# MENTAL HEALTH SERVICES ACT (MHSA)
# THREE-YEAR PROGRAM and EXPENDITURE PLAN
# COMMUNITY SERVICES AND SUPPORTS
# Fiscal Years 2005-06, 2006-07, and 2007-08

County: San Mateo Date: 11/15/05

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# EXECUTIVE SUMMARY

San Mateo County's proposed Mental Health Services Act (MHSA) Three-Year Program and Expenditure Community Services and Supports Plan is grounded in the vision and ideas of hundreds of stakeholders who participated in the MHSA planning process as well as the results of a community outreach process that involved over one thousand community members.

The San Mateo County Mental Health Services Division's mission provides a foundation:

> To provide public mental health services that promote wellness, resilience and equity and support individuals with emotional disturbance/mental illness to achieve their potential and live as contributing and successful members of their families and communities.

Transformation: Kathryn Powers, Director of the Federal Center for Mental Health Services, provided the mantra for San Mateo County's MHSA planning process.

TRANSFORMATION = VISION + BELIEF (VALUES) + ACTION
x CONTINUOUS QUALITY IMPROVEMENT[2]

San Mateo County's Plan embraces this vision of positive system transformation as well as the essential elements of the Mental Health Services Act: community collaboration; cultural competence; client/family driven mental health system; wellness/recovery and resilience focus; self-directed care; and integrated services.

Outcomes: San Mateo County's Plan will make a difference for seriously emotionally disturbed children and youth, and seriously mentally ill adults and older adults and their families. We believe that San Mateo County's recent planning process has the potential to fuel system reform that reaches far beyond the programs directly funded through the $4.9 million that is our annual MHSA budget. Among the anticipated outcomes resulting from San Mateo County's transformation:

- Equity and access for un-served populations through culturally sensitive and effective services
- Meaningful use of time and capabilities (school, work, and social and community activities)
- Reduced homelessness and increased access to safe and adequate permanent housing
- A network of supportive relationships
- Timely access to needed help, including times of crisis
- Reduction in incarceration in jails and juvenile halls
- Reduction in involuntary services and institutionalization, and fewer out-of-home placements



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## Program Strategies

San Mateo County's proposed Plan contains eight program strategies. MHSA planning participants under the leadership of the Mental Health Board and a Steering Committee had the difficult task of prioritizing these from among many worthwhile strategies, but there was strong support for the balance of strategies contained in the proposed Plan.

These eight program strategies fall into the three broad approaches that are summarized in Exhibit 4 and described in detail in Part II, Section 6 of the full Plan. These three broad approaches include:

- Outreach and Engagement Strategies, which will increase access to services for historically under-served populations and communities; and
- System Transformation Strategies, which will increase the cultural competence of the system, expand its use of evidence-based practices, and expand its capacity to utilize peers, family members, and consumers as providers of services; and
- Full Service Partnerships, which will use over 50% of the MHSA funding and provide intensive support for populations most in need of comprehensive services available 24/7.

Program strategies target engagement of un-served/under-served seriously emotionally disturbed (SED) children, adolescents, and transition age youth and seriously mentally ill (SMI) adults and older adults, including those with co-occurring alcohol and other drug and/or medical conditions. Increased equity in access and engagement, the reduction of disparities in access and engagement of ethnic/racial/linguistic and geographically under-served communities is a consistent focus across program strategies. Other areas of focus that are consistent across the program strategies are: peers and parent partners as integral members of the service delivery system, co-occurring disorders addressed wherever consumers are served, cultural competence throughout the system, and housing as a component of each of the Full Service Partnerships. It should be acknowledged that these MHSA initiatives build on existing strong agency and community partnerships including health and human services agencies, substance abuse providers, criminal justice, aging and older adult services, homelessness and housing development organizations, schools and community colleges, mental health providers, private philanthropic organizations and a network of city and County social support services.

## Full Service Partnerships (FSPs)

FSP's provide intensive support and treatment to individuals with the highest level of mental health need/risk. They have a high staff to client ratio and offer seven days per week/24-hour per day support. Highly individualized and flexible services provide "whatever it takes" to support individuals in the community.

### 1. Full Service Partnership, Children/Youth/Transition Age Youth

This program will help our highest risk children and youth with serious emotional disorders remain in their communities, with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. This program will also provide specialized services to transition age youth (TAY) aged 16 to 25 with serious emotional disorders 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 will be 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 our current mental health service population. Each FSP team will have specific population-focused expertise and services; however, supervision of both teams by a single person will assure collaboration between teams so that youth members are able to access age/development appropriate services and programs as they age and their individual needs change. Each FSP team will provide essential continuity in relationships while assuring access to specialized services (such as trauma-focused, gender or sexual-orientation focused treatment and support) across teams.

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| FSP, Children/Youth/Transition Age Youth (80 contracted slots)<br>This FSP program contains two 40-slot teams: one for Children/Youth, one for TAY, staffed to reflect the diversity of those populations. The program will use a Wrap Around approach including 24/7 response, high staff to client ratios for intensive mental health services, linkage to housing, supported education, AOD treatment and skills based interventions, parent partners and peer supports including a drop-in center. | Staff:<br>1.0 FTE Supervising Mental Health Clinician<br>1.0 FTE Mental Health Program Specialist<br>2.0 FTE Mental Health Counselors<br>4.25 FTE Mental Health Clinicians, certified or skilled in AOD assessment and treatment<br>2.37 FTE Parent/Caregiver Partner (Community Worker)<br>0.5 FTE Psychiatrist<br>Drop-in Center:<br>1.5 FTE Community Workers<br>1.5 FTE Work Study Peer Partners<br>Supported Education:<br>1.25 FTE Mental Health Counselors<br>+admin support, housing, flex funds and vehicles |

2. Full Service Partnership, Adults

This FSP for seriously mentally ill and dually diagnosed adults is based on effective practices of the AB2034 Program and national models of assertive community treatment. The program will offer a 1:10 staff ratio, intensive, field-based mental health services and "whatever it takes" to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities). There will be peer support, housing subsidies, and linkage to supported education, supported employment and other resources. Seriously mentally ill and dually diagnosed individuals to be served by the partnership include: 1) those eligible for diversion from criminal justice incarceration if adequate multi-agency community supports can be provided; 2) currently incarcerated individuals for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization; 3) individuals placed in locked mental health facilities who can succeed in the community with intensive supports; and 4) 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 will focus on engagement of Latino, African American and Pacific Islander populations that are over-represented in the criminal justice system and under-represented in the mental health system.

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| FSP, Adults<br>(55 contracted slots)<br>There will be mental health treatment and service coordination including integrated services for co-occurring AOD, peer support, housing support and subsidies, and linkage to supported education, supported employment, health care and access to community activities and resources. | Staff:<br>1.0 FTE Supervisor (Mental Health Program Specialist)<br>0.5 FTE Psychiatrist<br>1.0 FTE Nurse<br>2.0 FTE Mental Health Clinicians<br>1.0 FTE Peer Partner (Community Worker)<br>0.5 FTE Vocational Counselor<br>+admin support, housing, flex funds and vehicles |

3. Full Service Partnership, Older Adults (and Medically Fragile Transition Age Adults)
   The Full Service Partnership for Older Adults will offer intensive 24/7, field-based and in-home mental health services and supports for older adults and 'transition age' adults that are seriously mentally ill, are currently or at risk of being institutionalized, and could live in a community setting with more intensive supports. These older adults and transition age adults have a high rate of co-occurring medical conditions that exacerbate or impact their ability to remain in home/community environments. The program will particularly seek to serve Latino, Asian and Pacific Islander individuals as these populations are under-represented in the current mental health service population.

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| FSP, Older Adults/Medically Fragile Transition Age Adults<br>(60 contracted slots)<br>The program will include integrated treatment and service coordination, peer counseling and support, housing subsidies, an emergency shelter bed, dedicated board and care respite bed as well as physical health care support. | Staff:<br>1.0 FTE Supervisor (Mental Health Program Specialist)<br>0.5 FTE Psychiatrist<br>1.0 FTE Nurse<br>2.0 FTE Mental Health Clinicians<br>1.0 FTE Peer or Family/Caregiver Partner (Community Worker)<br>+admin support, housing, flex funds and vehicles |

Outreach and Engagement

4. Community Outreach and Engagement
   The goal is to identify and engage individuals that are currently un-served and need mental health services. This program will build bridges with ethnic and linguistic populations that experience health disparities and may experience mental health services as unresponsive to their needs. Strategies include population-based community needs assessment, planning and materials development as well as hiring of community based "navigators" and primary care based services to identify and engage diverse populations in services. Community Workers will build relationships with neighborhood and cultural leaders to ensure that under-served communities are more aware of the availability of mental health services and so that these leaders and their communities can have more consistent input about how their communities are served.

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| Navigator Program--Bilingual/bicultural community-based "navigators", contracted outreach workers, will collaborate with health outreach programs, community services and resources including the faith community. Outreach to Latino, Filipino, Chinese, Pacific Islander and African American populations of all ages with emphasis on specific communities in different parts of the County. Navigators may be peers or parent partners, but must be bilingual, bicultural and connected to the community. | Staff:<br>1.0 FTE Community Worker, Asian/Latino focused in northern region<br>1.0 FTE Community Worker, Latino/African American/Pacific Islander focused in southern region<br>0.5 FTE Community Worker, Latino focused on Coast<br>+ admin support and vehicles |
| Cultural Disparity Grants--Develop three year grant processes for capacity building in Filipino, Chinese, Pacific Islander and African American communities (building on existing Latino Access initiative): outreach, planning process/needs assessment, pilot projects, materials development, human resources development, networking and training for improved mental health resources and response to these communities. | Various contracts |
| Expand County-operated primary care interface team for children/youth in two regional primary care clinics with pediatric populations to provide consultation, assessment, and brief treatment in northern and southern regions, with the possibility of providing services to the Coastside region.<br>Create County-operated field-based primary care consultation, assessment, brief treatment team targeting SMI older adult clients of primary care providers serving Latino, African American, Asian populations in northern and southern regions. | Staff:<br>2.0 FTE bilingual/bicultural Mental Heath Clinicians (one Asian, one Latino)<br>1.0 FTE Child Psychiatrist<br>+admin support<br><br>1.0 FTE bilingual/bicultural Asian/Latino/or African American Mental Health Clinician<br>0.5 FTE Psychiatrist<br>0.5 FTE Nurse<br>+admin support and vehicle |
| Improve linkage to mental health services following crises by adding a licensed mental health clinician to the existing 24-hour crisis hotline operated by Youth and Family Enrichment Services during peak hours so there is enhanced ability to respond in the community to urgent situations and link that service to | Staff:<br>1.0 FTE licensed Mental Health Clinician<br>+admin support |

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| existing Community Response Team for added support during major community events. | |

System Development: Transformation

5. School Based Services

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| This program will identify and serve seriously emotionally disturbed youth at several middle schools. Many of these youth are at risk of school drop out, substance use/abuse, gang involvement/juvenile justice or child welfare involvement. This program will offer mental health services on-site at the school, eliminating barriers to access. | Staff:<br>4.0 FTE bilingual/bicultural Mental Health Clinicians<br>+admin support |

6. Pathways—A Court Mental Health Program

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| Pathways will be a partnership of the San Mateo County Courts, the Probation Department, the District Attorney, the Private (Public) Defender, the Sheriff's Office (local Police Chiefs as appropriate), Correctional Health, and the Mental Health Services Division. Pathways for SMI and dually diagnosed individuals (non-violent misdemeanants) will establish three paths to treatment: a) diversion from the criminal justice system b) post adjudication alternatives to incarceration; and c) post adjudication intensive supervision. For each of these paths, the goal would be improved outcomes for SMI and dually diagnosed offenders by integrating judicial and criminal justice sanctions/approaches and addressing individuals' underlying behavioral health problems that underlie or contribute to involvement in the criminal justice system. | Staff:<br>1.0 FTE Mental Health Clinician<br>0.5 FTE Family Liaison (Community Worker)<br>0.5 FTE Consumer Liaison (Community Worker)<br>+admin support<br><br>3 Probation Officers required by the Court will be pursued through other funding sources. |

7. Older Adult System of Care Development

This program will create a coherent, integrated system of care for seriously mentally ill older adults to support older adults to remain in their homes and community and in optimal health. The intent is to assist seniors to lead dignified and fulfilling lives, sustaining and maintaining independence and family/community connections to the greatest extent possible. This program builds on an existing in-

home assessment and brief treatment program and a well established (over 15 years) Senior Peer Counseling Program. To increase access by culturally and linguistically diverse populations, services will focus on specific ethnic/linguistic populations in different regions of the County.

