asian populations, and in South and Central County the focus is on African American, Latino, and Asian and Pacific Islander populations.

This program focuses on creating a coherent, integrated set of services for older adults, in order to assure that there are sufficient supports to maintain the older adult population in need in their homes and community, and in optimal health. The intent is to assist seniors to lead dignified and fulfilling lives, and in sustaining and maintaining independence and family/ community connections to the greatest extent possible. Peer Partners provide support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. They also recruit and participate in training volunteers to expand our existing senior peer counseling volunteer-based program in order to build additional bilingual/bicultural capacity. Senior peer counseling works with individuals and groups. “La Esperanza Vive”—a component of the current Senior Peer Counseling program, is a well-developed Latino-focused program in existence for over 25 years that recruits and trains volunteers, and provides peer counseling for Latino older adults. “La Esperanza Vive” provides a model for the development of other language/culture-specific senior peer counseling components. Senior Peer Partners serve homebound seniors through home visits and create or support the development of activities for mental health consumers at community sites

such as senior centers. In addition, and as desired by SMI older adults, Senior Peer Partners facilitate consumers to attend client-run self-help centers described under System Transformation. Staff are bilingual and bicultural. The Senior Peer Counseling program has been expanded to include a Chinese-focused component, a Filipino-focused component and a LGBTQQI-focused component. The field-based mental health clinical team provides in-home mental health services to homebound seniors with SMI. The team consists of psychiatrists, case managers, and a community mental health nurse, and provides assessment, medication monitoring, psycho-education, counseling and case management. The team partners with other programs serving older adults such as Aging and Adults Services and the Ron Robinson Senior Care Center with the goal of providing comprehensive care and to help consumers achieve the highest possible quality of life and remain living in a community-based setting for as long as possible.

The program has a very significant and robust outreach and engagement component that aims at identifying seniors in need through the various avenues alluded to in this program description.

Program: System Transformation and Effectiveness Strategies

Description:

All populations served by Behavioral Health and Recovery Services benefit, with an emphasis on improving services to ethnic and linguistic populations that experience disparities in access and appropriateness of services, and assuring integrated and evidence-based services to those with co-occurring disorders.

Throughout the MHSA outreach and planning processes, participants have spoken repeatedly about the need to fundamentally transform many aspects of the system to truly enact wellness and recovery philosophy and practice, and more successfully engage un-served ethnic and linguistic populations in services.

The System Transformation and Effectiveness Strategies program includes a focus on recovery/resilience and transformation; increased capacity and effectiveness of County and contractor services through an infusion of training, bilingual/bicultural clinicians, peers/peer-run services and parent partners; implementation of evidence based and culturally competent practices; family support and education training for all providers

serving all ages. Other system transformation strategies include expanded family support/education services for children/youth/transition age youth, and peer supports for adults and older adults, as well as consumer self-help centers.

HOUSING

MHSA Housing funds provide permanent supportive housing through a program administered by the California Housing Finance Agency (CalHFA) to individuals who are eligible for MHSA services and meet eligibility criteria as homeless or at-risk of being homeless.

The County's Behavioral Health and Recovery Services Division (BHRS) collaborated with the Department of Housing and the Human Services Agency's Shelter Services Division (HOPE Plan staff) to plan and implement the MHSA Housing program in the County.

Approved projects include: Cedar Street Apartments (14 units); El Camino Apartments (20 units); and Delaware Street Apartments (10 units).

BHRS has an open Request for Applications process for new projects, which can be located at this web address:

http://www.smchealth.org/sites/default/files/docs/1327533978MHSAHousingProgram_RFA.pdf

WORKFORCE EDUCATION AND TRAINING

FUNDING CATEGORY: WORKFORCE STAFFING SUPPORT

Program: Workforce Education and Training Plan Coordination and Implementation

Description:

The plan and all BHRS Training activities are overseen by a Workforce Development Director. The Director supervises a .5 FTE Community Resource Specialist. This team serves as staff to the BHRS Training Committee and has system-wide responsibility for:

- Managing implementation of the MHSA Education and Training Plan, and of the BHRS Training Plan;

- Managing the BHRS training budget;
- Providing research, data, and communication to the BHRS Training Committee to assist in oversight of the annual work plan;
- Recruiting and orienting Training Committee members to ensure that the Committee includes both, consumers and family members, and that it represents the cultural composition of the population served;
- Developing, maintaining and strengthening relationships with a wide range of regional stakeholders in education and training and workforce development, as well as among the provider, consumer and family communities, and cultural communities;
- Organizing and scheduling training events, including identifying trainers and consultants;
- Collaborating with consumer and family members staff to expand availability of consumer-family focused training;
- Developing strategies and modalities to provide training to staff, including use of team-based training experiences, the use of consultants, and electronic training resources (video/web) to expand access to training;
- Managing intern recruitment, placement, and training;
- Liaising with the Bay Area Regional Collaborative and other regional and statewide relevant bodies and initiatives; this includes collaborating to expand training resources available locally;
- Collaborating with the MHSA Coordinator regarding relevant cross-cutting MHSA activities and reporting requirements.
- Participating in the development of pipeline workforce development strategies;
- Evaluating training activities and reporting outcomes to the Training Committee;
- Developing an annual report for staff, clients and family members to determine the extent to which training and workforce development activities are contributing to the transformation of the system of services and supports.
- Preparing and submitting periodic reports to all internal and external organizations to ensure compliance with existing guidelines.

FUNDING CATEGORY: TRAINING AND TECHNICAL ASSISTANCE

Program: Targeted Training For and By Consumers and Family Members

Description:

This program aims at providing a range of trainings activities, as follows:

- A. Trainings delivered by and for consumers and family members. Examples include Paving the Way, a San Mateo model that provides training and supports for consumers and family members joining our workforce, and that also supports existing staff to welcome new consumer/family staff; Hope Awards, which highlight personal stories while educating consumers, families, staff, and the general public about recovery and stigma; Inspired at Work, which provides a framework for consumers and family members to get support and to explore issues involved with entering and remaining in the workforce.
- B. Trainings provided by consumers and family members to providers and the general public designed to increase understanding of mental health issues and to reduce stigma. Examples include Stamp Out Stigma, a community advocacy and educational outreach program dedicated to eradicating the stigma associated with mental illness through forum-type presentations in which individuals with mental illness share their personal experiences with the community at large; Breaking the Silence, a training activity designed to address issues of gender identification in youth and the effects of community violence; consumer-led trainings by youth/TAY, directed to audiences of all ages. Youth/TAY will be targeted as an audience for these trainings as well.
- C. Trainings provided by consumers and family members to increase understanding of mental health issues and substance use/abuse issues, recovery and resilience, and available treatments and supports. Examples include NAMI's Provider Education Training, an intensive training to providers led by consumers, family members, and experts; In Our Own Voice, NAMI-sponsored consumer-to-consumer presentations about their experiences, which is usually presented in a number of settings, including hospitals; Family to Family, a NAMI-sponsored 12-week course taught by families to families of consumers about mental health, treatments, and how to focus on self-care; Peer to Peer, a NAMI-sponsored 9-week course taught by consumers to consumers about mental health, treatments, and recovery; Voices of Recovery, a

client and family driven-advocacy and support effort for those who have been affected by addiction.

- D. In addition, this program also provides for selected consumers and family members to attend leadership trainings to support increased involvement of consumers and family members in various committee, commission, and planning roles. Examples include: CMHACY (California Mental Health Advocates for Children and Youth) Conference; educational visits to The Village; attendance to NAMI, Heart & Soul, and other community-based training activities to help perfect the leadership skills of consumers and family members.
- E. Trainings for the community to reduce stigma and increase understanding of behavioral health consumer and family issues. One example is the Crisis Intervention Training (CIT), which provides training to police officers in local communities about the nature of behavioral health issues, and is designed to increase understanding, reduce stigma, and lay the groundwork for more appropriate responses to consumers and family members by local police. Consumers and family members present to first responders regarding their experience of mental illness, as well as the role and concerns of family members and consumers in promoting wellness and working with law enforcement. Consumers and family members also address issues of stigma, and raise awareness regarding appropriate law enforcement interventions for consumers and their families.

Program: Trainings to Support Wellness and Recovery

Description:

San Mateo County BHRS engages in training to extend and support consumer wellness and recovery. An example of an activity to this end is the implementation of Wellness Recovery Action Plan Trainings (WRAP). WRAP is a self-help approach to achieve and maintain wellness that has been used successfully with mental health consumers and consumers with co-occurring disorders. With a train-the-trainer approach, consumers, family members, and selected staff (County and contracted providers) are trained as Master Trainers. The “Master Trainers” then provide training and support in developing WRAP plans for consumers and staff throughout our system.

Program: Cultural Competence Training

Description:

Training in the area of cultural competence is designed to reduce health disparities in our community, to provide instruction in culturally and linguistically competent services, and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities are made available to consumers, family members, providers, and those working and living in the community. The Training Plan has identified a number of components designed to address these issues, such as the use of the CA Multi-Cultural Scale to assess our system of services; trainings to increase the effective use of interpreters in service delivery; creation of a clinical consultation resource for providers working with Filipino consumers; addressing cultural issues when providing services to consumers suffering from co-occurring disorders and domestic violence. Trainings are also used to help support key cultural disparity initiatives currently underway as part of our work on reduction of disparities. The different cultural disparity initiatives funded through CSS have been focused on the following populations: Chinese; Filipino; Pacific Islander; African American; Latino; LGBTQI.