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| This initiative creates an Older Adult Clinical Services Manager to develop and manage older adult services and system of care with linkages to other older adult systems. In addition to the older adult focused FSP and primary care based services, this initiative includes ethnically/linguistically appropriate senior peer counseling and in-home nurse supports for medications and other daily requirements for SMI individuals. | Staff:<br>1.0 FTE Older Adult Clinical Services Manager<br>3.0 FTE contracted Peer/Family Partners (Community Workers)<br>0.5 FTE Nurse Case Manager with linkage to Aging and Adult Services to provide home care assistance to home bound older adults.<br>+admin support and vehicle |

8. System Transformation and Effectiveness Strategies

Throughout the MHSA outreach and planning process, participants addressed the need to transform many aspects of the system to truly enact wellness and recovery philosophy and practice and increase effectiveness, particularly with un-served ethnic and linguistic populations. Elements identified as critical to system transformation included a renewed focus on recovery/resilience and increased capacity and effectiveness of current County and contractor services through an infusion of training, hiring bilingual/bicultural clinicians, expanded peer/peer-run services and hiring of consumers and parent partners as service providers as well as implementation of evidence-based and culturally competent practices. All populations served by the Mental Health Services Division will 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.

System-wide Training:

- Multi-year integrated services program development and training for co-occurring alcohol, other drug, and psychiatric disorders for all providers serving all ages. System design process will be co-chaired by the County's Mental Health Director and AOD Administrator and will include County and contracted service providers from AOD and the Mental Health Services Division.
- Cultural competence training for all providers serving all ages.
- Sexual orientation and gender focused services effectiveness training for all providers.
- Family support and education training for all providers (consider SAMHSA toolkit).
- Cognitive behavioral approaches for all clinicians serving all ages, including Trauma-focused Cognitive Behavioral Therapy for those serving populations affected by trauma (children/youth in the child welfare system, girls and young women, etc.).
- Wellness and recovery training including the SAMHSA wellness management and recovery toolkit and Wellness Recovery Action Plans (WRAP) for providers serving transition age youth, adults and older adults. Wellness and recovery training would include modules led by consumers and family members.

- Other Evidence Based Practices as resources permit, which might include expansion of Functional Family Therapy (FFT) and Dialectical Behavioral Therapy, now available to a small proportion of clients, mostly in specialty programs.

Consumer and Family/Parent Partners Academy:

- Intended to address the major expansion in consumer and parent/family member employment, especially bilingual individuals.
- Training and continuing education and support for these individuals.
- The design of the Academy curriculum will begin this fall, involving peers and parent partners as well as service providers.
- This training program will build on a long-term collaborative program with the San Mateo Community College District (College of San Mateo) including a peer counseling program, human services certificate program, private non-profit organizations and the Human Services Agency's Vocational Rehabilitation Services (VRS) supported employment services.

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| Peer and Parent Partners bilingual/bicultural to offer Asian, Latino, African American and other consumers and families support, consultation, self-help groups, peer counseling and social activities. | Staff:<br>6.0 FTE County-employed Peer Partners (Community Workers)<br>5.0 FTE contracted Parent Partners (Community Workers)<br>0.2 FTE Benefits Specialist<br>+admin support |
| Neighborhood-based peer run self-help center in East Palo Alto or South Redwood City area with adult focus and Latino/African American/Pacific Islander bilingual/bicultural capability. | Contracted expansion of existing service with 2.0 FTE bilingual/bicultural Peer Self-help Partners<br>+admin support |
| Expand staffing in each of five regional County clinics (North, Central, South, East Palo Alto, and Coastside) and add a contractor resource to increase capacity for evidenced-based, culturally competent practices including integrated treatment for co-occurring disorders, cognitive behavioral treatment, including skills development and gender sensitive/LGBTQ sensitive trauma focused treatment. | Additional Clinical Staff:<br>5.0 FTE bilingual/bicultural Mental Health Clinicians serving adults and older adults<br>4.0 FTE bilingual/bicultural Mental Health Clinicians serving children and youth<br>1.0 FTE Contractor Resource to develop and sustain integrated treatment of co-occurring disorders in contract agencies.<br>+admin support |
| Expand cultural/linguistic internships for clinicians in-training. | Add 10 internship stipends. |
| Expand access to job developer and job coach by FSP enrollees and others. | Expand State Department of Rehabilitation/Department of Mental Health Cooperative Agreement |

## Planning Process

San Mateo County's Mental Health Services Act (MHSA) Community Services and Supports planning process was designed to facilitate meaningful participation from a broad range of stakeholders including members of historically un-served and under-served communities. A structured planning process involved the Mental Health Board (MHB); a MHSA Steering Committee; and Child and Youth, Transition Age Youth, Adult and Older Adult Work Groups. All MHB, MHSA Steering Committee and Work Group Meetings were open to the public.

Each of the four Work Groups met in a series of five full and half day facilitated meetings from March to June 2005. The Work Groups gave stakeholders the opportunity to review the results of prior planning efforts, local service utilization data, descriptions of existing community services and supports, summaries and presentations on best practice research and findings from focus groups and community meetings. Work Groups were also the locus for providing input into the planning process and prioritizing target populations, focus issues, and high priority strategies for each age group. Throughout the process, Work Groups forwarded their recommended priorities to the Steering Committee for review and comment.

The President of the San Mateo County Board of Supervisors and the Chair of the MHB co-chaired ongoing MHSA Steering Committee Meetings. Comprised of over 50 community leaders, including all MHB members, the Steering Committee met monthly to review Work Group deliberations and priorities and to provide comment and feedback to the Work Groups. This planning culminated in a joint meeting on June 10th at which Work Group members and Steering Committee members reviewed the priorities of all four Work Groups and reflected on the feedback from the community outreach process. They worked in small groups and one large plenary to generate an integrated set of priorities and budget reflecting the recommendations of all four Work Groups.

The Mental Health Services Division conducted an intensive community outreach process to assure there would be substantial, meaningful input from consumers, family members, and representatives of populations that have been historically un/under-served by the Mental Health Services Division and would be unlikely to participate in formal planning meetings. The Mental Health Services Division partnered with numerous community stakeholders to conduct over 100 focus groups and community meetings targeting un/under-served populations, which were held in all communities in the County between March and June, and input was received from over 1,000 individuals. The two Youth Commissioners serving on the Mental Health Board also conducted a mental health awareness survey of high school students that generated over 1,000 responses.

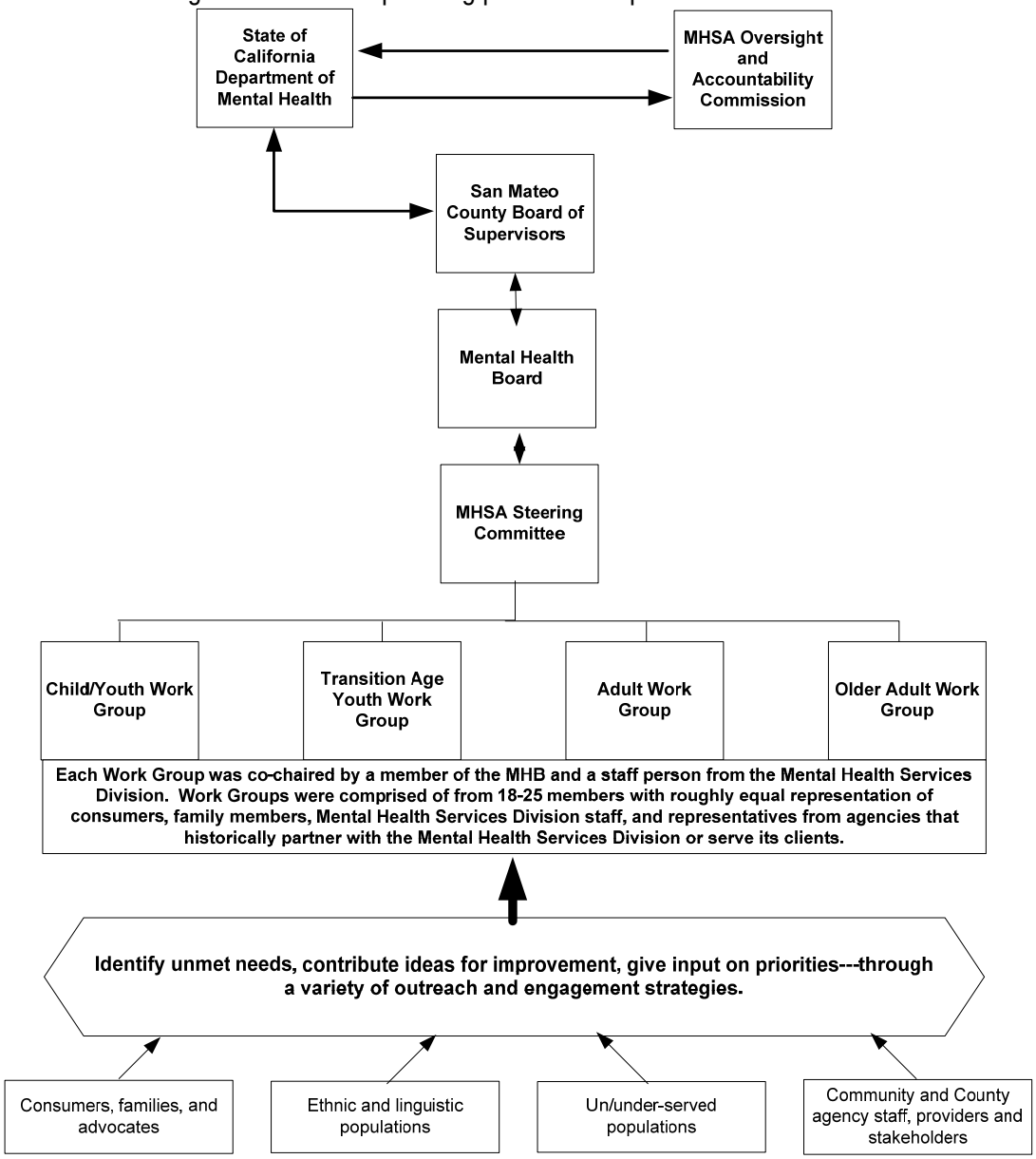
Notes from Steering Committee and Work Group meetings, focus group and community meetings, and information about the MHSA and San Mateo County's local planning process were updated regularly on the County's Network of Care website http://sanmateo.networkofcare.org

# PART I: COUNTY / COMMUNITY PLANNING PROCESS & PLAN REVIEW

## SECTION 1: PLANNING PROCESS

### 1.1 DESCRIPTION OF LOCAL PUBLIC PLANNING PROCESS

San Mateo County's local Mental Health Services Act (MHSA) planning process was designed to facilitate meaningful participation from a broad range of stakeholders including members of historically un-served and under-served communities. The information collected through an ambitious outreach process was integrated within a more structured planning process involving the Mental Health Board (MHB), a MHSA Steering Committee, and Child and Youth, Transition Age Youth, Adult and Older Adult Work Groups. The structure used to govern the entire planning process is depicted below.



Richard Gordon, President of the San Mateo Board of Supervisors, and Raja Mitry, Chair of the Mental Health Board, agreed to co-chair the MHSA Steering Committee, and worked with Mental Health Services Division staff to develop the composition, roles and responsibilities of the Steering Committee and Work Groups depicted in the graphic above. The Mental Health Board approved the draft planning process proposal before it was submitted for approval to the California Department of Mental Health (DMH). Together, the Steering Committee co-chairs secured the commitment of a broad cross-section of community and organizational leaders and mental health consumers, family members and advocates to comprise the Steering Committee (Appendix A).

The vision, mission, and values of the Mental Health Services Division identified in Appendix B were enhanced by principles for the planning process (Appendix C) that were adopted to assure consistency with the Mental Health Services Act; meaningful and effective involvement of consumers and their families, providers, other stakeholders and the diverse populations and communities of San Mateo County; and accountability of the process back to its participants.

Mental Health Board members (including two consumers, two family members and the two youth commissioners) agreed to serve as co-chairs of the MHSA Work Groups along with Mental Health Services Division staff, and together the co-chairs recruited 18-25 members for each of the four Work Groups (Appendix D). They attempted to achieve a balance of ethnic/linguistic diversity, representation from consumers, family members, mental health services providers, and representatives of agencies that historically collaborate with the Mental Health Services Division or serve its consumers. Securing the genuine involvement of a broad cross section of consumers and family members was viewed as central to the success of the MHSA planning process, and there were limits placed on the number and proportion of County staff and mental health providers who could be on any one work group to assure balance. To facilitate the sustained involvement of consumers and family members, stipends, taxi vouchers and travel arrangements were provided and meetings were located throughout the County including neighborhoods closer to consumer and family residences, rather than at County offices. As a result, the Work Groups responsible for developing the priorities that would guide the MHSA transformation involved a significant number of consumers and family members, some of whom had never participated in any form of mental health planning process. (One of the benefits of the Work Group process was that some participants became interested as a result of the process in becoming regular participants in the Mental Health Board child/youth, adult, and older adult committees, which have an ongoing role in advising the Mental Health Board.) The Work Groups used a flexible approach that incorporated into the process any community or consumer members that additionally attended one or more sessions. The table below summarizes the composition of the Work Groups. Co-chairs and facilitators attempted to design the meeting activities to assure meaningful participation of all the Work Group members, and they assured consumer and family member participants were not marginalized in the process.

Please note that Work Group and Steering Committee members identified themselves in one or more of the categories below.

| Membership | Child/Youth Work Group | Transition Age Work Group | Adult Work Group | Older Adult Work Group | Steering Committee |
|---|---|---|---|---|---|
| Consumers | 3 | 3 | 6 | 5 | 7 |
| Family Members | 3 | 1 | 5 | 4 | 7 |
| Mental Health Services Providers | 7 | 6 | 6 | 7 | 14 |
| County Staff | 8 | 6 | 9 | 5 | 11 |
| Partners (e.g. CBO's and other county agencies serving individuals with mental illness | 4 | 4 | 4 | 1 | 25 |
| Additional Participants | 12 | 18 | 19 | 14 | |

In addition, the Steering Committee itself was comprised of seven consumers and seven family members out of a total number of 51. Additional participants at each of the meetings included consumers, family members, and other stakeholders who did not participate on a regular basis.

The Mental Health Services Division also conducted an intensive community outreach process to assure there would be substantial, meaningful input from consumers, family members, and representatives of populations that have been historically un-served or under-served by the Mental Health Services Division and would be unlikely to participate in formal planning meetings. The design for the Communication Plan for Transforming the System: Sources of Input to Mental Health Services Act (MHSA) Planning (Appendix E) evolved from an initial meeting of over 20 consumers, family members, providers, and MHB members in early February, and by the time it was approved by the Steering Committee, it contained a plan for outreach to dozens of community-based agencies, cultural organizations, community centers, regional leaders, and other institutions that serve populations and communities that are historically un/under-served by the Mental Health Services Division. The Mental Health Services Division partnered with numerous community stakeholders to conduct over 100 focus groups and community meetings targeting un/under-served populations, which were held in all communities in the County between March and June, and input from over 1,000 individuals was received.

As a first step, a focus group protocol and questions for different groups (consumer, family member, community member, or un-served community) were developed to address issues of access, services and supports, and quality of life. Questions were open-ended and qualitative in nature, with the goal of gaining a wide-range of perspectives. Facilitators from the Mental Health Services Division, consumers, family members, consultants, and community agency staff were trained in the focus group protocol. With a goal of securing the voice of populations that are historically un/under-served, outreach focused on consumers and family members, historically un/under-served populations and regions, community organizations and service providers.

Meetings and focus groups were held in all regions of the County in venues where un/under-served populations reside or are served including juvenile hall, jail, group homes, senior centers, community centers, schools, homeless shelters, and other venues. Some focus groups were conducted in Spanish, Tagalog, Chinese, and Tongan. Results were recorded, posted on the Mental Health Services Division's Network of Care website http://sanmateo.networkofcare.org, coded and assembled into a data base that facilitated analyzing perceptions by age group, culture or language, region, as well as by provider, consumer or family member. Written reports and visual slide presentations summarizing findings were generated for each Work Group and reviewed prior to prioritizing issues, target populations and strategies. The Mental Health Services Division sees outreach activities for the MHSA planning process as a starting point to a sustained dialogue with neighborhood and cultural leadership so that communities can be informed of the mental health services available and can participate in shaping how those services are delivered. Through the outreach process, the Mental Health Services Division now has contacts among community and cultural leaders that will be used to sustain this dialogue.

An outreach list of all the focus groups and community meetings that were held along with the number of participants in each may be found in Appendix F. Copies of the Community Input and Feedback reports and presentation can be found in Appendix G and H. In addition, we have maintained the detailed reports for each focus group on our Network of Care website. The Mental Health Services Division expects the findings of this substantial outreach effort to inform many years of system improvement initiatives.

The following outreach strategies were used to identify participants for the focus groups and community forum meetings:

- Posters and fliers were created and placed at clinics, as well as in high-traffic venues throughout the County such as libraries, stores and Laundromats. The flyers were also mailed to a 1,500 person database developed over time. E-mail was used for some outreach. The posters and fliers announced the MHSA planning process and its intent to transform the system, making it more responsive to the needs of the un/under-served and inviting individuals to attend community meetings scheduled throughout the county. Bilingual flyers were used to target non-English speaking communities.
- Refreshments and food were provided, and participants were offered stipends for their time and to cover childcare expenses. Taxi vouchers were provided to facilitate transportation for those who needed assistance.
- Several focus group meetings were conducted in Spanish (6), Tagalog (2), Chinese (2) and Tongan (2), and other events were facilitated with interpreters and translated materials. Focus groups were conducted whenever possible by facilitators of the same culture, for example, groups targeting African American perspectives were led by African American facilitators.
- Instead of expecting people to attend an event off-site, there was outreach to people where they live, for example, in long-term care facilities and group homes. Senior Mental Health Services Division staff interviewed their home-bound clients.
- Multilingual mass media was used to inform the community and invite participation in the regional community public forums. Advertisements were placed in local newspapers in English and Spanish, on-line at community websites, and on television through public service announcements in Spanish and English. Two people participated in a local Chinese language televised talk-show that focused on the MHSA.

- Individuals and organizations with a history of organizing consumers and family members and working with un/under-served populations were solicited to assist in the outreach effort, and they also enlisted community leaders to help (e.g. faith community and leaders of cultural organizations).
- Local government contacts helped the Mental Health Services Division organize outreach to local community-based organizations for the community forums in their region.
- A dedicated e-mail box was created for people to submit recommendations directly to the planning process.
- Our Network of Care website contained information about the MHSA, information about the local planning process including information about how to be involved, a meeting calendar, copies of recent documents and meeting notes, and an immediate "respond" button for people who wanted to send questions or comments.

As a measure of the level of financial commitment to consumer, family member, and un/under-served population involvement, the following expenditures were directly related to sustaining consumer, family member, and un/under-served population involvement in planning:

- Personal stipends at $25 per meeting—$14,800 for 592 stipends.
- Travel payments—$954 for taxi vouchers.
- Food at meetings— $27,852 for 100+ meetings involving over 1,000 people.

## 1.2 DESCRIPTION OF HOW THE PROCESS WAS COMPREHENSIVE & REPRESENTATIVE

As can be seen from the list of focus groups and public community forum meetings described in 1.1 above and attached in Appendix F, San Mateo County's MHSA planning engaged a significant number of consumers, family members and representatives of un/under-served populations throughout the community. *To reach un/under-served youth*, focus groups were held at schools, health centers, juvenile hall, foster care programs, youth centers, and programs that provide counseling to youth. Forty-one groups involving 586 participants addressed transition age youth issues. Thirty-eight groups involving 456 participants addressed child and youth issues. In addition, the MHB youth commissioners developed a survey and distributed it to over 1,000 high school students. *To reach un/under-served adults,* focus groups were held in homeless shelters, SNF/locked facilities and mental health rehabilitation centers, supported housing, at the jail, at community centers and with landlords. *To reach un/under-served older adults,* focus groups were held at senior centers, group homes, and home-bound older adults were interviewed by staff. Twenty-two groups involving 276 participants addressed older adult issues. *To reach culturally/linguistically diverse and un/under-served populations,* focus groups were conducted in Spanish, Tagalog, Chinese and Tongan and focus groups that targeted African Americans were organized in convenient locations throughout the County. There were at least 82 people who participated in Spanish, 29 who participated in Tagalog, 33 who participated in Chinese, and 12 who participated in Tongan. In addition, there were representatives of these communities who participated in English. A Native American consumer was a member of the Adult Work Group, and Native American community members participated in two community meetings. *To reach geographically un/under-served populations,* focus groups and larger community meetings were organized in consort with broadly recognized community leadership in Daly City, South San Francisco, Pacifica, Half Moon Bay, Pescadero, Redwood City, and East Palo Alto, as well as many other population centers in the County. *To reach the faith community,* there was a focus group held with religious leaders. *To reach family members,* National Alliance for the Mentally Ill (NAMI) members participated in focus groups and invited all their members to a focused discussion regarding the

MHSA, existing family support groups participated in focus groups, and a forum was held specifically inviting the perspectives of parents. There were at least 107 participants in the process who identified themselves as family members. *To reach consumers,* consumer leaders designed and facilitated a "Consumer Speaks" forum and smaller focus groups were held in mental health programs, residential settings, juvenile hall, the jail, and at the monthly "supper club." There were at least 387 participants in the process who identified themselves as consumers. The outreach process focused on inclusion of mental health consumers and their families and un-served populations who are not generally part of advocacy efforts.

A series of five full and half day facilitated Work Group meetings were used to afford stakeholders a forum for providing input into the planning process. The Work Groups were organized by age group (child/youth, transition age youth, adult, and older adult) with each Work Group comprised of 18-25 consumers, family members, providers and representatives of agencies that historically collaborate with the Mental Health Services Division or serve its clients. Work Groups were co-chaired by a Mental Health Board member and a Mental Health Services Division staff member. Over a period of three months, each Work Group met for a total of 30 hours to review the results of prior planning efforts, local service utilization data, descriptions of existing community services and supports, summaries and presentations on best practice research and findings from the focus groups and community meetings. Work Groups were also the locus for prioritizing target populations, focus issues, and high priority strategies for each age group. Throughout the process, Work Groups forwarded their recommended priorities to the Steering Committee for review and comment. While each Work Group spent time considering the issues related to untreated mental illness identified by the State, the Work Group process devoted more time to considering which un/under-served populations were in greatest need and which strategies could best address their needs and contribute to the transformation of the mental health system. Work Groups forwarded to the Steering Committee recommended priorities relating to:

- Which un/under-served populations should be served by Full Service Partnerships;
- What outreach and engagement strategies should be implemented throughout the system and serving all age groups; and
- What transformational structures, strategies and supports were most important to improving the quality of life of the consumers within each age group.