Program: Evidence-Based Practices Training for System Transformation

Description:

System transformation is supported through an ongoing series of trainings that increase utilization of evidence-based treatment practices that better engage consumers and family members as partners in treatment and that contribute to improved consumer quality of life. Recommendations for training on evidence-based practices to incorporate into the different series may come from consumers, family members, or public and private agency staff by submitting a form to the Workforce Development Director, who then submits the request to the Training Committee for consideration. Suggested trainings shall be consistent with the values of the MHSA and shall contribute to the creation of a more culturally competent system.

- A. Some of the practices considered aim at improving family functioning, parenting, communication and at helping parents and youth to reduce problem behaviors

through evidence-based and promising practices such as: Functional Family Therapy or FFT (a family-based intervention with at-risk youth in the criminal justice system with a focus on using family and consumer strengths to help youth gain control of their behaviors. This practice has been found to be effective with clients of diverse cultural backgrounds); Teaching Pro-Social Skills or TPS (a strength-based approach for at-risk youth designed to increase pro-social behaviors, involving educational and criminal justice partners in coordinated delivery of related services.)

- B. Other practices considered involve interventions designed to help children, youth, their parents and others overcome the negative effects of traumatic life events such as child sexual or physical abuse, traumatic loss of a loved one, domestic, school, or community violence, or exposure to disasters, or war trauma. Examples include: Trauma Focused Cognitive Behavioral Therapy or TF CBT (the model integrates cognitive and behavioral interventions with traditional child abuse therapies that focus on enhancement of interpersonal trust and empowerment); Seeking Safety (with a focus on harm reduction for adult and youth consumers severely impacted by trauma; this is a strength-based approach designed to improve the ability of consumers to make safe, effective choices in their lives, and it's an integrated co-occurring approach to treatment.)
- C. This program also includes training experiences to help clinicians teach coping skills for individuals with serious, self-harming personality disorders; an example is Dialectical Behavior Therapy, which is a practice focused on developing skills to more effectively deal with distress; many elements of this approach have been successful in integrated treatment for co-occurring clients.
- D. Training in delivery of integrated treatment for clients suffering from co-occurring disorders is also included in this program. Training experiences considered include Motivational Interviewing and Enhancement and trainings to promote a welcoming environment for these clients.
- E. Training in delivery of integrated services to seriously mentally ill youth and adults by multi-disciplinary teams prepared to serve clients 24/7. Examples include Assertive Community Treatment and other relevant services provided in Full Service Partnerships.

The Workforce Development Director routinely contacts participants in various EBPs (and other) training activities six-months after training has been completed to assess the degree to which the training has resulted in changed treatment practice.

Program: Expanded Site-Based Clinical Consultation

Description:

Staff surveys have indicated that the preferred means of training is through clinical consultation on specific treatment challenges. San Mateo County has piloted this approach with the hiring of a Coordinator of Integrated Dual Disorder Treatment who meets with treatment teams to reinforce principles and practices introduced through the intensive training practicum developed by Kenneth Minkoff, MD and Chris Cline, MD. This model has been replicated with trainings offered via Program #5 above, and reinforced with contracted clinical consultants retained to meet with treatment teams implementing such evidence-based practices. Consultations on working with individuals with co-occurring mental health and developmental disabilities on a quarterly basis is a good illustration of this type of training experience. In addition, the Workforce Development Director receives requests from both Community-Based Organizations and County treatment teams and compiles an inventory of expert practitioners, including consumers and family members, available to provide time-limited clinical consultations. The Workforce Development Director presents requests to the Training Committee for approval. Criteria for approval include, among others, extent to which the consultation reinforces the use of evidence-based practices, extent to which the consultation supports the vision and values of the MHSA, and the degree to which the consultation includes plans for disseminating learning to other treatment teams.

FUNDING CATEGORY: MENTAL HEALTH CAREER PATHWAY PROGRAMS

Program: Attract prospective candidates to hard to fill positions via addressing barriers in the application process

Description:

Multiple workgroup discussions concluded that strategies are necessary to address ongoing vacancies in positions which are difficult to fill. Psychiatry and community mental health nurses were identified as job classifications in which qualified staff has been challenging to obtain and retain. Cultural diversity in all positions across the board was also identified as an ongoing deficit. Consideration was given to how to address these shortages in partnership with the County's Human Resources Division in order to strategize solutions.

Strategies include creating an expedited application process by:

- working with the County's Human Resources Division to remove barriers to the application process e.g. the protracted length of time between recruitment, interviewing, and hiring
- designating hard to fill positions for a fast track application process
- reviewing and revising current job classifications/descriptions as necessary, in partnership with the County's Human Resources Division
- identifying barriers in the application process including: where and how positions are advertised; elimination of duplications in fingerprinting requirements whenever possible; streamlining of civil service requirements as permitted; and broadening employment opportunities for targeted hard-to-fill disciplines such as child and gerontology psychiatrists, nurses, etc.

Program: Attract prospective candidates to hard to fill positions through incentives

Description:

San Mateo County competes with other similar organizations and the private sector to hire employees with specialized, needed skills into a number of positions that are difficult to fill. Offering financial incentives to attract and retain candidates to these positions was identified as an important tool, since such incentives increase the appeal of working for community mental health services among potential job candidates.

Strategies include the development of incentives to encourage the application and retention of qualified individuals into hard to fill positions by:

- prioritizing hard to fill applicants in the loan assumption approval process
- supporting child and gerontology psychiatry positions with part-time work as they complete fellowship
- encouraging nurse employees in direct service and contract provider agencies to take advantage of MHSA statewide stipend program for advanced nursing training
- being flexible when tailoring practicum requirements to the needs of candidates for hard to fill positions (in coordination with contracted educational agencies)

Program: Promote mental health field in academic institutions where potential employees are training in order to attract individuals to the public mental health system in general, and to hard to fill positions in particular

Description:

In addition to incentives and breaking down application barriers, workgroup members identified positive marketing of mental health careers as an important objective in attracting qualified individuals to hard to fill positions.

Strategies include increasing exposure to the mental health field and to County employment opportunities, by:

- working with institutions of higher education such as UCSF, Cal State East Bay, and San Mateo Community College system –among others, to coordinate direct and indirect outreach including tailoring recruitment information and participation at career fairs
- expanding and/or creating pipeline relationships between prospective feeder institutions (high school, undergrad, grad) and providers
- strengthening partnerships with professional development programs (i.e., Nursing, MSW, MFT, etc.)
- promoting County placements to fulfill practicum requirements
- partnering with nurse practitioner student practicum to promote the mental health field, and provide career mentoring

Program: Promote interest among and provide opportunities for youth/Transition Age Youth (TAY) in pursuing careers in mental health

Description:

Focus groups and informal discussions have revealed a consistent interest in mental health careers among youth, including TAY youth. Through these discussions, youth/TAY youth revealed the barriers to entering mental health field, and were able to describe ways in which they believed youth could be engaged and retained in the mental health pathways. Such barriers included TAY not knowing what jobs are available in mental health settings, what such jobs entailed, what positions they qualified for, and how to train/apply for such positions. Once youth interest in the mental health field has been achieved, youth have indicated it is essential for them to have ongoing learning experiences to deepen their understanding and commitment to the field. Such experiences also provide early training, and assist with creating a more competent and diverse pool of trainees and applicants to the field.

Strategies include informing youth/TAY, including those not in school, of opportunities to engage in exploring a career in mental health, by:

- promoting BHRS activities, including workforce development activities on social networking and popular blog sites
- providing information and shadowing to high school students regarding careers in mental health
- delivering BHRS presentations in schools, promoting BHRS's campus tours, providing fliers promoting careers in mental health
- developing informational materials that reflect youth informed language and learning styles
- establishing mental health job fairs for middle and high school youth
- connecting with high school community service programs to provide BHRS site opportunities that meet the community service requirements
- providing opportunities for youth to be trained by and work with seasoned professionals
- broadening outreach to community colleges outside San Mateo County e.g. Foothill, San Francisco City College

Strategies also aim at creating exposure to BHRS programs and providing work experience opportunities for youth/TAY by:

- developing mental health training academies in high schools to include psychology, health and/or rehab/social work course work, and internship placements
- implementing a mentoring/summer internship program similar to local summer jobs programs already established in the community
- working with High School Career Centers on pipeline strategies
- providing management and leadership skills development opportunities
- building on existing peer education programs in High Schools
- connecting with School counselors
- attending schools' career and job fairs to do outreach
- sponsoring summer internships
- developing a list of internships/volunteer experiences
- developing a paraprofessional training program for youth (e.g., conflict resolution for youth)

Program: Engage adult workers into the mental health workforce

Description:

Many adult workers consider career change after developing a long work history, and accumulating excellent work and life experience. Giving the current economic downturn, many experienced adult workers are changing careers or returning to the workforce, and healthcare is an attractive option. Mental healthcare can best benefit from the experience of these workers by providing them with opportunities to engage in mental healthcare occupational experiences.

To engage “unretiring” and/or displaced working adults and older adults and/or those considering a career change and/or those returning to the workforce (including but not limited to individuals leaving the business world, returning veterans, retired law enforcement, individuals involved in the faith community) to consider a career in mental health, by:

- developing an outreach effort that informs and encourages retired or displaced adults about potential careers in mental health
- establishing partnerships with relevant community organizations such as Peninsula Works and Job Train to develop pipeline strategies
- offering pre-employment job readiness workshops
- developing outreach and a curriculum specific to career retraining (e.g. NAMI Provider Training), in collaboration with community colleges, adult schools, vocational training and ESL programs,
- creating internships for adult individuals not enrolled in mental health practicums

Program: Increase diversity of staff to better reflect diversity of client population

Description:

A concentrated effort needs to be made to create a workforce that is more reflective of the communities served, and that has the skills and knowledge needed to best provide services to these individuals. Traditional efforts to attract diverse workers into mental health jobs have had limited success, and it has become clear by discussions with

relevant stakeholder groups, that strategies can be employed to increase interest in these positions.