The Mental Health Services Division took a variety of steps to ensure the substantial involvement of consumers and family members, not only as participants in Work Group sessions, but as leaders in the planning process. The planning process convened the co-chairs to guide the scheduling of Work Group and Steering Committee meetings, plan the agendas, and review and revise materials to be shared with Work Group and Steering Committee members.

The dates, times and locations of each of the Work Group and Steering Community meetings were broadly publicized through the Kick-off meeting, mailings, and posting on the Network of Care website. A poster was created reminding people of the opportunity to participate at the Mental Health Board meeting each month, during which time was allotted for public comment.

Ongoing Steering Committee Meetings were co-chaired by the President of the San Mateo County Board of Supervisors and the Chair of the Mental Health Board. Comprised of over 50 community leaders, including all Mental Health Board members, the Steering Committee met monthly to review Work Group

deliberations and priorities and to provide comment and feedback to the Work Groups. This planning culminated in a joint meeting at which Work Group members and Steering Committee members reviewed the priorities of all four Work Groups and working in small groups and one large plenary generated an integrated set of priorities and budget reflecting the recommendations of all four Work Groups.

A more detailed discussion of the Work Group and Steering Committee process through which planning priorities were established is provided in Section 3 that follows.

## 1.3 PLANNING PROCESS LEADERSHIP & PLANNING

San Mateo's MHSA planning process has benefited from the participation of many stakeholders and countless hours of investment. The Steering Committee has been co-chaired by the President of the San Mateo County Board of Supervisors, Richard Gordon, and the Mental Health Board Chair, Raja Mitry, with significant involvement of MHB consumer and family members. Eunice Kushman, Katherine Kerns, Jim Fields, Alison Mills, Josephine Thompson, Valerie Gibbs, Stacy Clement, Natasia Kawi, and Andrew Calman each spent substantial time in their roles guiding the process, leading outreach initiatives, and co-chairing Work Groups. The MHSA planning process has been coordinated by Louise Rogers, Deputy Director of Operations for the Mental Health Services Division. She has overseen the planning and outreach processes and coordinated the work of contractors and staff who have supported the planning process. This has been an 80% time commitment since February. Gale Bataille, Mental Health Director, continues to spend 20% time addressing MHSA planning issues at state and local levels. In addition, Chris Coppola and Deborah Torres, the Deputy Directors of Adult and Youth Services, Carlos Morales, Adult Clinical Services Manager, and Diane Dworkin, the Supervisor of Older Adult Services, have each committed 20-30% time since February co-chairing Work Groups with MHB members. Two consulting firms, MCPP Healthcare Consulting and Paul Gibson and Associates, have provided substantial meeting facilitation, analysis, and document production to support the planning process. Jade Moy has provided analyst and planning support for the process. Pam Machado, Glenda Masis and Linda Lopez have provided primary administrative support for the process.

## 1.4 DESCRIPTION OF TRAINING PROVIDED TO STAKEHOLDERS

It is one thing to engage consumers, family members and other community members who historically do not participate in community planning processes and it is quite another to provide them with the kind of support, information and training that allows them to participate as equal partners with other Work Group and Steering Committee members who spend their lives looking at data, considering research and planning initiatives. Furthermore, there were large numbers of representatives from agencies that collaborate with the Mental Health Services Division or serve its clients (e.g. probation, housing, education) in the process who while professionals in their fields nonetheless, are not all grounded in issues related to the delivery of mental health services or the principles and values of the MHSA and its intent to transform how those services are delivered. The first major education and training activity was the full-day, March 4th Kick-off described below.

A March 4th, full-day Mental Health Services Act Kick-off launched San Mateo County's MHSA planning process. The Kick-off included 227 consumers, family members, Mental Health Services Division staff, Mental Health Board members, county administrators and staff from programs that routinely collaborate with the Mental Health Services Division and/or serve its clients. The purpose of the Kick-off was to orient these stakeholders to the MHSA, to begin to train stakeholders in issues related to mental health and the

transformation called for in the MHSA and to outline the various opportunities for stakeholders to become more involved in the planning process. As this proposal describes, virtually every meeting conducted during this process blended education and training of stakeholders with priority setting exercises that ultimately guided the development of this plan. As a result of this approach, San Mateo County's MHSA planning process has achieved two critical goals: building a core group of stakeholders' knowledge and understanding of the current mental health system, the MHSA, and the opportunity it poses to transform how services and supports are delivered and to create a plan generated by those stakeholders in such a way that they feel more than buy-in to this plan, but have a sense of ownership and authorship. In the end, the extent to which stakeholders were first oriented and trained and then afforded opportunities to make key recommendations and decisions throughout the process will result in a plan and a set of priorities that will be implemented with enthusiasm and rigor.

The Kick-off included a series of educational presentations by mental health experts, consumers, and family members designed to orient individuals to the MHSA, the principles of wellness and recovery and consumer-driven treatment services, the characteristics of a culturally competent system, and the goal of transforming the mental health system. Each presentation included consumers and family members providing their perspectives. After an overview, Pat Jordan, consultant, with Suzanne Aubrey and Felicitas Rodriguez, family members, presented Community Services and Supports for Children, Youth and Families. Vickie Smith from California Institute for Mental Health (CIMH) presented Community Services and Supports for Adults and Older Adults with Alison Mills, consumer, and Sharon Roth, family member. Roberto Gurza, Mental Health Services Division Cultural Competence Coordinator, and Linford Gayle, consumer and Coordinator of the Office of Consumer and Family Affairs, presented Cultural Competence. Jay Mahler, Linford Gayle, and Theresa Bassett, presented perspectives as consumers on Recovery and Resilience. These presentations also reflected Filipino, Latino, and African American perspectives.

The event concluded with attendees breaking into groups of 6-10 to identify the qualities of a transformed system. The lists generated were organized into a summary that organized these characteristics by theme and ranking them in order of those most frequently identified by stakeholders. This list was reviewed at all Work Group planning meetings throughout the process. (See Kick-off in Appendix I.)

Education and training did not end with the Kick-off. Every Work Group meeting was devoted in large part to providing information to Work Group members. Part II, Section 1, describes in detail how significant portions of every Work Group and Steering Committee meeting was devoted to training the stakeholders charged with shepherding the planning process. These activities included:

- Developing summaries of a wide range of prior planning efforts conducted by the Mental Health Services Division, housing, health, and criminal justice, as well as seminal studies like Mental Health: A Report of the Surgeon General and its supplement Mental Health: Culture, Race and Ethnicity; and the President's New Freedom Commission on Mental Health Report;
- Developing detailed data books that summarized County prevalence and service utilization data to underscore the populations that are historically un/under-served;
- Developing summaries of evidence-based practice research;
- Organizing a series of 60-minute presentations on a wide variety of 'best practices' that were delivered during the two days of Work Group meetings in Session II. Mental Health Services Division and Health Department staff, mental health contract providers, consumers and family

members led these presentations. Through these presentations, Work Group members were introduced to:

- Mental Health Services Courts;
- Supported housing strategies;
- Evidence-based practice (dialectical behavior therapy, cognitive behavior therapy, etc.)
- Wellness and recovery and wellness recovery action plans (WRAP);
- Integrated mental health and substance abuse treatment approaches;
- Trauma-focused treatment practices;
- Peer-based services and supports;
- Supported education and employment models;
- Family support services;
- Crisis service systems; and
- Culturally competent treatment approaches.

The materials described above were also distributed to Work Group members. Summaries were explicitly developed to avoid (or explain) jargon and abbreviations that are unfamiliar to members. The Work Group chairpersons were available between meetings to answer Work Group member questions and to help them understand these materials. Further, materials distributed in advance of meetings were also scheduled for discussion in Work Group meetings. Presentations like the 'best practices' presentations were immediately followed by questions and answers to help all stakeholders achieve a shared understanding of the materials. More specific accounts of the information that was presented and the presenters are contained in Part II of this document.

The regional public community forums that were held each began with a brief training component designed to provide information about the Mental Health Services Act and its vision, and what is known already about unmet need in those specific communities. Several consumers designed the training content for the Consumer Speaks forum, which was presented by consumers Alison Mills and Linford Gayle.

Training on evidence based practices for law enforcement and mental health collaboration was incorporated in a joint planning meeting, Criminal Justice and Mental Health: Planning for Transformation, attended by over 90 people.

Training provided throughout this process is summarized below by function:

a. Administrative / management: The Mental Health Services Division Director briefed County agency directors soon after the passage of the MHSA. The Mental Health Director and Deputy Director provided training about the MHSA to Mental Health Services Division and contractor administrative and clinical leadership and continue to provide and obtain information through monthly leadership meetings. Some individuals in these groups also participated in the Kick-off, Steering Committee or Work Groups. The San Mateo County Board of Supervisors also held a special study session to review requirements and anticipated programs to be funded to support system transformation.

b. Direct services—County staff: The Mental Health Services Division Director, Deputy Director, and a Quality Management staff person between them attended staff meetings for most of the direct

services teams to provide basic information about the MHSA and seek input in the planning process.

c. Direct services—contractors: Representatives of the contract agencies participate in the monthly leadership meetings described above. In addition, the Mental Health Services Division Director and Deputy Director provided information at monthly Contractor's Association meetings. The Deputy Director provided training and sought input from contractors at a focus group convened for that purpose. Some contractor representatives participated in the Kick-off, Steering Committee or Work Groups.

d. Support services: Support services staff were included in the County staff team meetings described above and a subset of them assisted with the Kick-off and other community events and received the same training as the other participants.

e. Interpreters: Interpreters participated in each of the public community forum meetings described below, and facilitated the non-English language focus groups. They received training about the Mental Health Services Act as part of the orientation and training for focus groups facilitators.

f. General public: The general public received information about the Mental Health Services Act and data about unmet need in specific communities through the public community forum meetings. Outreach for these events has been described above. In addition, public service announcements were made in English/Spanish on public television, and the Chinese community received information through a local televised talk show. Written information was provided on San Mateo County's Network of Care website and community websites such as EPA.net, East Palo Alto's community website, and the Half Moon Bay Review, the Coastside community weekly newspaper and website.

g. Mental Health Board: The Mental Health Board has addressed the MHSA on its agenda since before Proposition 63 passed and received regular briefings from the Mental Health Services Division Director and staff. Some MHB members participated in State sponsored training. After the launch of San Mateo County's local planning process, the MHB opted to extend its meeting in order to provide for regular MHSA presentations on its agenda.

h. Community events: 227 people attended the Kick-off meeting March 4, 2005, described above. In addition, 55 people attended public community forum meetings in North County, 63 attended public community forum meetings in South County/East Palo Alto, 55 attended public community forum meetings on the Coast. These events included training provided by Louise Rogers, Mental Health Services Division Deputy Director and MHSA Coordinator, as described above. In addition, many community members participated in the focus group activities described above. Over 33 consumers attended the public Consumer Speaks forum led by consumers, and 22 family members and 2 consumers attended the public forum designed to address issues of parents and families. These events also included training about the vision of the MHSA.

# SECTION 2: PLAN REVIEW

The first programs and strategies were reviewed in draft form based on priorities ranked at the June 10th Joint Steering Committee and Work Groups meeting. These draft programs and strategies along with the narrative draft of sections 1 -3 of the proposal were reviewed at the Mental Health Board on August 3rd, and the Steering Committee on August 5th. In addition, the draft was posted on the Mental Health Network of Care website and sent out to all Work Group participants. Subsequently, on August 15th, a joint meeting of the MHB and Steering Committee was held to review the first draft of the proposal. On August 16th, Mental Health Services Division staff presented an overview of the draft to the Board of Supervisors in a special study session.

The Mental Health Board approved release of the MHSA Three-Year Program and Expenditure Community Services and Supports Plan for a 30-day public comment period on September 7, 2005. Stakeholders subsequently met to discuss the draft Plan at each Work Group on September 9th or 12th, a Consumer Forum on September 10th, and the Steering Committee on September 15th.

On October 11, the Mental Health Board held a public hearing in which 12 individuals made public comment. This is included in the record of substantive comment contained in Appendix O. On October 20, substantive public comment and revisions to the MHSA Community Services and Supports Plan were reviewed at a joint meeting of the Mental Health Board and the MHSA Steering Committee.

The Mental Health Board voted to accept the Three-Year Program and Expenditure Community Services and Supports Plan and approved submission to the San Mateo County Board of Supervisors on November 2nd.

The San Mateo County Board of Supervisors reviewed the Three-Year Program and Expenditure Community Services and Supports Plan and placed the matter on its Consent Agenda for its November 8 meeting. The matter was continued for one week and on November 15 the Board of Supervisors unanimously adopted a resolution authorizing the President of the Board to accept and approve submission of the Three-Year Program and Expenditure Community Services and Supports Plan to the California Department of Mental Health.

# PART II: PROGRAM AND EXPENDITURE PLAN

## SECTION 1: IDENTIFYING COMMUNITY ISSUES RELATED TO MENTAL ILLNESS & RESULTING FROM LACK OF COMMUNITY SERVICES AND SUPPORTS

### 1.1 MAJOR COMMUNITY ISSUES

As the description of the priority setting process below will reveal, the Work Groups did not limit their focus to the California Department of Mental Health (DMH)-defined 'issues resulting from untreated mental illness' but rather focused upon un/under-served populations, Full Service Partnerships (FSPs), and high priority strategies that were felt to contribute most substantially to transforming the system and achieving the DMH/MHSA outcomes. These issues are in bold and starred** below.

State DMH-defined List:

| Children/Youth | TAY | Adults | Older Adults |
|---|---|---|---|
| 1. Inability to Remain in Mainstream School*** | 1. Homelessness** | 1. Homelessness** | 1. Homelessness |
| 2. School Failure | 2. Hospitalizations | 2. Hospitalizations | 2. Hospitalizations |
| 3. Hospitalizations | 3. Emergency Medical Care | 3. Emergency Medical Care | 3. Emergency Medical Care** |
| 4. Peer & Family Problems | 4. Inability to work | 4. Inability to work** | 4. Inability to work |
| 5. Out-of-Home Placement** | 5. Inability to manage independence** | 5. Inability to manage independence** | 5. Inability to manage independence** |
| 6. Involvement in Child Welfare** | 6. Isolation | 6. Isolation | 6. Isolation** |
| 7. Involvement in Juvenile Justice** | 7. Involuntary Care | 7. Involuntary Care** | 7. Involuntary Care |
| | 8. Institutionalization | 8. Institutionalization** | 8. Institutionalization** |
| | 9. Involvement in Juvenile Justice** | 9. Incarceration** | 9. Incarceration |
| | 10. Involvement in Child Welfare** | | |
| | 11. Out-of-Home Placement** | | |

### 1.2 DESCRIPTION OF CRITERIA USED TO IDENTIFY ISSUES AND PROCESS FOR PRIORITIZING

A series of five full and half day facilitated Work Group meetings were used to afford stakeholders a forum for providing input into the planning process. The Work Groups were organized by age group (child/youth, transition age youth, adult, and older adult) with each Work Group comprised of 18-25 consumers, family members, providers and representatives of agencies that historically collaborate with the Mental Health Services Division or serve its clients. Work Groups were co-chaired by a Mental Health Board member and a Mental Health Services Division staff member. Over a period of three months, each Work Group met for a total of 30 hours to review the results of prior planning efforts, local service utilization data, descriptions of existing community services and supports, summaries and presentations on best

practice research and findings from the focus groups and community meetings. Work Groups were also the locus for prioritizing target populations, focus issues, and high priority strategies for each age group. Throughout the process, Work Groups forwarded their recommended priorities to the Steering Committee for review and comment. While each Work Group spent time considering the issues related to untreated mental illness identified by the State, the Work Group process devoted more time to considering which un/under-served populations were in greatest need and which strategies could best address their needs and contribute to the transformation of the mental health system. Work Groups forwarded to the Steering Committee recommended priorities relating to:

- Which un/under-served populations should be served by Full Service Partnerships;
- What outreach and engagement strategies should be implemented throughout the system and serving all age groups; and

What transformational structures, strategies and supports were most important to improving the quality of life of the consumers within each age group.

Ongoing Steering Committee Meetings were co-chaired by the President of the San Mateo County Board of Supervisors and the Chair of the Mental Health Board. Comprised of over 50 community leaders, including all Mental Health Board members, the Steering Committee met monthly to review Work Group deliberations and priorities and to provide comment and feedback to the Work Groups. This planning culminated in a joint meeting at which Work Group members and Steering Committee members reviewed the priorities of all four Work Groups and working in small groups and one large plenary generated an integrated set of priorities and budget reflecting the recommendations of all four Work Groups.

The remainder of this section outlines the priority setting process conducted by the Work Groups, Steering Committee, and Mental Health Services Division staff.

## COMMUNITY OUTREACH, ENGAGEMENT & INPUT PROCESSES

As described in Part I: Section 1.4, the process sought community input through a Kick-off event and a series of public community forums and focus groups with consumers, family members, community members, and members of historically un/under-served communities. Community input and feedback was shared with the Work Groups and helped inform their process.

### Focus Groups and Community Forums

As a part of the planning process, the Mental Health Services Division sought community input through public forums and focus groups throughout the County. The information gathered from these conversations was used to inform Work Group deliberations on how to transform the mental health system. A separate report and slide presentation was produced for each age group and presented to the respective Work Group and the Steering Committee.

Facilitators met with:

- Dozens of parents, family members, and consumers, young and old;
- People who are homeless;
- People of un/under-served ethnic groups, including African Americans, Latinos, Filipinos, Chinese, and Tongans;
- People who have been victims of domestic violence;

- Pregnant and parenting teens;
- Community organizations; and
- Advocates for consumers and families.

The information gathered from these conversations was transcribed, summarized, coded, and analyzed by sub-populations and across groups. The data was also analyzed thematically by Work Group in the areas of:

- Access;
- Prevention and intervention;
- Service delivery and supports and services; and
- Quality of life.

Separate written reports were produced summarizing the input specifically from under-served ethnic populations, including Latinos, Filipinos, Chinese, and Tongans.

Among the most prominent findings from the focus groups:

- Access to services was universally seen as being insensitive, complex, and discouraging;
- Families felt deterred from a substantive involvement in treatment;
- Services themselves were largely praised, although many called for a broader array of options;
- The need for integrated substance abuse and mental health services was frequently identified;
- Better coordination is needed between the Mental Health Services Division and other agencies serving the same population, particularly in relation to consumers who utilize child welfare or primary care services or are involved with the juvenile justice and criminal justice system.
- More emphasis on consumer involvement in treatment planning and service delivery is needed; and
- Improvement in the cultural competence of providers and the cultural relevance of treatment services were both identified as important needs.

For a complete discussion of the results of these focus groups, see Community Input and Feedback reports and slide presentations in Appendix G and H.

WORK GROUPS: With the goal of identifying high-priority areas for the Mental Health Services Division, each Work Group reviewed current demographic data and best practice research on mental health, assessed strengths and weaknesses in the mental health system, identified gaps in services among un/under-served populations and identified priorities for target populations and transformative strategies to be funded through the MHSA. The work of each group culminated in a joint meeting with the Steering Committee where strategies were prioritized by age group and integrated into a single set of prioritized strategies and a budget to support them.

Since Work Groups were comprised of consumers, family members, providers and county agency representatives (e.g. probation, child welfare, housing, education, health, aging and adult, criminal justice and senior services), there was an uneven understanding of the mental health system and the research that supports those services. For these individuals to participate meaningfully and equally, a significant investment was needed in training members about mental health issues, County demographics and needs, current best practice research, the MHSA, and the existing operations of the mental health system. As

such, Mental Health Services Division staff and consultants generated a wide range of summaries and presentations to educate participants throughout the process to ensure that they had a deep understanding of the current mental health system and the MHSA mandate to transform that system.

A description of each Work Group's priority setting process follows.

## WORK GROUP PRIORITY SETTING PROCESSES

### CHILD/YOUTH WORK GROUP

The Child/Youth Work Group (CYWG) met three times throughout the spring. Each meeting included a review of current work to date, presentation of educational materials on mental health, and exercises aimed at identifying and prioritizing areas of high need for children with mental illness.

#### *Child/Youth Work Group Session I*

The first Work Group Session was a full day meeting designed to provide an intensive orientation to Work Group members, to offer members an opportunity to assess the extent to which qualities and characteristics of a transformed system exist in the current system and to conduct processes through which they prioritized:

- Issues related to untreated mental illness;
- Un-served and under-served populations; and
- Gaps in the existing mental health service system.

*Orientation*

Work group members were given a wide range of materials selected to orient members and prepare them for the work to come. These materials were presented to Work Group members with the goal of providing a comprehensive picture of mental health needs in San Mateo County, issues relating to access for un/under-served populations, and general considerations for the mental health needs of children. Written summaries of the following materials were presented and discussed at the beginning of the first Work Group meeting:

- 2004 Community Health Assessment: Health and Quality of Life in San Mateo County;
- Achieving the Promise: Transforming Mental Health Services Care in America (President's New Freedom Commission on Mental Health);
- Mental Health: A Report of the Surgeon General and Mental Health: Culture, Race and Ethnicity, a supplement to the first report;
- Latino Access Study, a local study conducted in 2003 that focused upon Latino access to mental health services;
- Young Hearts and Minds: Making a Commitment to Children's Mental Health Services (Little Hoover Commission);
- San Mateo County Mental Health Services Division Strategic Plan;
- San Mateo County SAMHSA Proposal for Youth Transition Partnership;
- Human Services Agency Child Welfare Redesign System Improvement Plan Goals, Strategies and Milestones prepared by Stability/Re-Entry Design Team, Services Array Team and the Family Connections Design Team.

*San Mateo County Data Summary:* A slide presentation on County population, demographic, prevalence and mental health service delivery data (San Mateo County Data Summary for Planning) was also delivered. All Work Group members were provided copies of the slide show presentation and the back up data set.

*Findings and Conclusions: Planning 3: Wellness/Recovery/Resiliency Services and Support System Planning Checklist*

The CYWG also reviewed the State DMH Planning Checklist 3 during this first meeting, using this process to orient members to the qualities of a transformed system and then using that framework to assess the current performance of the public mental health system in San Mateo County. A rating scale allowed participants in the CYWG to rate different qualities of the mental health system 0-5, with 0 stating that the component or quality is entirely absent. A five (5) indicated that the service or quality is "a real strength in the system."

Through this exercise the CYWG achieved a better understanding both of the qualities of a transformed system and the extent to which the current system manifested these qualities. The completed DMH Planning Checklist 3 rating results for the CYWG is provided in Appendix J.

The desired qualities identified by a majority of CYWG members as not strongly apparent in the current system included:

- The adverse effects of mental health stigma including shame, guilt and blame are understood and mitigated.
- Parents and other family/caregiver members receive easily understood information on emotional disorders, the process for obtaining prompt access to needed mental health screening, assessments and care, entitlements to care, and legal rights and protections.
- Children, youth and their families/caregivers are offered easily understood information necessary to be full and credible participants in service planning.
- Case coordination is provided to ensure that services are coordinated, the type and intensity are appropriate, and that services are driven by the child and family's changing needs over time.
- Services are coordinated and delivered through linkages between public and private providers.
- Children and their families have access to culturally appropriate comprehensive services across physical, emotional, social and educational domains.
- Children are provided mental health services in their home and community to the extent possible. Mental health services are provided in the most community-integrated setting appropriate to the child's needs.
- Families' informal/natural sources of support are included in formal service planning and delivery; and
- The absence of any services and supports that incorporates the ten essential elements of wraparound.