Some of these strategies include recruiting diverse populations (targeting language skills in addition to specific minority groups), by:

- utilizing existing cultural initiatives and outreach collaboratives to deliver information regarding potential career opportunities
- developing appropriate recruiting materials relevant to specific populations
- utilizing media outlets that target specific populations
- creating structures/processes to oversee implementation of recruiting efforts
- contacting and engaging with culture-specific organizations such as the Historically Black Organizations or HBOs regarding career opportunities
- outreaching to college fraternities and sororities with diverse memberships
- targeting schools that have a high concentration of students of color for outreach and recruitment
- ensuring diverse hiring and promotion panels (for both recruitment and retention)
- participating in community events, i.e. health fairs, county fairs, ethnic events, to promote BHRS career opportunities

Program: Retain diverse staff

Description:

Current input from existing diverse staff, as well as from the participants in the workforce development group, indicate that diverse staff want to promote in mental health care, but are not always sure how, or if they have the skills necessary to move up in the organizations. The following interventions are designed to address the issue of ongoing skills development as well as staff understanding of the systems and opportunities to participate in these systems.

Strategies include achieving diverse staff retention by:

- creating exposure and interest across job classes, including administrative/clerical staff, via mentoring
- promoting cross-training and temporary job changes
- providing exposure to management and executive level staff
- developing a leadership academy for supervisors
- offering “promotion readiness” workshops for current staff

- re-examining workload distribution and bilingual pay differential of staff receiving such differential

Program: Expand existing effort and create new career pathways for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the County system

Description:

San Mateo County BHRS and contracted agencies have been successful in hiring, promoting and fully utilizing dozens of community workers and family partners into their respective systems of care. In addition to providing essential practical support, guidance and training, recruitment and hiring teams have also worked hard to battle stigma, and to create a safe working culture for these essential new employees. That said, much more work remains to be done in relation to the issue of stigma and how it impacts the recruitment and retention of consumers and family members. As consumers and family members become more fully integrated into the system, it is imperative that these valuable workers be retained, and that their skills and leadership needs be brought to all levels of their respective organizations.

Strategies include enhancing current and creating new professional development opportunities for consumers and family members –from entry level to top leadership positions, by

- considering consumer and family member role in developing career paths (e.g. personal experience)
- using youth/young adults as peer partners in order to help with engagement, support, and peer education
- providing financial support for consumers and family members pursuing education, in order to assist with expenses not covered by other sources
- creating a mentorship program especially developed for consumers and family members, with participation from supervisors and management
- broadening employment opportunities
- offering and supporting consumer and family volunteer opportunities
- providing technical assistance to BHRS contractors not currently employing consumer/family members

- building upon/expanding existing collaborations (i.e., College of San Mateo), and creating new ones, to support consumers and family members in their pursuit of certifications and advanced degrees.
- offering paid or unpaid internships for consumers/family members
- creating a Family Partner Certification Program
- empowering current and former mental health consumers to seek employment opportunities in the BHRS system
- expanding support of consumers and family members during the application process in order to guide them through it by providing assistance on how to understand the HR lingo, and/or by conducting “mock interviews” to assist in the development of interviewing skills

Program: Ongoing engagement and development of client and family workers

Description:

Consumer and family member employees are a precious resource within the behavioral health system of care. They are not only essential in providing sensitive, appropriate services to highly diverse populations, but they are also inherently transforming the systems of care by their presence in the workforce. Their empathy, experience and advocacy skills are creating the shift toward total health and wellness which reinforces every aspect of the San Mateo County mission to provide high quality, community based health care.

Strategies include increasing retention rates for consumer and family partner employees, by

- building upon/expanding WRAP and similar current initiatives to support physical and emotional health of consumers and family members
- building upon/expanding BHRS’s efforts to successfully integrate consumer and family members in the workforce as essential to providing meaningful services and supports
- utilizing the BHRS Stigma Initiative as a vehicle to address workplace issues
- supporting flexible work schedule

FUNDING CATEGORY: FINANCIAL INCENTIVE PROGRAMS

Program: Stipended Internships to Create a More Culturally Competent System

Description:

This action provides stipends to 10 trainees from local universities who contribute to expand the diversity as well as the linguistic and cultural competence of our workforce. Our stipend program for interns offers a fixed amount to students in our system to assist in covering their expenses in hopes they will pursue careers in public mental health. The Workforce Development Director conducts the outreach to graduate schools to identify a diverse pool of trainees, and works with mental health programs to develop placements and provide ongoing training. The objectives of this program include increasing the availability of culturally and linguistically competent services to all consumers and family members of BHRS; and increasing the knowledge and understanding of trainees of the values and commitments of recovery-based, strength-based services offered in BHRS.

PREVENTION AND EARLY INTERVENTION (LOCAL)

Program: Early Childhood Community Team

Description:

The Early Childhood Community Team project incorporates several major components that build on current models in our community, in order to support healthy social emotional development of young children. A Team comprises a community outreach worker, an early childhood mental health consultant, and a licensed clinician and targets a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners also available to support young families. Per the recommendation of our planning workgroup, the initial BHRS PEI team site was targeted to serve communities with a high proportion of Latino and/or isolated farm worker families, and communities or communities experiencing a significant degree of interpersonal violence, which has significant impact on families and young children.

The community outreach worker is a key team member, who networks within the community and community based services to identify young families with children between birth and three and connects them with necessary supports. Another role includes offering groups for families with young children, using the Touchpoints Program. This approach, developed by Brazelton, is based on the concept of building relationships between children, parents and providers around the framework of “Touchpoints,” or key points in early development. Participants learn how to use relationship-building and communication strategies when they deliver care and interact with children and families.

The second team member (Early Childhood Mental Health Consultant) focuses on supporting social emotional development in child care settings by providing early childhood mental health consultation. This service typically consists of the following activities:

- Observing the interaction of the caregiver(s) with young children
- Observing a child’s interaction with caregiver(s) and other young children
- Consulting with the caregiver(s) regarding overall support of positive social emotional development
- Consulting with the caregiver(s) on developmental or behavioral concerns regarding a specific child
- Facilitating family and caregiver meetings
- Facilitating referrals for additional services for children and families

Child care is provided by licensed family day care providers, license exempt providers, and family/friends/neighbors. The child care resource and referral agency in San Mateo works with all of these types of child care settings and manages a database with all types of providers, searchable by specific community. It provides support for the county’s child care providers and preschool programs, investing in professional development and helping improve program quality through a variety of workshops, programs and support services—however, most services are offered in central San Mateo and may not be attended by providers from other parts of the County. By making early childhood mental health consultation available to more child care providers, the team reaches families at risk and in distress at an early point in the developmental process. The outreach worker is also able to identify and connect with family/friend/neighbor providers that may not have been previously known to the resource and referral agency and facilitate their connection to ongoing supports.

The third team member is a licensed clinician who provides brief, focused services to families that are identified with a need by the community outreach worker, the early childhood mental health consultant or partners in the network of community services such as primary care providers (note that brief services are defined as less than one year). The clinician screens for postpartum depression and facilitates appropriate service plans with primary care and/or mental health services.

Program: Community Interventions for School and Transition Age Youth

Description:

This project focuses on school age and transition age youth, reaching out to them in non-traditional settings such as schools and community based agencies, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations. The project provides population and group based interventions to at-risk children and youth 6-25.

The first intervention, Teaching Pro-social Skills (TPS), addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up poor; peer rejection; low quality child care and preschool experiences; after-school care with poor supervision; school failure, among others. Teaching Pro-social Skills is based on Aggression Replacement Training (ART). ART was developed by Arnold P. Goldstein, Barry Glick and John C. Gibbs, and takes concepts from a number of other theories for working with youth, and incorporates them into a comprehensive system. Peer learning and repetition are elements of the model. ART is an evidence based program broadly utilized. Social skills training, anger control, and moral reasoning are the main components of both ART and TPS.

The second intervention, Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services

Project SUCCESS is a research-based program that builds on the findings of other successful prevention programs by using interventions that are effective in reducing risk factors and enhancing protective factors. Project SUCCESS counselors use the following intervention strategies: information dissemination, normative and prevention education, problem identification and referral, community based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. The counselors primarily work with adolescents individually and in small groups; conduct large group prevention/education discussions and programs, train and consult on prevention issues with alternative school staff; coordinate the substance abuse services and policies of the school and refer and follow-up with students and families needing substance abuse treatment or mental health services in the community.

The third intervention, Seeking Safety, is an approach to help people attain safety from trauma/PTSD and substance abuse. It targets Transition Age Youth through their contacts with community based organizations. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD. The key principles of Seeking Safety are:

- 1) Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
- 2) Integrated treatment (working on both PTSD and substance abuse at the same time)
- 3) A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse
- 4) Four content areas: cognitive, behavioral, interpersonal, case management
- 5) Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues)

A fourth intervention, the Middle School Initiative, utilizes a variety of strategies to assist children and youth in the middle school setting who are having behavioral issues. The program works not only with the students, but with parents and teachers, providing technical assistance to the teachers, and support and education to the parents. A

notable characteristic of this program is that many students refer their peers to the program, which indicates a high level of buy-in on the part of the clients.

Program: Prevention and Recovery in Early Psychosis (PREP)

Description:

PREP aims at achieving remission through early detection, meticulous diagnosis and an array of evidence-based treatments; rehabilitation by providing clients with the tools that they need to keep their illness under control for the long term; recovery, by restoring clients to a normal, productive life; and respect through including the client and seeking his or her consent, as well as involving the family—whichever way the client defines “family”.