*Findings and Conclusions: Issues Resulting from Untreated Mental Illness; Un/Under-Served Populations; and Gaps in Service System*

*Issues Resulting from Untreated Mental Illness*

In the first session, the CYWG also considered the State DMH list of issues resulting from untreated mental illness and brainstormed additional issues. As can be seen, CYWG members identified many issues that were not "results of untreated mental illness" ranging into a far wider array of issues for consideration in the process.

The CYWG identified the following issues to consider in addition to the DMH list of issues:

- Inclusion of youth in the planning process;
- Quality of life in the community, the presence/lack of positive resources for youth;
- The barriers of acculturation into the mainstream culture that is experienced by first and second generation immigrant families;
- Problems of victimization for severely emotionally disturbed (SED) children/youth;
- Transportation and other access supports;
- Poverty; and
- Runaway youth (who eventually end up in the juvenile justice system).

*Un/Under-Served Populations*

Next the CYWG reviewed and discussed an initial list of sub-populations that are un-served or under-served. This discussion was aided by a review of service utilization data that compared service utilization by ethnicity and age to prevalence data. CYWG members voted their priority using three pop-up notes for the sub-populations that had been listed. CYWG identified children/youth in the custody of the juvenile justice system as the highest priority un-served population, followed by children who are served by other systems of services (e.g. education, health, child care, child welfare). Children in homeless families, children aged 6-12, and children in foster care were also identified as under-served. The Prioritized Sub-populations List is included in Appendix J. It includes the voting totals for all populations considered in this discussion.

*Gaps in Service System*

Next the CYWG members considered the gaps in the service system. As with un/under-served populations, the Work Group members were given three pop-up notes to vote for their highest priority gaps in the systems. In order from most critical to least, CYWG members identified the following gaps in the service system:

- Hot line and mobile crisis response and consultation services 24/7 rather than Psychiatric Emergency Services (PES) [11 votes];
- After school and summer structured services/activities for special needs children/youth, especially for families in poverty who must work [7 votes];
- Partnering with education/teachers, juvenile justice, child welfare, other systems [4 votes];
- Dual diagnosis (metal health/substance abuse) treatment [4 votes]; and
- Residential options for teen moms [4 votes].

A total of 30 possible gaps were considered with eleven others receiving 1-3 votes and with thirteen others receiving no votes. A complete list of gaps considered and the votes received by each is contained in Prioritized System Gaps, in Appendix J.

*Steering Committee Review & Guidance*

On March 24th, between Sessions I and II, the Steering Committee met to review the work conducted by all four Work Groups. Written Work Group Session Reports were distributed to Steering Committee members in advance of this meeting and chairpersons of each Work Group gave presentations. The Steering Committee was given an opportunity to provide feedback to each Work Group. The first such meeting was done in one large plenary comprised of over 60 individuals. Based upon feedback from participants, this format was changed for future meetings, with Steering Committee members broken into groups defined by age (child/youth, transition age youth, adult, older adult) to allow for more discussion and debate. Feedback from the Steering Committee was summarized and provided to each Work Group at Session II.

*Child/Youth Work Group Session II*

Session II comprised one full-day meeting and one half-day meeting. No priorities were established during Session II as the purpose of Session II was to provide CYWG members with comprehensive training on the wide range of best practice strategies that could be a part of a transformed system and to ask CYWG members to identify gaps in the existing system as well as examples of best practice services and supports.

*Reflections on Work Completed & Steering Committee Feedback:*
As with all Work Group sessions, the CYWG began by reviewing the results of the previous session and in considering input and guidance provided by the Steering Committee. As such, the CYWG reviewed and discussed the following, with the note that CYWG members should keep these materials in mind during the deliberations of the Work Group, especially during the third session:

- The Session I Work Group report;
- The Rating summaries for Planning Checklist 3;
- A Feedback Report from the Steering Committee;
- The Kick-off Vision Summary; and
- A report on the Outreach Plan which was just getting under way.

*Educational Materials:*
The following educational materials were shared with Work Group members:

- MHSA Program and Expenditure Plan Example -- Child, Youth and Families
- Population Based Interventions and Evidence-Based Child and Adolescent Psychosocial Interventions from Washington State Paper on evidence-based practices
- From Promise to Practice: Mental Health Services Models that Work for Children and Youth, toolkit by Fight Crime: Invest in Kids California
- The Mental Health Services Act and Juvenile Justice Youth from Multi-Association Joint Committee (MAJC)
- Incarceration of Youth Who are Waiting for Community Mental Health Services in California prepared for Rep. Henry A. Waxman, U.S. House of Representatives

- Statistical Data, Center for the Promotion of Mental Health Services in Juvenile Justice
- Exemplary Practices in Adolescent Development, Sierra Health Foundation
- Study Finds Gaps in Mental Health Care for Children in Medi-Cal from California Healthline, California HealthCare Foundation
- Screening Tool Detects Teen SA in Behavioral Health Settings, Mental Health Weekly
- Issue Brief: Best Practices from National Initiative to Improve Adolescent and Young Adult Health by the Year 2010Executive Summary, Evidence-Based Practices in Mental Health Services for Foster Youth, CIMH
- Compeer, print of website

*Education & Training Presentations:*

In addition, there were a series of presentations regarding best practice structural and service strategies, some including additional materials (referenced with each presentation). After each presentation, the Work Group had a brief Q & A session.

*Wrap Around/Child and Family Teams*

- Using a packet of materials focused on key values and the Wrap Around approach, Lori Durand and Jennifer Newberry described the current program offered by the Mental Health Services Division.

*Parent Involvement/Family Partnership Services*

- Jennifer continued with a presentation on family involvement at all levels of the system, using a packet of materials that included "Eight Top Ways to Hinder Parent Involvement" and an article titled "Not Just the Usual Suspects."

*Juvenile Justice Programs*

- Toni DeMarco presented an overview of current mental health services provided in the Juvenile Justice system, noting that San Mateo County was unique among counties in the scope of services being provided. She distributed a packet that summarized the services, including the new Functional Family Therapy service, an evidence-based practice.

*Education System Programs*

- Sue Larramendy and Nancy Littlefield presented an overview of current mental health services provided in school-based settings, including Therapeutic Day Schools, and Milieu Enhanced Classes, as well as clinic based services provided under 26.5 that are part of the individual education plan (IEP).

*Integrated Services for Co-Occurring Mental Health and Substance Abuse (SA)*

- David Mineta and Ramsey Khaso presented data on the prevalence of SA need in San Mateo County youth, with informational packets from Healthy Communities San Mateo and the State Department of Alcohol and Drug Programs. They emphasized the growth in gang membership and the explosion of methamphetamine use.

*Child Welfare System Programs*

- Mark Lane distributed a packet titled "Services for Children and Families", and provided an overview of the top three strategies for redesigning the Child Welfare (CW) system, all of which have a significant mental health component: 1) A differential response system that seeks to provide some response to the 92% of CW referrals that do not become a part of CW change oriented services; 2) Team based decision making for out-of-home placement decisions, and eventually other case planning decisions for the 8% receiving change oriented services; and, 3) Planning for

youth that come into the system and stay until emancipation, seeking to link them to long term relationships.

*Primary Care System Programs*

- Sylvia Espinoza and Barbara Mauer presented an overview of the need for on-site mental health services and psychiatric backup in primary care and a brief review of the national models that show the effectiveness of this strategy for engaging hard to reach populations.

## Gaps Analysis: Structural Service and Support Strategies

Over the course of Sessions II and III, the CYWG completed the Transformative Services grid, based upon the Exhibit 4 Gaps Analysis Chart included in the first draft of the DMH planning guidelines (See Appendix J). The CYWG assessed the extent to which each structural, service or support strategy was in place in the County. Several of the DMH listings are overlapping and so were combined. The CYWG was asked to complete the Transformative Services grid considering:

- Whether each strategy was needed in the new system;
- How this strategy would improve access and outcomes for un/under-served populations; and
- What culturally competent elements must be in place for the strategy to be successful.

Desirable key elements were described for many of the strategies. The Session II CYWG Report (See Appendix J) provides a detailed summary of the Work Group discussion of each structural, service or support strategy.

As the CYWG discussed the above strategies and supports, it used the Transformative Services grid to record the extent to which each kind of service already existed in the current system, the scope of availability, and specific local examples of each kind of service or support. By consensus, the Work Group members rated each type of services as: not available; available, but more needed; or sufficient capacity. In most all instances, services were identified as either not being evident or being insufficiently available. Prior to Session III, more of this detail was added to the Transformative Services Grid so it could be used in the priority setting process.

### *Steering Committee*

The Steering Committee met on April 29th and heard reports from all four Work Groups who presented their findings in relation to the transformational structures, services and supports that should be part of the transformed system. The Steering Committee broke into four groups to discuss these reports and to provide feedback to each Work Group.

### *Child/Youth Work Group Session III*

Work Group members were provided with a written report summarizing findings from the 100 focus groups and community forums. Separate reports were prepared for each Work Group allowing the findings to focus on issues relevant to that Work Group. Session III was comprised of one half-day and one full day of deliberations that was comprised of two distinct parts. First, a slide show presentation summarizing the findings from the focus groups and community forums was presented to ensure that input from un/under-served populations was incorporated in the priority setting process to follow. The second part of Session III focused upon identifying and recommending to the Steering Committee:

- The highest priority target populations for child/youth services;
- The discrete population to recommend for being served by the Full Service Partnership (FSP); and
- The highest priority transformational structures, services, and supports to be funded through the MHSA.

*Review of the Work Completed to Date*

As in other sessions, the CYWG Session III began with a review of materials of prior deliberation including the themes from the Kick-off, the Work Group's priority listing of un/under-served populations, the Steering Committee discussion of the CYWG report and presentation, the updated Transformative Services grid, and utilization data regarding un/under-served populations.

*Presentation on Outreach Process*

Louise Rogers presented a written report and slide show presentation on Community Input and Feedback, which provided very useful material regarding how mental health and mental health services are perceived by the community. Please see Appendix G for the Child/Youth Work Group Community Input and Feedback Report for details on the report itself.

*Review and Prioritize the Transformative Services Grid*

The Work Group reviewed the latest draft of the Transformative Services grid which was revised to reflect discussions during the last session. The group completed the first round of prioritization, with the following strategies in the top third, or A level list:

- Core competencies: values driven evidence-based and promising clinical services;
- School based services. Need more capacity, different options, and different sites, including preschools and child care settings;
- Home-based services and supports;
- Family partnership programs;
- On-site services in primary care clinics;
- Outreach and screening services in a variety of community settings;
- Mobile crisis services; and
- Development of housing options.

*Review and Discuss Levels of Care Model and Projections*

The Work Group reviewed a handout on the Level of Care Model (See Section 3) and asked questions, then reviewed the draft projections for developing Full Service Partnership services. There was a lively discussion with many questions about implementation of such a model. The sense was that it would require many changes in the Mental Health Services Division as well as among system partners.

*Review Transformative Services List and List of Un/Under-served Populations*

The Work Group worked with both the list of un/under-served populations and the Transformative Services grid and matched up services to target populations. This is reflected in the final version of the grid. See Appendix J. The list of target populations included:

- Young single parents
- Children/youth with mental health and developmental disabilities
- Children/youth in the juvenile justice (JJ) system
- Children/youth in the child welfare (CW) system

- Homeless families and their children
- Children ages 0-5
- Children/youth ages 6-12
- Children/youth with mental health/substance abuse dual diagnosis
- Children/youth with moderate impairment
- Migrant families and their children
- Young women/girls
- Those impacted by trauma
- Asian/Pacific Islander children/youth
- Latino children/youth
- Gang-involved youth

Following the matching of populations to the service grid, there was a final round of voting on the remaining two-thirds of services, to put them into clusters B and C. The fact that a service is in List C does not mean it is not needed—it is a description of phasing importance, rather than elimination from consideration (See Transformative Services grid in Appendix J). These priorities were submitted to the Steering Committee. The consultants and Mental Health Services Division staff used this information to construct financial models incorporating only the A priority strategies from each Work Group. This financial model was presented to the joint Steering Committee and Work Group meeting on June 10th and in a facilitated process, the Steering Committee and Work Groups integrated the recommendations from all four Work Groups into one set of priority strategies. This process is described below after the summaries of Sessions I-III for the other three Work Groups.