The PREP Program is among the most comprehensive programs of science-based early diagnosis, treatment, and rehabilitation services for schizophrenia available in the United States. Unlike older treatments—which aim primarily at palliative care—the PREP Program aims to prevent the onset of full psychosis, and, in cases in which full psychosis has already occurred, seeks to remit the disease and to rehabilitate cognitive capacities damaged by the disease. PREP carefully braids together five evidence-based practices into one integrated treatment approach, and uses community education and outreach to facilitate early identification of individuals at risk of psychosis, a huge factor in preventing the ravages associated with untreated psychosis and schizophrenia. Once the clients are engaged, PREP provides Cognitive Behavioral Therapy to help them manage their symptoms and better understand their condition. When medication is needed, PREP uses algorithm medication management to identify the lowest possible dosage creating the least possible side effects. PREP engages the client and family in Multifamily Groups that create a supports system and promote a positive therapeutic community within the family. PREP uses Strength-Based Care Management to help the client and family develop relapse prevention plans and a life plan that builds upon strengths and provides goals for the future. Finally PREP provides vocational planning that reinforces the life plan with tangible goals for a career.

Program: Primary Care/Behavioral Health Integration

Description:

This program supports BHRS' efforts towards becoming more effectively integrated to better serve our clients. Services funded include system-wide co-location of BHRS practitioners in Primary Care settings to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. The model utilizes essential elements of IMPACT model to identify and treat individuals in primary care who do not have Serious Mental Illness, and are unlikely to seek services from the formal mental health system. Some of these elements are listed below.

Collaborative care, which functions in two main ways:

- The individual's primary care physician works with a care manager/behavioral health consultant to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)
- Care manager and primary care provider consult with psychiatrist to change treatment plans if individuals do not improve

Care Manager/Behavioral Health Consultant. The care manager:

- Educates the individual about depression/other conditions
- Supports medication therapy prescribed by the individual's primary care provider if appropriate
- Coaches individuals in behavioral activation and pleasant events scheduling/self management plan
- Monitors symptoms for treatment response
- Completes a relapse prevention plan with each individual who has improved

Psychiatrist, who consults to the care manager and primary care physician on the care of individuals who do not respond to treatments as expected

Program: Total Wellness for Adults and Older Adults

Description:

Prevention and Early Intervention funds a few key program elements of a larger initiative called Total Wellness. More details of the Total Wellness project can be found under the Innovation Component program description below. Included in the Total Wellness project is an integrated training piece; it entails a universal prevention strategy that focuses on education of professionals on co-morbidity and related issues. The trainings target all types of providers (county clinics and contract providers serving that population.)

The trainings aim at providing professionals with the necessary information to help them understand the interconnectedness and the interdependence between mental and physical health. Such trainings help bridge a much needed gap in knowledge.

Program: Community Outreach and Engagement, and Capacity Building

Description:

This program strategy identifies and engages individuals by building bridges with ethnic and linguistic populations that experience health disparities and may experience behavioral health services as unresponsive to their needs. Strategies include population-based community needs assessments, planning and materials development as well as hiring of community based “navigators”, and primary care-based behavioral health services to identify and engage diverse populations. This program includes health equity initiatives targeting African American; Chinese; Filipino; Latino; Pacific Islander; LGBTQQI; and Spirituality. The program includes two regional collaborative enterprises: The East Palo Alto Mental Health Advisory Group and the North County Outreach Collaborative.

Target population: Individuals who are currently un-served and need behavioral health services.

Program: Anti Stigma Initiative

Description:

There are several components to this initiative regarding stigma, which is designed to form the foundation for a long term effort to focus specific activities within San Mateo County, and not duplicate MHSA statewide initiatives and media campaigns.

Areas of focus are:

- Coordination and oversight of local anti-stigma initiatives, as well as coordination with state level media and other projects.
- Development of educational materials to dispel myths and misperceptions about mental illness, substance use, or co-occurring conditions.
- Participants in the PEI planning process agreed that within schools, health, human services, criminal justice and benefits organizations (social security, health plans), there is stigma that needs to be addressed through staff development and training. BHRS has already identified stigma as an issue in its overall MHSA training plan. Through this Anti Stigma Initiative the intention is to expand access to the planned BHRS training, engaging individuals employed in schools health, human services and benefits agencies throughout the San Mateo community.
- This program also supports anti-stigma programs that provide trainings and presentations featuring consumers and family members as presenters
- The centerpiece of the initiative is a community driven project that enlisted the participation of seven different cultural groups to develop community-generated presentations depicting perceptions about stigma, for use in different communities with the purpose of educating, raising awareness, and ultimately connecting people with services.

PREVENTION AND EARLY INTERVENTION (STATEWIDE)

Program: Training, Technical Assistance, and Capacity Building

Description:

Three areas of focus for this component were identified through our stakeholder process: The first area involves training BHRS and contractors' staff to become trainers in the ASIST model. The funding for this training for trainers allows such staff to provide clinical and "Gatekeepers" training for providers and community members in San Mateo and neighboring communities. Making these training opportunities available has greatly increased the capacity of community members and providers to respond, among other things, to suicidality. The second area involves an outreach and education effort aimed at providing primary care practitioners with training in Evidence Based Practices, in order to help them address in their offices an array of mental illness identification strategies including suicidality. This area of focus recognizes the fact that that individuals across cultural groups and ages tend to have a connection with a primary care provider; it also recognizes that the majority of individuals who completed suicide had a recent primary care visit. The third area of focus involves technical assistance collaboration with stakeholders from non-traditional mental health settings in order to develop community capacity building strategies targeting broad audiences through different topics addressing public perception on behavioral health issues (stigma, suicide, etc.).

All three areas have created and realized opportunities for neighboring counties to participate and benefit.

CAPITAL FACILITIES AND INFORMATION TECHNOLOGY

Program: eClinical Care

Description:

San Mateo County has had no viable opportunities under the Capital Facilities section of this component due to the fact that the guidelines limit use of these funds only to County owned and operated facilities. Virtually all of San Mateo's mental health

facilities are not owned but leased by the County, and a considerable portion of our services is delivered in partnership with community-based organizations.

Through a robust stakeholder process it was decided to focus the resources of this component to fund eClinical Care, an integrated business and clinical information system (electronic health record) as well as ongoing technical support. The system continues to be improved and expanded in order to help BHRS better serve the clients and families of the San Mateo County behavioral health stakeholder community.

INNOVATION

Program: Total Wellness

Description:

We build on several emerging, innovative practices for this program we have called TOTAL WELLNESS. Research shows that people with serious mental illness have a range of healthcare issues that compromise their ability to pursue recovery, and the behavioral health system should function as their entry point into primary healthcare --if they are not already being served or if they are underserved. Building on learnings from practices that have been successful in the primary care setting, Total Wellness aims at improving the health status of seriously mentally ill individuals who suffer chronic health conditions, adapting some of the strategies in those practices for use in the behavioral health system.

Total Wellness also builds upon and supports the practices of the Nurse Practitioners that have for almost two decades have been located in BHRS clinics, providing assistance and backup to their provision of general healthcare services in the behavioral health setting.

The incorporation of nurse care manager and peer health and wellness services aims to assure the smooth and seamless collaboration of all care providers, primarily by the coordinating function of the Nurse Care Managers, the follow up/direct assistance function of the Peer Health and Wellness Coaches, and the overall communication and close collaboration of the entire care team. This aims to ensure a seamless service experience for clients.

Nurse Care Managers, in partnership with Peer Health and Wellness Coaches and other care team members as needed work with individuals who have elevated levels of blood pressure, glucose and lipids, assuring that:

- they are connected to ongoing healthcare in a primary care medical home (using the mental health/substance use entry point as the entry point into primary healthcare as well as access to other services)
- they get clinical preventive screenings (for example, mammograms and other cancer screenings), as well as appropriate primary and specialty healthcare for chronic health conditions (by coaching and/or supporting them in primary care visits or arranging for peers to accompany them)
- they follow up on medications prescribed for physical health conditions
- they engage in a Chronic Disease Self Management Program

The nurse care managers also link people to benefits counseling, the Smoking Cessation classes, and plan and co-lead with Peer Health and Wellness Coaches ongoing groups that support weight management and physical exercise.

A key feature of this innovative approach is the utilization of peers as health and wellness coaches, assisting seriously mentally ill individuals in the management of their health conditions.

WE WOULD LIKE TO HEAR YOUR FEEDBACK REGARDING THE PLAN ORGANIZATION AND CONTENTS! Please send your comments to Sandra M. Santana-Mora, San Mateo County MHSA Coordinator, 225 37th Avenue, 3rd floor, San Mateo, CA 94403. Email: ssantana-mora@smcgov.org, 650.573.2889.

THANK YOU!

Next Steps

This document will be revised during the 30 day public comment period to include any new information and funding priorities as discussed and approved through the stakeholder process with the MHSA Steering Committee. Public comment will close on June 6, 2012, when a hearing will be hosted by the MHSARC from 3 to 5, in room 100 of 225 37th Avenue, in San Mateo.

A note about the summary funding information below: Due to the shift at the State level prompted by A.B. 100, commencing on July 1st, 2012, the County will begin receiving monthly MHSAs allocations. Since no State level agency will produce an estimate of funding available to counties, it is impossible to say at this time what exactly will be our allocation. To respond to this uncertainty we are proposing maintenance of funding levels as of FY 11/12 until we gain clarity about how the revenues will behave. We will keep the stakeholder community up to date regarding any developments in this regard.

County: San Mateo

Date: 5/2/2012

	MHSAs Funding					
	CSS	WET	CFTN	PEI	INN	Local Prudent Reserve
A. Estimated FY 2012/13 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	\$0	\$1,717,341	\$482,323	\$5,470,709	\$4,041,077	
2. Estimated New FY 2012/13 Funding	\$13,338,474			\$3,172,589	\$869,003	
3. Transfer in FY 2012/13 ^{a/}	\$0	\$0				\$0
4. Access Local Prudent Reserve in FY 2012/13	\$0			\$0		\$0
5. Estimated Available Funding for FY 2012/13	\$13,338,474	\$1,717,341	\$482,323	\$8,643,298	\$4,910,080	
B. Estimated FY 2012/13 Expenditures	\$13,174,150	\$516,000	\$482,323	\$4,478,339	\$1,107,240	
C. Estimated FY 2012/13 Contingency Funding	\$164,324	\$1,201,341	\$0	\$4,164,959	\$3,802,840	

^{a/}Per Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2012	\$600,000
2. Contributions to the Local Prudent Reserve in FY12/13	\$0
3. Distributions from Local Prudent Reserve in FY12/13	\$0
4. Estimated Local Prudent Reserve Balance on June 30, 2013	\$600,000

San Mateo County Health System

Behavioral Health and Recovery Services

Vision, Mission, Values and Strategies

These statements were developed out of a dialogue involving consumers, family members, community members, staff and providers sharing their hopes for the newly formed Behavioral Health and Recovery Services Division. The members of the Behavioral Health and Recovery Services community agree to support the Vision, Mission, and Values, and to strive to demonstrate these concepts within our individual and collective responsibilities.

THE VISION:

Individuals, families, and communities fulfill their promise and successfully pursue their dreams in a society where stigma and discrimination against those with mental illness and/or alcohol and drug addiction are remnants of the past.

THE MISSION:

We build opportunities for people with or at risk of alcohol and drug addiction and mental health challenges to achieve wellness and/or recovery through partnership, innovation, and excellence.

OUR VALUES:

Person and Family Centered

We promote culturally responsive person-and-family centered recovery.

Potential

We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery.

Power

The people, families, and communities we serve and the members of our workforce guide the care we provide and shape policies and practices.

Partnerships

We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity.

Performance

We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness and addiction and to promote the health of the individuals, families and communities we serve.

OVERARCHING BEHAVIORAL HEALTH AND RECOVERY SERVICES STRATEGIES

- **Prevention and Early Intervention:** Implement prevention and early intervention approaches for mental health and alcohol and drug addiction problems among at-risk populations. Partner with ethnic and linguistic communities to develop culturally competent strategies for community education and outreach that reduce stigma and discrimination about behavioral health problems, and promote early identification.
- **Reducing Cultural and Linguistic Disparities:** Improve access to mental health and alcohol and drug treatment for under/unserved populations. Promote organizational and individual cultural competency through education, training, workforce development, hiring strategies, and policy changes.
- **Welcoming and Engagement:** Create processes for entering behavioral health treatment that support a sense for clients and family members that “this is the right place”; are designed to maintain connection with services and supports; and are timely, culturally competent, and integrated with other services people need, for example health care, human services, the justice system, and education.
- **Empowering Clients and Families:** Partner with clients and family members to define recovery and wellness and to direct policy and services accordingly. Expand client and family self-help activities.
- **System of Care Enhancements and Supports:** Develop a full continuum of proven practices and supports (self-help, education, treatment, employment, housing, other) appropriate to individual need that promote life worth living in the community and recovery from mental illness, alcohol and drug addiction, and co-occurring disorders. Improve coordination of care among providers and the match between the level of care provided and the level of care and intensity of services needed by clients at any time.
- **Total Wellness:** Reduce disparities in access to health care for people with mental illness and alcohol and drug addictions. Improve their health outcomes through chronic disease prevention, early intervention, health care, and disease management approaches.

PLEDGE

TO FIGHT THE STIGMA OF MENTAL HEALTH AND SUBSTANCE USE CONDITIONS

I, _____, PLEDGE TO:
(YOUR NAME HERE)

- LISTEN TO PEOPLE WHO LIVE WITH A MENTAL HEALTH CONDITION OR A SUBSTANCE USE DISORDER AND REMEMBER THAT THE ILLNESS IS NOT THE PERSON
- EMPHASIZE PEOPLE'S ABILITIES, NOT THEIR LIMITATIONS
- CHALLENGE NEGATIVE STEREOTYPES ABOUT MENTAL ILLNESS OR SUBSTANCE USE IN THE MEDIA AND/OR AMONG THE PEOPLE I KNOW
- HONOR THE COURAGE AND PERSONAL STORIES OF THOSE WHO LIVE WITH MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

PRINTED NAME*: _____

EMAIL*: _____

TELEPHONE: _____

**May we include your name on our website and/or related printed materials as having signed this pledge?*

YES ___ NO ___

(Your contact information will **NOT BE** included. Your name will not be used in connection to any subject other than our stigma work.)

**May we contact you OCCASIONALLY about our stigma work?*

YES ___ NO ___

(No more than two or three times per 12-month period)



YOUR NAME COUNTS

Add your name to the growing list of people and organizations that oppose the discrimination of people living with mental health conditions and substance use disorders!

THANK YOU!

By signing this pledge you are helping to eradicate stigma and discrimination against people with mental health and substance use challenges.

Excerpt of letter sent by CMHDA to the Senate and to the Assembly Budget Committees regarding the Governor's FY 2012-13 Budget for Community Mental Health. The full text can be found here: http://www.cmhda.org/go/portals/0/cmhda%20files/public%20policy/1203_jan%20budget%20and%20presentations/cmhda%20memo%20on%20mh%20budget%20proposals%202012-13%20january%20budget_final.pdf

Clarifications to the Mental Health Services Act

CMHDA supports the majority of the Governor's proposals to streamline and clarify requirements in the Mental Health Services Act (MHSA), as found in Trailer Bill Language (TBL) #601. Specifically, CMHDA supports the following major components of the Governor's proposal because they are consistent with the state budget adopted last year, as well as with 2011 Realignment, which moves decisions "closer to the people" and streamlines state government. *CMHDA urges the Legislature to approve these proposals:*

- Delete the requirement that the Mental Health Services Oversight & Accountability Commission (MHSOAC) approve counties' plans for Innovation, prior to counties receiving Innovation funds. Instead, authorize counties to expend funds for Innovation, upon approval by the county Board of Supervisors.
- Require counties (instead of the state department) to establish a Prevention and Early Intervention (PEI) program designed to prevent mental illnesses from becoming severe and disabling. Delete the state department's authority to increase PEI allocations under certain conditions. Instead, authorizes counties to increase PEI expenditures under those conditions.
- Delete the requirement that the MHSOAC issue "guidelines" for PEI and Innovation expenditures, and require the county (instead of the state department) to revise its PEI program, in consultation with mental health stakeholders, to reflect what is learned to be effective.
- Delete the current limitation that statewide PEI allocations be increased only when the MHSOAC determines counties are receiving necessary services for SMI persons, have established prudent reserves, and there are additional revenues available in the fund.
- For MHSA 3-year plans, require counties' plans to be adopted by the county Board of Supervisors and submitted to the MHSOAC. Additionally, delete the requirement that the state department establish requirements for the content of counties' plans and updates. Instead, counties would develop plans that are consistent with statutes.
- Delete the requirement that the state department, in consultation with CMHDA, MHSOAC, and the Mental Health Planning Council, annually inform counties of the amounts of funds available for services to children, adults and seniors. This is no longer necessary since starting in FY 2012-13, the Mental Health Services funds will be transferred to the counties on a monthly basis. Each year, the state budget will provide the estimated revenues in the Mental Health Services Fund. All unexpended/unreserved funds will be distributed by the controller to each local Mental Health Service Fund on or before the 15th day of each month. The

proportion of unexpended/unreserved funds that each county will receive will be based on a formula developed by the Department of Finance in collaboration with CMHDA.

However, CMHDA has concerns with the following proposals and *urges the Legislature to reject them*:

- The Governor proposes to delete the requirement that counties contract with the state department to implement the services provided under the MHSA.
 - CMHDA supports the language that currently exists in the Act related to the performance contract. We believe the state-county performance contract should be retained for both realignment 1991 and the MHSA, as currently required by statute. The performance contract was originally developed and added WIC Sections 5650 et seq., during the initial realignment as a way to outline state and county statutory and regulatory responsibilities. The MHSA added Section 5897(c) to also implement MHSA programs through the Performance Contract, which we believe is a reasonable way to provide transparency and clarity for the state, the counties and stakeholders.

- The Governor proposes to require the California Department of Public Health (DPH), in consultation with counties and stakeholders, to “administer a project to reduce disparities in mental health.” Additionally, prior to making other MHSA allocations, the Governor proposes to appropriate \$60 million to DPH for the purposes of this project, on a one-time basis, and permits the funds to be expended without regard to fiscal year.
 - CMHDA opposes this proposal. CMHDA strongly supports a sustainable approach to the development of a statewide project to reduce disparities, but has serious concerns about the Administration’s proposal (TBL #601) to amend the Act to give the state the authority to withhold funds from counties for this purpose. We are not only concerned about the precedent of amending the Act to set aside local funds for a state-level project of any kind, but also believe this is inconsistent with the intent of the Act, which is that all MHSA funds (other than those for state administration) be provided to communities where counties and stakeholders develop services that reflect local priorities consistent with the Act. We continue to fully agree that reducing disparities is a major and important stated goal of the Act, and that all counties must implement sustainable programs that demonstrate achievement of this goal. However, before giving the state the authority to appropriate county funds to the state to implement this specific project, we would like to explore whether there are other alternatives to ensuring a statewide approach to this project. Further, it is imperative to the long term sustainability of efforts to reduce disparities that counties be integrally involved in this statewide project, since these funds would otherwise be distributed to local communities for their use.