TRANSITION AGE YOUTH WORK GROUP

The Transition Age Youth Work Group (TAYWG) met three times throughout the spring. Each meeting included a review of current work to date, presentation of educational materials on mental health, and exercises aimed at identifying and prioritizing areas of high need for transition aged youth with mental illness.

*Transition Age Youth Work Group Session I*

The first Work Group Session was a full day meeting designed to provide an intensive orientation to Work Group members, to offer members an opportunity to assess the extent to which qualities and characteristics of a transformed system exist in the current system and to conduct processes through which they prioritized:

- Issues related to untreated mental illness;
- Un-served and under-served populations; and
- Gaps in the existing service system.

*Orientation*

Work group members were given a wide range of materials selected to orient members and prepare them for the work to come. These materials were presented to Work Group members with the goal of providing a comprehensive picture of mental health needs in San Mateo County, issues relating to access for under-served populations, and general considerations for the mental health needs of transition age youth. Written

summaries of the following materials were presented and discussed at the beginning of the first Work Group meeting:

- 2004 Community Health Assessment: Health and Quality of Life in San Mateo County
- Achieving the Promise: Transforming Mental Health Services Care in America (President's New Freedom Commission on Mental Health Services)
- Mental Health: A Report of the U.S. Surgeon General and its supplement Mental Health: Culture, Race and Ethnicity.
- Latino Access Study Quality Improvement Study from Latino Access Study Committee, San Mateo County mental Health Services Division
- Young Hearts and Minds: Making A Commitment to Children's Mental Health Services from Little Hoover Commission
- San Mateo County Mental Health Services Division Strategic Plan
- San Mateo County SAMHSA Proposal 8 for San Mateo County Youth Transition Partnership
- Human Services Agency Child Welfare Redesign System Improvement Plan Goals, Strategies and Milestones prepared by Stability/Re-Entry Design Team, Services Array Team and the Family Connections Design Team.
- Transition to College 2003-2004 Year End Program Review

*San Mateo County Data Summary:* A slide presentation on County population, demographic, prevalence and mental health service delivery data (San Mateo County Data Summary for Planning) was also delivered. All Work Group members were provided copies of the slide show presentation and the back up data set.

*Findings and Conclusions: DMH Planning Checklist 3/4: Wellness/Recovery/Resiliency Services and Support System Planning Checklist*

The State DMH Planning Checklist 3/4 (a transition age youth version was created by integrating items from both the Child/Youth and the Adult checklists) was used to assess the current performance of the public mental health system in San Mateo County. A rating scale allowed participants in the Transition Age Youth Work Group to score different qualities of the mental health system 0-5, with 0 stating that the component or quality is entirely absent. A five (5) would indicate that the service or quality is "a real strength in the system."

Through this exercise the TAYWG achieved a better understanding both of the qualities of a transformed system and the extent to which the current system manifested these qualities. The completed DMH Planning Checklist 3/4 rating results for the TAYWG are provided in Appendix K.

The desired qualities identified by a majority of TAYWG members as not strongly apparent in the current system included:

- Expectations of recovery are maintained.
- Resources to meet educational objectives are available.
- The adverse effects of mental health stigma including shame, guilt and blame are understood and mitigated.
- Parents and other family/caregiver members receive easily understood information on emotional disorders, the process for obtaining prompt access to needed mental health screening, assessments and care, entitlements to care, and legal rights and protections.

- Services and supports build on child, youth and family/caregiver strengths.
- Children, youth and their families/caregivers are offered easily understood information necessary to be full and credible participants in service planning.
- Clients participate in service planning, development and governance of the agencies and/or service systems.
- Children and their families have access to culturally appropriate comprehensive services across physical, emotional, social and educational domains.
- Services are flexible and allow children and families to integrate them into their daily routines.
- Children are provided mental health services in their home and community to the extent possible. Mental health services are provided in the most community-integrated setting appropriate to the child's needs.
- Families' informal/natural sources of support are included in formal service planning and delivery.
- Community employment is supported.
- Community activities are supported.
- Community recreation is supported.
- Services are culturally appropriate for the client, family and ethnic community.
- Services a client needs should be identified through a single plan and personal service coordinator.
- Clients have access to and availability of staff who are aware of them 24/7 by phone, in person, or e-mail as appropriate.
- Clients who decline to participate and have demonstrated adverse impacts of untreated mental illness receive frequent outreach and offers of support.
- Services and supports are individualized, build on strengths, and meet the needs of children and families across the life domains to promote success, safety, and permanency in home, school, and the community.
- The plan is developed and implemented based on an inter-agency, community/neighborhood collaborative process.
- Wraparound teams have adequate and flexible funding.
- Outcomes are determined and measured for the system, for the program, and for the individual child and family.

*Findings and Conclusions: Issues Resulting from Untreated Mental Illness; Un/Under-Served Populations; and Gaps in Service System*

*Issues Resulting from Untreated Mental Illness*

In the first session, the TAYWG also considered the State DMH list of issues resulting from untreated mental illness and brainstormed additional issues. As can be seen, TAYWG members identified many issues that were not "results of untreated mental illness" ranging into a far wider array of issues for consideration in the process.

The TAYWG identified the following issues to consider in addition to the State DMH list of issues:

- Substance abuse issues;
- Family disintegration;
- Issues of sexuality and gender, including abuse, molestation, prostitution, unwanted pregnancy, sexually transmitted diseases, abortion;
- Grief over loss and trauma;

- Not finishing school;
- Social isolation;
- Victimization;
- Death;
- Young adults with children;
- Gang involvement;
- Dealing with family members' mental illness, genetic issues;
- Very dysfunctional home lives with domestic violence and other issues;
- Lack of trust in the system; and
- Poverty.

*Un/Under-Served Populations*

Next the TAYWG reviewed and discussed an initial list of sub-populations that are un/under-served. This discussion was aided by a review of service utilization data that compared service utilization by ethnicity and age to prevalence data. TAYWG members voted their priority using three pop-up notes for the sub-populations that had been listed. TAYWG members identified youth transitioning from highly structured residential placements, including juvenile hall and foster care and gay/lesbian/transgender/questioning youth as the two highest priority populations, followed by undocumented youth, gang-involved youth, and youth with co-occurring disorders. The list of sub-populations considered and the final tally of votes is included in Appendix K.

*Gaps in Service System*

Next the TAYWG members considered the gaps in the service system. As with un/under-served populations, the Work Group members were given three pop-up notes to vote for their highest priority gaps in the system. In order from most critical to least, TAYWG members identified the following gaps in the service system:

- Affordable housing specific to transition age youth, including scattered supported living sites, group housing, shelter and single room occupancy (SRO) [5 votes];
- A drop-in center that is fun and interactive, a place to do outreach, serve homeless youth (like Safe Haven in San Francisco) [4 votes];
- Flexible funding to support housing startup, job startup, and other needs [4 votes]; and
- Assertive community treatment (ACT) level outreach including peer team members to engage youth who are not willing to come into services [4 votes]

A total of 32 possible gaps were considered with twelve others receiving one to three votes and with 13 others receiving no votes. A complete list of gaps considered and the votes received by each is contained in Appendix K.

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***Steering Committee Review & Guidance***

On March 24th, between Sessions I and II, the Steering Committee met to review the work conducted by all four Work Groups. Written Work Group Session Reports were distributed to Steering Committee members in advance of this meeting and presentations were made by the chairpersons of each Work Group. The Steering Committee was given an opportunity to provide feedback to each Work Group. The first such meeting was done in one large plenary comprised of over 60 individuals. Based upon feedback from

participants this format was changed for future meetings, with Steering Committee members broken into groups defined by age (child/youth, transition age youth, adult, older adult) to allow for more discussion and debate. Feedback from the Steering Committee was summarized and provided to each Work Group at Session II.

*Transition Age Youth Work Group Session II*

Session II was comprised of one full-day meeting and one half-day meeting. No priorities were established during Session II as the purpose of Session II was to provide TAYWG members with a comprehensive training on the wide range of best practice strategies that could be a part of a transformed system and to ask TAYWG members to identify gaps in the existing system as well as examples of best practice services and supports.

*Reflections on Work Completed & Steering Committee Feedback:*
As with all Work Group sessions, the TAYWG began by reviewing the results of the previous session and in considering input and guidance provided by the Steering Committee. As such, the TAYWG reviewed and discussed the following, with the note that TAYWG members should keep these materials in mind during the deliberations of the Work Group, especially during the third session.

- The Session I Work Group report;
- The Rating summaries for Planning Checklist 3/4;
- A Feedback Report from the Steering Committee;
- The Kick-off Vision Summary; and
- A report on the Outreach Plan which was just getting under way.

Youth Speak Out:
This second session then held an open session with youth members of the TAYWG and additional attendees. Youth were asked to speak to what had worked well for them in their experience of mental health services, what did not work, and what needs they saw for the system. The full listing of their comments is found in the Session II Work Group Report in Appendix K.

*Educational Presentations:*
There were a series of presentations regarding service strategies, some including additional materials (referenced with each presentation). After each presentation, the Work Group had a brief Q & A session.

*Youth Transition to Adult Committee (YTAC) and Dialectical Behavioral Therapy (DBT)*

- Doug Fong presented on the process for entering into the current transition age youth program and the types of services provided.

*Supported Education*

- Tim Stringari, College of San Mateo (CSM), presented an overview of the Supported Education program, the previous Stepping Stones program, and the current thinking at CSM about meeting the needs of transition age youth.

*Gender Sensitive Services for Transition Age Young Women*

- Andrea Aiello presented a summary of a recent report sponsored by the state Women's Mental Health Services Policy Council that focuses on needs and best practices in gender sensitive services.

*Mental Health Services and Substance Abuse Services*

- Carlos Morales presented an overview of the stages of change, application to Substance Abuse services and the need for the mental health system to acknowledge that co-occurring disorders are an expectation, not an exception, in planning and delivering services.

*Assertive Community Treatment (ACT), Integrated Service Agencies, and First Break Programs*

- Carols Morales presented information on intensive programs such as ACT teams, Integrated Service Agencies (e.g. The Village in Long Beach), and First Break programs (originated in Australia, now being piloted in Oregon).

*Supported Employment Services*

- Michael Schocket from Caminar presented information about the Supported Employment program that is offered to youth.

*Supported/Transitional Housing*

- Donna Browne-Cubie from Young Adult Independent Living (YAIL) presented information about the services provided at YAIL. Several of the youth attending the Work Group meetings reside at YAIL and added to the discussion.

### *Gaps Analysis: Structural, Service and Support Strategies*

Over the course of Sessions II and III, the TAYWG completed the Transformative Services grid, based upon the Exhibit 4 Gaps Analysis Chart included in the first draft of the DMH planning guidelines (See Appendix K). The TAYWG assessed the extent to which each structural, service or support strategy was in place in the County. Several of the State DMH listings are overlapping and so were combined. The Work Group was asked to complete the Transformative Services grid considering:

- Whether each strategy was needed in the new system;
- How this strategy would improve access and outcomes for un/under-served populations; and
- What culturally competent elements must be in place for the strategy to be successful.

Desirable key elements were described for many of the strategies. The TAYWG was able to review the work of the CYWG and build on their ideas. The Session II TAYWG Report (See Appendix K) provides a detailed summary of the Work Group discussion of each structural, service or support strategy.