March 26, 2012

TO: Honorable Members, Senate Committee on Budget and Fiscal Review
Honorable Members, Assembly Budget Committee

FROM: Patricia Ryan, Executive Director;
Kirsten Barlow, Associate Director, Legislation and Public Policy
California Mental Health Directors Association

SUBJECT: Governor's FY 2012-13 January Budget for Community Mental Health

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, I am writing to communicate our perspective on the Governor's substantial January Budget proposals for Fiscal Year (FY) 2012-13 that would impact California's community mental health system.

2011 Realignment: Implementation of Medi-Cal Specialty Mental Health Realignment

The 2011-12 state budget signed by Governor Brown included the Governor's proposal to realign many public safety and health and human services to counties. Among these realigned programs are Medi-Cal Specialty Mental Health services and substance use treatment services (including Drug Medi-Cal). However, since AB 100 (Committee on Budget, Statutes of 2011) provided funding for Medi-Cal Specialty Mental Health, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), for FY 2011-12, these two programs are not realigned until FY 2012-13.

CMHDA is concerned with the adequacy of the Administration's baseline estimated revenues to be allocated to counties for Medi-Cal Specialty Mental Health and EPSDT. In particular, the January Budget includes baseline allocations that net to \$34.9 million less than the figures presented by the Administration last summer. Notably, the EPSDT figures are \$85 million less in the January Budget, despite the Governor's proposal to transfer Healthy Families enrollees to Medi-Cal and the likely impact of the Katie A. settlement on the EPSDT caseload. Additionally, the factors being utilized by the Administration for developing the allocations for Medi-Cal Specialty Mental Health and EPSDT include prior-year state General Fund savings approaches, which are no longer relevant under 2011 Realignment since the fund source for the programs are new dedicated tax revenues. Also, the Administration applied State Maximum Allowances (state reimbursement rate caps) to its estimates, which are eliminated beginning FY 2012-13 due to the enactment of AB 1297 (Chesbro, Statutes of 2011). *We urge the Legislature and Administration to ensure that the baseline figures for Medi-Cal Specialty Mental Health and EPSDT are adequate for counties to provide medically necessary services to eligible beneficiaries in these federal entitlement programs.*

Additionally, CMHDA recommends the following key policy issues be addressed in legislation to enact the 2012-13 realignment of Medi-Cal Specialty Mental Health and EPSDT to counties.

- **Allocations and Distributions of Funds to Counties:** In a careful review of existing statutes, CMHDA has identified many policies that must be repealed or significantly amended to reflect that Medi-Cal Specialty Mental Health and EPSDT will be funded through the 2011 Realignment dedicated revenues.¹ In addition to modifying this new source of program funds, the cost-sharing arrangement between the state and counties must also be amended since the state budget will no longer provide an allocation of state General Funds through the state budget process. CMHDA proposes that new statutory language be added to specify the manner in which county distributions of 2011 Realignment funds for these programs will be made. This language could be modeled after AB 100 (Committee on Budget, Statutes of 2011), which requires 2011-12 redirected Mental Health Services Act funds for Medi-Cal Specialty Mental Health and EPSDT to be allocated by the State Controller, based on a formula determined by the state (Department of Finance) in consultation with the California Mental Health Directors Association [see Welfare and Institutions Code (WIC) 5892 (j)].
- **First Right of Refusal in Contracting with the State:** Under Realignment 2011, the state is realigning to counties the financial risk and responsibility for providing Medi-Cal Specialty Mental Health and EPSDT services to eligible beneficiaries. Therefore, it is reasonable to delete existing statutes that give counties the *voluntary option* of contracting with the state to serve as the county Mental Health Plan (MHP).² Counties must carefully consider the current mandate protections provided under Proposition 1A for realigned programs, as well as the potential future protections that would be provided by Governor Brown's ballot measure, the Schools and Local Public Safety Protection Act of 2012, if passed. Additionally, current statute gives the state broad authority to capture any anticipated matching funds from a county (including 1991 realignment funds and Mental Health Services Act funds), should a county exercise its right to refuse to contract with the state. Absent certainty about the Governor's ballot measure to provide counties with state constitutional protections for realigned programs, maintaining this statute poses great risk to counties who could face an unfunded mandate scenario in the event 2011 Realignment funds for this program are insufficient.
- **Self-Insurance Risk Pools:** In order to efficiently implement counties' obligations for Medi-Cal Specialty Mental Health and EPSDT and assure statewide access and compliance with the applicable state plans and waivers, counties of all sizes must be permitted to use Realignment 2011 dedicated sales tax revenues in pooled funding accounts to address identified regional and statewide needs. Existing law currently limits the establishment of risk pools to small counties (population under 200,000).³
- **Administrative Activities:** While existing law limits the state's imposition of administrative requirements for Medi-Cal Specialty Mental Health, these provisions might be strengthened to ensure counties are consulted prior to the addition of any new administrative requirements.⁴ Since counties will be administering Medi-Cal Specialty Mental Health using the limited resources provided by 2011 Realignment dedicated revenues, it will be more important than ever to contain the state's administrative requirements to ensure counties have adequate resources to meet the entitlement service needs of eligible populations. Administrative requirements should be designed to

¹ See WIC Sections 5720, 5724, 5778(c)(1) through (4), 5778(c)(6) through (9), and 5778(d)(2).

² See WIC Sections 5775, 5777, 5897(f), and 14685.

³ See WIC Section 5778(c)(4)(D).

⁴ See WIC Sections 5750 and 14684.

ensure federal requirements are met, with additional state requirements significantly limited.

Clarifications to the Mental Health Services Act

CMHDA supports the majority of the Governor's proposals to streamline and clarify requirements in the Mental Health Services Act (MHSA), as found in Trailer Bill Language (TBL) #601. Specifically, CMHDA supports the following major components of the Governor's proposal because they are consistent with the state budget adopted last year, as well as with 2011 Realignment, which moves decisions "closer to the people" and streamlines state government. *CMHDA urges the Legislature to approve these proposals:*

- Delete the requirement that the Mental Health Services Oversight & Accountability Commission (MHSOAC) approve counties' plans for Innovation, prior to counties receiving Innovation funds. Instead, authorize counties to expend funds for Innovation, upon approval by the county Board of Supervisors.
- Require counties (instead of the state department) to establish a Prevention and Early Intervention (PEI) program designed to prevent mental illnesses from becoming severe and disabling. Delete the state department's authority to increase PEI allocations under certain conditions. Instead, authorizes counties to increase PEI expenditures under those conditions.
- Delete the requirement that the MHSOAC issue "guidelines" for PEI and Innovation expenditures, and require the county (instead of the state department) to revise its PEI program, in consultation with mental health stakeholders, to reflect what is learned to be effective.
- Delete the current limitation that statewide PEI allocations be increased only when the MHSOAC determines counties are receiving necessary services for SMI persons, have established prudent reserves, and there are additional revenues available in the fund.
- For MHSA 3-year plans, require counties' plans to be adopted by the county Board of Supervisors and submitted to the MHSOAC. Additionally, delete the requirement that the state department establish requirements for the content of counties' plans and updates. Instead, counties would develop plans that are consistent with statutes.
- Delete the requirement that the state department, in consultation with CMHDA, MHSOAC, and the Mental Health Planning Council, annually inform counties of the amounts of funds available for services to children, adults and seniors. This is no longer necessary since starting in FY 2012-13, the Mental Health Services funds will be transferred to the counties on a monthly basis. Each year, the state budget will provide the estimated revenues in the Mental Health Services Fund. All unexpended/unreserved funds will be distributed by the controller to each local Mental Health Service Fund on or before the 15th day of each month. The proportion of unexpended/unreserved funds that each county will receive will be based on a formula developed by the Department of Finance in collaboration with CMHDA.

However, CMHDA has concerns with the following proposals and *urges the Legislature to reject them:*

- The Governor proposes to delete the requirement that counties contract with the state department to implement the services provided under the MHSA.
 - CMHDA supports the language that currently exists in the Act related to the performance contract. We believe the state-county performance contract should be retained for both realignment 1991 and the MHSA, as currently required by

statute. The performance contract was originally developed and added WIC Sections 5650 et seq., during the initial realignment as a way to outline state and county statutory and regulatory responsibilities. The MHSAs added Section 5897(c) to also implement MHSAs programs through the Performance Contract, which we believe is a reasonable way to provide transparency and clarity for the state, the counties and stakeholders.

- The Governor proposes to require the California Department of Public Health (DPH), in consultation with counties and stakeholders, to “administer a project to reduce disparities in mental health.” Additionally, prior to making other MHSAs allocations, the Governor proposes to appropriate \$60 million to DPH for the purposes of this project, on a one-time basis, and permits the funds to be expended without regard to fiscal year.
 - CMHDA opposes this proposal. CMHDA strongly supports a sustainable approach to the development of a statewide project to reduce disparities, but has serious concerns about the Administration’s proposal (TBL #601) to amend the Act to give the state the authority to withhold funds from counties for this purpose. We are not only concerned about the precedent of amending the Act to set aside local funds for a state-level project of any kind, but also believe this is inconsistent with the intent of the Act, which is that all MHSAs funds (other than those for state administration) be provided to communities where counties and stakeholders develop services that reflect local priorities consistent with the Act. We continue to fully agree that reducing disparities is a major and important stated goal of the Act, and that all counties must implement sustainable programs that demonstrate achievement of this goal. However, before giving the state the authority to appropriate county funds to the state to implement this specific project, we would like to explore whether there are other alternatives to ensuring a statewide approach to this project. Further, it is imperative to the long term sustainability of efforts to reduce disparities that counties be integrally involved in this statewide project, since these funds would otherwise be distributed to local communities for their use.

Transfer Medi-Cal Specialty Mental Health Administration to DHCS

CMHDA supports the Administration’s continued efforts to transfer state administrative responsibilities for Medi-Cal Specialty Mental Health from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS). However, we have identified concerns and questions about a number of provisions contained in the Governor’s proposed TBL #614, which are described below.

- **Adds broad authority for DHCS to circumvent public participation in establishing program requirements and sanctions**⁵: While CMHDA supports DHCS’ desire to review existing DMH administrative directives and regulations to identify modifications that would improve efficiency, we oppose the proposals to give DHCS sweeping authority to utilize non-regulatory methods to establish requirements and sanctions. Specifically, the proposal authorizes DHCS to impose monetary sanctions -- and to choose not to renew its contract -- if a county Mental Health Plan fails to comply with statutes, regulations, or “similar instructions.” Additionally, the trailer bill proposes to

⁵ See the following WIC Sections of TBL #614: Section 14704 (p. 1); Section 5775(e) (p. 8); Section 5777(b) and (c)(2) (p. 10); Section 5778 (b)(6)(C) (p. 21); and Section 14021.5 (p. 41).

authorize DHCS to use regulations or “other similar instructions” in the establishment of a process for resolution of disputes about claims or recoupments of funds. We believe legislative and regulatory methods – not administrative directives – should be used to describe and authorize the imposition of administrative remedies that could result in the loss of counties’ financial resources for realigned Medi-Cal Specialty Mental Health services. The state’s legislative and regulatory rulemaking processes offer transparency and provide vital opportunities for public notice and participation. *CMHDA urges the Legislature to reject these proposals.*

- **Authorizes DHCS to withhold federal Medicaid funds if a county fails to comply with state requirements**⁶. Under existing law, the state is authorized to withhold state funds from counties that do not comply with the state’s requirements for Medi-Cal Specialty Mental Health. However, we believe it is inappropriate to authorize DHCS to additionally withhold *federal* matching funds in such cases if a county’s expenditures were completed in a manner that complied with all *federal* requirements. *CMHDA urges the Legislature to reject this proposal.*
- **Additional information needed to fully assess some proposals:**
 - On page 5, in WIC Section 5724 (a), the trailer bill proposes to add the phrase “electronic claims processing and interim payment” to an area of law that is related to the methodology used to reimburse counties for Medi-Cal Specialty Mental Health services. We are unclear about the Administration’s rationale for adding this language to statute. *CMHDA urges the Legislature to request additional information about this proposal.*
 - On pages 18 and 19, in WIC Section 5778 (b)(4), the trailer bill proposes to strike existing statutes that describe the state’s, counties’, and subcontractors’ financial responsibilities for federal audit exceptions or disallowances. We are unclear of the Administration’s rationale for deleting these requirements from existing law. *CMHDA urges the Legislature to request additional information about this proposal.*

Eliminate Funding for Community Treatment Facilities

CMHDA opposes the Governor’s proposal to eliminate \$750,000 General Fund for Community Treatment Facilities. We believe this proposal could result in significant harm for children and youth, and lead to increased juvenile detentions, acute hospitalization, self-harm, and even suicide for the young persons in need of care at these facilities. Currently, three licensed Community Treatment Facilities offer the highest level of care and supervision available for youth in California. In particular, Los Angeles, San Bernardino, San Diego, and Riverside counties report that these facilities are often the only safe and secure in-state treatment option for children and youth experiencing the most severe and chronic mental health difficulties. *CMHDA urges the Legislature to reject this proposal.*

Increase Counties’ Costs for Purchasing State Hospital Beds

CMHDA is concerned with the Governor’s proposal to increase counties’ costs for purchasing state hospital beds, thereby saving \$20 million General Fund. We do not have sufficient information about this proposal to fully determine its impact on counties – particularly about how the state will determine the costs of services that counties would pay that would result in an additional \$20 million of charges to counties. We request additional information about the new

⁶ See WIC Section 5775 (e) of TBL #614 (p. 8)

rates the Administration proposes to charge counties, and how they arrive at those rates for the purchase of state hospital beds. *CMHDA urges the Legislature to request additional information about this proposal.*

Transfer Incompetent to Stand Trial Treatment to County Jails

CMHDA is concerned about the potential local impact of the Governor's proposal to save \$3 million General Fund by "treating defendants found to be incompetent to stand trial in county jails, rather than state hospitals, when medically appropriate." While the Administration's draft trailer bill indicates the state intends to provide the treatment and provide reasonable reimbursement to county jails for the cost of the beds, we need more information about the proposal to fully determine its impact on counties and individuals who are incompetent to stand trial. In particular, we are concerned the proposal does not indicate how many individuals and in what counties the proposal would be implemented. Given the wide variability among county jails, in terms of jail space and treatment capacity, it is vital the Administration provide additional details about the proposal's scope and intent to collaborate with counties. *CMHDA urges the Legislature to request additional information about this proposal.*

Senate Bill 1136 (Steinberg) – Mental Health Services Act

Bill Summary:

Under existing law, the State Department of Mental Health is authorized and required to perform various functions relating to the care and treatment of persons with mental disorders. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. Existing law establishes the Mental Health Services Oversight and Accountability Commission (commission) to oversee the administration of various parts of the Mental Health Services Act. The act provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

This bill would require the commission to assist in providing technical assistance, as specified, and would require the commission to work in collaboration with, and in consultation with, various entities in designing a comprehensive joint plan for coordinated evaluation of client outcomes. This bill would require the California Health and Human Services Agency to lead the comprehensive joint plan effort. This bill would transfer various functions of the State Department of Mental Health under the Mental Health Services Act to the State Department of Health Care Services and the Office of Statewide Health Planning and Development. This bill would make various technical and conforming changes to reflect the transfer of state those mental health responsibilities. This bill would require all projects included in the innovative programs portion of the county plan to meet specified requirements. Existing law requires each county mental health program to prepare and submit a 3-year plan that includes specified components. This bill, in this regard, would require the plan to be a 3-year program and expenditure plan adopted by the county board of supervisors and submitted to the commission, would require annual updates, and would require plans to be certified by the county mental health director and the county auditor controller, as specified. This bill would require the State Department of Health Care Services to inform the California Mental Health Directors Association and the commission of the methodology used for revenue allocation to the counties.

This bill would require the State Department of Health Care Services, in consultation with the commission and the California Welfare Directors Association, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, as prescribed. This bill would authorize require the Governor or the Director of Health Care Services to appoint, subject to confirmation by the Senate, a Deputy Director of Mental Health and Substance Use Disorder Services of the State Department of Health Care Services. This bill

also would state the intent of the Legislature to create an Office of Health Equity to comprehensively address issues of health disparity, promote healthy communities, and improve individual health outcomes.

Existing law requires the State Department of Mental Health to adopt as part of its overall mission the development of community-based, comprehensive, interagency systems of care that target seriously emotionally and behaviorally disturbed children, as specified. This bill would instead authorize, rather than require, these provisions to be implemented.

This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

Source: <http://www.billtrack50.com/BillDetail/185443>

The full text of the bill as (substantially) amended on April 16 can be found here:

http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1101-1150/sb_1136_bill_20120416_amended_sen_v98.pdf



April 20, 2012

Senate Pro Tempore Darrell Steinberg
State Capitol Room 205
Sacramento, CA 95814

**SUBJECT: SB 1136 (Steinberg) Health: Mental Health: Mental Health Services Act
As Amended on April 16, 2012 – SUPPORT IF AMENDED
Set for Hearing in Senate Health Committee on April 25, 2012**

Dear Senate Pro Tempore Steinberg:

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, we are writing to communicate our position on your bill, SB 1136, which makes a number of changes and clarifications to the Mental Health Services Act (MHSA), a ballot initiative approved by California voters in 2004.

CMHDA believes that, with a few important exceptions, SB 1136 clarifies and streamlines administrative requirements in the MHSA, consistent with the state budget adopted last year, as well as with 2011 Realignment, which moves decisions “closer to the people.” CMHDA strongly supports the elimination of unnecessary bureaucracy; a streamlined funding distribution process; strong local oversight of MHSA planning, expenditures, and services; and an integrated approach to state and local evaluation, accountability, and data collection/reporting. Every dollar spent on unnecessary bureaucracy is a dollar not spent on essential services to meet the needs of residents in our communities.

Specifically, CMHDA strongly supports the bill’s provision deleting a requirement that the state department establish requirements for the content of communities’ MHSA plans [Section 5848, subdivision (c)]. The Act, as approved by voters, clearly outlines the required elements of the plan and updates. In recent years, the Department of Mental Health (DMH) has annually released lengthy guidance to counties for development of local plans and updates. This guidance has included dozens of enclosures and required attachments, which have proven administratively burdensome and cumbersome for local stakeholders to navigate. The deletion

of this unnecessary, additional layer will allow more effective local program planning for the expenditure of funds and delivery of critical services.

Second, CMHDA strongly supports the bill's provision deleting the current limitation that statewide Prevention and Early Intervention (PEI) allocations be increased only when the Mental Health Services Oversight & Accountability Commission (MHSOAC) determines counties are receiving necessary services for severely mentally ill persons, have established prudent reserves, and there are additional revenues available in the fund [Section 5892 (a)(4)]. The deletion of this provision will allow for more local flexibility in determining how to expend funds and design services to meet community needs, as long as they continue to align with statutory expenditure requirements. Furthermore, CMHDA also strongly supports the addition of subdivision (e) to Section 5840, which would allow for PEI funds to be used to broaden the provision of community-based mental health services by adding PEI services or activities to these services.