As the TAYWG discussed the above strategies and supports it used Transformative Services grid to record the extent to which each kind of service already existed in the current system, the scope of availability and specific local examples of each kind of service or support. By consensus, the Work Group members rated each type of services as: not available; available, but more needed; or sufficient capacity. In most all instances, services were identified as either not being evident or being insufficiently available. Prior to Session III, more of this detail was added to the Transformative Services grid so it could be used in the priority setting process.

### *Steering Committee*

The Steering Committee met on April 29th and heard reports from all four Work Groups who presented their findings in relation to the transformational structures, services and supports that should be part of the transformed system. The Steering Committee broke into four groups to discuss these reports and to provide feedback to each Work Group.

*Transition Age Youth Work Group Session III*

Work Group members were provided with a written report summarizing findings from the 100 focus groups and community forums. Separate reports were prepared for each Work Group allowing the findings to focus on issues relevant to that Work Group. Session III comprised one half-day and one full day of deliberations with two distinct parts. First, a presentation was made regarding a high school survey conducted Mental Health Board youth commissioners, followed by a slide show presentation summarizing the findings from the focus groups and community forums to ensure that input from un/under-served populations was incorporated in the priority setting process to follow. The second part of Session III focused upon identifying and recommending to the Steering Committee:

- The highest priority target populations for transition age youth services;
- The discrete population to recommend for being served by the Full Service Partnership (FSP); and
- The highest priority transformational services, strategies and supports to be funded through the MHSA.

*Review of the Work Completed to Date*

The Work Group reviewed the themes from the Kick-off, the Work Group's priority listing of un-served and under-served populations, the updated Transformative Services grid and the data regarding un/under-served populations. The Work Group reviewed the summary discussion from the Steering Committee, focusing their attention on the recommendation that there be some kind of ongoing mechanism that engages youth in oversight of the system as well as the issue of communication about and across the system.

*Review of High School Surveys*

The two MHB youth commissioners presented preliminary information from a survey they conducted in seven County high schools, receiving over 1,000 surveys. See Appendix N for a complete copy of the final report.

- The survey was distributed to high schools that were willing to participate, located in various parts of the County. It was completed in different classes, depending on the school (for example, all physical education classes or all health classes).
- Review of the completed surveys indicates high levels of stress. There was a discussion of what "stress" means to different students and the importance of understanding those differences.
- Students seemed to know about mental health issues and mental health services and how to access services.

Presentation on Outreach Process

Louise Rogers presented a written report and slide show presentation on Community Input and Feedback, which provided very useful material regarding how mental health and mental health services are perceived in the community. Please see Appendix G for the Transition Age Youth Work Group Community Input and Feedback Report for details on the report itself.

Review and Prioritize the Transformative Services Grid

The Work Group reviewed the latest draft of the Transformative Services grid, which was revised to reflect discussions during the last session. Added categories included:

- Expand capacity of psychiatric services to ensure that there is access to medication services along with other strategies in new programs developed with MHSA funding;

- Outreach to at-risk ethnic individuals and neighborhoods, using a model like the Real Alternative Program (RAP) program in San Francisco;
- Transportation and the need to develop innovative programs that would assist youth in having access to driver's license, insured cars—maybe a club for sharing rides, or something like the FlexCar system that people can join.

The group completed the first round of prioritization, with the following strategies in the top third, or A level list:

- Core competencies: values driven evidence-based and promising clinical services;
- Development of housing options;
- Outreach services to persons who are homeless or at-risk of homelessness, or gang/at-risk of gang-involved;
- Supportive employment;
- Youth and family run services including peer support, self-help groups and mentoring programs;
- Family partnership programs—family support and consultation services, parenting support and consultation services, self-help groups with youth peer partners as a part of the team;
- Outreach and community-based services to at-risk un-served populations and communities; and
- Supportive education services.

### Review and Discuss Levels of Care Model and Projections

The Work Group reviewed a handout on the Level of Care Model (See Section 3) and asked questions, then reviewed the draft projections for developing Full Service Partnership services. There was a lively discussion with many questions about implementation of such a model. The sense was that it would require many changes in the Mental Health Services Division as well as among system partners.

### Review Transformative Services List and List of Un-served and Under-served Populations

The Work Group worked with both the list of un/under-served populations and the Transformative Services grid and matched up services to target populations, this is reflected in the final version of the Transformative Services grid. See Appendix K. The list of target populations included:

- Gay/lesbian/bisexual/transgender/questioning youth;
- Latino youth;
- Asian/Pacific Islander youth;
- Homeless youth;
- Juvenile justice involved youth and those transitioning;
- Child welfare involved youth and those transitioning;
- Gang-involved youth;
- Youth with a history of trauma;
- Undocumented youth; and
- Youth that are resistant to services.

Following the matching of populations to the service grid, there was a final round of voting on the remaining two-thirds of services, to put them into clusters B and C. The fact that a service is in List C does not mean it is not needed—it is a description of phasing importance, rather than elimination from consideration (See Appendix K). These priorities were submitted to the Steering Committee. The consultants and Mental Health Services Division staff used this information to construct financial models incorporating only the A

priority strategies from each Work Group. This financial model was presented to the joint Steering Committee and Work Group meeting on June 10th and in a facilitated process, the Steering Committee and Work Groups integrated the recommendations from all four Work Groups into one set of priority strategies. This process is described below after the summaries of Sessions I-III for the Adult and Older Adult Work Groups.

ADULT WORK GROUP

The Adult Work Group (AWG) met three times throughout the spring. Each meeting included a review of current work to date, the presentation of educational materials on mental health, and an identification and prioritization of areas of high need for adults with mental illness.

*Adult Work Group Session I*

The first Work Group Session was a full day meeting designed to provide an intensive orientation to Work Group members, to offer members an opportunity to assess the extent to which qualities and characteristics of a transformed system exist in the current system and to conduct processes through which they prioritized:

- Issues related to untreated mental illness;
- Un-served and under-served populations; and
- Gaps in the existing service system.

*Orientation*

Work group members were given a wide range of materials selected to orient members and prepare them for the work to come. These materials were presented to Work Group members with the goal of providing a comprehensive picture of mental health needs in San Mateo County, issues relating to access for un/under-served populations, and general considerations for the mental health needs of adults. Written summaries of the following materials were presented and discussed at the beginning of the first Work Group meeting:

- 2004 Community Health Assessment: Health and Quality of Life in San Mateo County
- Adult Protective Services and Clients with Mental Health Problems: An Analysis of Unmet Need from San Mateo County Health Department Aging and Adult Services
- Achieving the Promise: Transforming Mental Health Services Care in America (President's New Freedom Commission on Mental Health Services)
- Mental Health: A Report of the U.S. Surgeon General and its supplement Mental Health: Culture, Race and Ethnicity.
- Latino Access Study Quality Improvement Committee by San Mateo County mental Health Services Division Latino Access Study Committee
- How Stigma Interferes with Mental Healthcare: An Expert Interview with Patrick W. Corrigan, PsyD from Medscape Psychiatry & Mental Health
- San Mateo County Mental Health Services Division Strategic Plan Adult/Older Adult
- SMCCCD Services to Students with Psychological Needs and Students with Psychological Disabilities, San Mateo Community College District Board Report
- San Mateo County DR/MH Cooperative Program Summary of Work Center Focus Groups, The Results Group

- San Mateo County Office of Housing Continuum of Care Exhibit 1
- San Mateo County Options Project: Analysis and Report

*San Mateo County Data Summary:* A slide presentation with a review of County population, demographic, prevalence and Mental Health Services Division delivery data (San Mateo County Data Summary for Planning) was also delivered. All Work Group members were provided copies of the slide show presentation and the back up data set.

*Findings and Conclusions: Discussion of DMH Planning Checklist 4: Wellness/Recovery/Resiliency Services and Support System Planning Checklist*

The AWG also reviewed the DMH Planning Checklist 4 to assess the current performance of the public mental health system in San Mateo County, using the Fist of Five scoring method (group showing of hands). A rating scale allowed participants in Adult Work Group to score different qualities of the mental health system 0-5, with 0 stating that the component or quality is entirely absent. A five (5) would indicate that the service or quality is "a real strength in the system." This allows the group to tally all scores and to see how diverse opinions are.

Through this exercise the AWG achieved a better understanding both of the qualities of a transformed system and the extent to which the current system manifested these qualities. The completed DMH Checklist 4 rating results for the AWG are provided in Appendix L.

The desired qualities identified by a majority of AWG members as not strongly apparent in the current system included:

- Expectations of recovery are maintained.
- Administrators, staff and consumers exchange information freely.
- Psycho-social rehabilitation is emphasized.
- Clients learn to manage and manage their own resources.
- Clients are treated involuntarily as little as possible and clients are encouraged to develop advance directives for involuntary treatment when it occurs.
- Clients needs and preferences determine service structure and opportunity.
- Clients participate in service planning, development and governance of the agencies and/or service systems.
- Clients and staff share responsibility for safety.
- Community recreation is supported.
- Community interaction with other than the mental health community is encouraged and supported.
- Family members are welcomed and appropriately involved – spouses, children, siblings and parents.
- Services are culturally appropriate for the client, family and ethnic community.
- Services a client needs are identified through a single plan and personal service coordinator.
- Clients have access to and availability of staff who are aware of them 24/7 by phone, in person, or e-mail as appropriate.

- Mechanisms exist to maintain the relationship with persons who graduate and/or drop out so that they can access services if necessary.
- Clients who decline to participate and have demonstrated adverse impacts of untreated mental illness receive frequent outreach and offers of support.

Sixteen of the 33 characteristics listed in the DMH Planning Checklist 4 were identified by a majority of AWG members as a weakness of the existing system.

*Findings and Conclusions: DMH Issues of Untreated Mental Illness, Un/Under-Served Populations & Gaps in Service System*

*DMH Issues of Untreated Mental Illness*

The group did not attempt to prioritize the issues resulting from untreated mental illness identified by the Steering Committee and State DMH. But the Work Group's review of the highest priority un-served populations and the gaps in the service system identified two clear consequences of untreated mental illness:

- *Untreated substance abuse* resulting from the fragmentation of the substance abuse and mental health treatment systems and the resulting absence of fully integrated substance abuse/mental health treatment.
- *Difficult access to mental health services for consumers with physical health challenges*. The group identified an issue related to the challenge of not being able to address simultaneously the primary care and mental health needs of medically fragile consumers. Specifically, it was noted that medically fragile consumers whose health needs require hospitalizations have more difficulty accessing the level of mental health treatment required by their mental health condition.

*Un/Under-Served Populations*

The Work Group was divided into two groups comprised of 10 members each with a blend of consumers, family members, staff, and providers in each small group. The groups were asked to brainstorm an initial list of adult sub-populations that are un-served or under-served. Once the groups identified their lists, each group reported out to the full Work Group after which each member was asked to vote their priority using three pop-up notes for the sub-populations that had been listed. The Prioritized Sub-populations List is included in Appendix L. Using this process, the AWG identified the following un/under-served populations as being of the highest priority:

- Consumers in the criminal justice system, specifically those with medication needs;
- Consumers who are dually diagnosed;
- Cultural/linguistic communities, including African American, Filipino, Asian, Middle Eastern, Tongan, Latino and Native American;
- Consumers who are English language learners;
- Medically fragile individuals;
- Individuals who do not meet the SMI criteria and so cannot access services; and
- Individuals who are homeless.

All of the above populations received at least four votes. The Native American sub-population was identified only in the Adult Work Group. One Adult Work Group member was Native American.

*Gaps in Service System*

Next the AWG members considered the gaps in the service system. As with un/under-served populations, the Work Group members worked in two groups to first brainstorm the list and then were given three pop-up notes to vote for their highest priority systems in the gap. In order from most critical to least, AWG members identified the following gaps in the service system:

- Mental health court [7 votes];
- Housing [7 votes];
- Life skills services [5 votes];
- Day/partial hospitalization programs [5 votes];