Additionally, CMHDA supports strong local oversight and a robust community engagement process. A critical component of the MHSOAC has always been its strong stakeholder engagement provisions, which were not impacted by AB 100 (Committee on Budget, Statutes of 2011). Requirements include the engagement of stakeholders, including clients and family members, in the development of each plan and update, a 30-day public comment period on the draft plan and update, plan review by the local mental health board, and a public hearing. CMHDA supports the bill's provisions that further strengthen local oversight authority by requiring the three-year program and expenditure plans and updates be adopted by local Boards of Supervisors and submitted to the MHSOAC [Section 5847, subdivision (a)]. AB 100 left a certain level of ambiguity in the area of plan adoption. While state-level plan approval requirements were deleted, the submission requirements were retained – but without an identified recipient. SB 1136 would clarify the process for counties and their stakeholders, while providing for important oversight by local elected officials. This gives local stakeholders an important opportunity to work with both their local mental health boards and Boards of Supervisors to ensure an inclusive planning process and appropriate expenditure of funds.

Despite these many areas of agreement and support, we respectfully offer our concerns about a few provisions of the bill. CMHDA could support the bill without reservation if these particular provisions were amended as requested below. Additionally, we have identified a small number of technical suggestions we believe would improve clarity, which are described later in the document as well. We appreciate your consideration of these suggestions.

Concerns

- *County Funds Allocations*

In Welfare and Institutions Code (WIC) Sections 5847(d) (page 12) and 5891(c) (page 17), the bill adds a new requirement that Department of Health Care Services (DHCS) annually *inform* CMHDA and MHSOAC of the methodology used for revenue allocation to the

counties, and requires the State Controller to use the methodology provided by DHCS for revenue allocation to the counties.

CMHDA has two primary concerns with the current language in these sections of the bill. First, the language implies that DHCS will also *determine* the methodology. We respectfully request that CMHDA's historical involvement with Department of Mental Health (DMH) in the determination of this methodology be honored as the state administrative responsibility shifts to DHCS.

The MHSAs distribution methodology to which CMHDA contributed significantly and that has been used since initial implementation of the Act includes factors such as U.S. Census data, data on the prevalence of mental illness, county poverty levels, existing county resources, small county base allocations, and other factors developed by CMHDA to address the need for equitable distribution of MHSAs tax revenues. In fact, CMHDA also currently develops distribution methodologies for other community mental health programs, including Medi-Cal Specialty Mental Health and realignment to assist the state department in addressing the need for equitable distribution of resources on a county and statewide basis.

Requested Amendment: CMHDA respectfully requests Section 5847(d) be removed from the bill (page 12), and offer the following amendment to Section 5891(c) (page 17, lines 25-26):

(c) Commencing July 1, 2012, on or before the 15th day of each month, *pursuant to a methodology provided by the State Department of Health Care Services, **developed in consultation with the California Mental Health Directors Association***, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

- *MHSA Revenue and Expenditure Reports*

The bill adds Section 5899 to the Act (page 24), which requires counties to submit an "Annual MHSA Revenue and Expenditure Report" to DHCS and the MHSOAC that contains specified information and is intended to allow for evaluation of all major service categories funded by MHSAs. The bill requires DHCS to develop instructions for the report, and for counties to submit the report electronically to both DHCS and the MHSOAC.

CMHDA notes that this Report is currently required by counties under DMH regulations (Section 3510), but was not a requirement in the original Act. We would prefer that this level of specificity as to administrative reporting be handled by state agencies and counties administratively, rather than codified in state law. Existing state law already provides

MHSOAC the authority to obtain data and information from local entities to utilize in its oversight, review and evaluation capacity (WIC Section 5845), and contains numerous requirements that counties comply with state reporting requirements (e.g., WIC Sections 5610, 5650.5, 5664, 5801, 5809, 5882).

Additionally, the state department's forms and instructions for these Reports have changed on a nearly annual basis. Therefore, it seems that it would be helpful to allow for modifications to be made over time as information needs and data sources of the state and counties change.

Requested Amendment: CMHDA believes the requirements set forth in subdivision (a) of Section 5899 (page 24) contain sufficient guidance to ensure that an Annual MHSA Revenue and Expenditure Report is developed and submitted by counties annually. However, we request that the specificity included in subdivisions (b) and (c) of Section 5899 be removed from the bill, and that the intent and purpose of the report be simply added to subdivision (a) as follows:

*5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report **to be used for evaluation purposes**. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.*

- *Innovative Programs*

In Section 5830 (b),(c), and (d) (pages 5 and 6), the bill would require all projects included in the Innovative Programs portion of county MHSA plans to meet a number of very specific requirements.

CMHDA is concerned that this additional language would establish a state-level perspective on what local communities may consider to be an "innovative approach". The purpose of Innovative Programs is already defined in the statute [Section 5230(a)], and the language in the bill places into state law a level of specificity and micromanagement that concerns counties. The language added in subdivisions (b) through (d) of Section 5830 would place into statute the administrative guidelines from a DMH Information Notice issued in 2009.

While counties have been *guided* by this DMH Information Notice in the development of their Innovative Programs, we are concerned that local flexibility and creativity may be inhibited if the counties are required under state law to select from a specified menu of approaches and purposes considered to be "innovative." The proposed language additionally requires that innovative projects proven to be "successful" transition to another category of funding.

Requested Amendment: We believe existing law as passed by voters in 2004 already states the required purposes of the Innovative Programs counties develop with local stakeholder input, and respectfully request the additional language contained in Section 5830 (b), (c), and (d) be removed from the bill.

Technical Suggestions

- *Comprehensive Joint Plan for a Coordinated Evaluation*

In Section 5845(d)(12) of the bill (page 10), the MHSOAC is required to work in collaboration with DHCS, the California Mental Health Planning Council, and in consultation with CMHDA, to design a comprehensive joint plan for coordinated evaluation of client outcomes in the community-based mental health system. The bill requires the California Health and Human Services Agency to lead the effort.

CMHDA would suggest this provision be added to a different section of the Act, for technical reasons. Currently, Section 5845 establishes the MHSOAC, describes its membership, and authorizes it to perform a number of activities in carrying out its duties and responsibilities. Since the language of this provision of the bill charges the California Health and Human Services Agency to *lead* the evaluation effort described, in collaboration with others, we believe a better location for this language would be in Section 5899, which requires the development of the Annual MHSOAC Revenue and Expenditure Report for evaluation purposes.

Suggested Amendment: We would suggest the language currently contained in Section 5845(d)(12) (page 10) be deleted, and then added to Section 5899, with minor, technical edits. As a result, Section 5899 would read as follows:

*5899. (a) **The California Health and Human Services Agency shall** work in collaboration with the **Mental Health Services Oversight and Accountability Commission**, State Department of Health Care Services, the California Mental Health Planning Council, and in consultation with the California Mental Health Directors Association, to design a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in **Section 5845, subdivision (a)**.*

*(b) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report **to be used for evaluation purposes**. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.*

- *Establishment of Performance Outcomes*

Section 5848(c) of the bill (page 14) requires that DHCS establish the performance outcomes for services funded by the MHSOAC *jointly* with the MHSOAC, and in collaboration

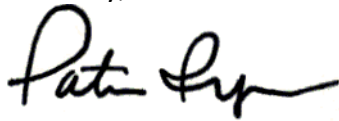
with CMHDA. Since the California Mental Health Planning Council has a clear role under existing law pertaining to oversight of the community mental health system, we believe this body should be included in this activity as well.

Suggested Amendment: In order to include the California Mental Health Planning Council, we would suggest amending Section 5848(c) to read as follows:

(c) ~~The department shall establish requirements for the content of the plans.~~The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established *jointly* by the ~~department~~ *Department of Health Care Services, the **California Mental Health Planning Council**, and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.*

Thank you for your continued commitment to and leadership in California's community mental health system. We appreciate your goal of providing clarity to the continued implementation of the Mental Health Services Act, and thank you for considering our suggestions to this bill. Please do not hesitate to contact us at (916) 556-3477, ext. 108, pryan@cmhda.org, or kbaylor@co.slo.ca.us with any questions you may have.

Sincerely,



Patricia Ryan
Executive Director, CMHDA



Karen Baylor
Mental Health Director, San Luis Obispo County
President, CMHDA

Cc: Honorable Chair and Members, Senate Health Committee
Diane Van Maren, Policy Consultant, Office of Senate Pro Tempore Steinberg
Scott Bain, Consultant, Senate Health Committee
Joe Parra, Kirk Feely, Consultants, Senate Republican Caucus
Michelle Baass, Consultant, Senate Budget Committee
Andrea Margolis, Consultant, Assembly Budget Committee
Kelly Brooks, California State Association of Counties
Cyndi Hillery, Regional Caucus of Rural Counties
Jolena Voorhis, Urban Counties Caucus
Kiyomi Burchill, Assistant Secretary, California Health & Human Services Agency
Vanessa Baird, Deputy Director, DHCS
Kathy Gaither, Chief Deputy Director, DMH
John Doyle, Carla Castaneda, Department of Finance
Sherri Gauger, Executive Director, MHSOAC
Jane Adcock, Executive Director, California Mental Health Planning Council



**San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act
P u b l i c C o m m e n t F o r m**

Personal information (OPTIONAL)

Name: _____ Agency/Organization: _____

Phone Number: _____ Email address: _____

Mailing address: _____

Stakeholder group you identify with:

MH Client/Consumer AOD Client/Consumer Family Member

Education Law Enforcement/Criminal Justice Probation

Social Services Service Provider Other (specify) _____

Your comments here (please use as many pages as you need):

Please turn over →

You may also send your comments via letter or email to Sandra Santana-Mora, San Mateo County MHSA Coordinator
ssantana-mora@smcgov.org - 225 37th Avenue – 3rd Floor – 650.573.2889

Comments: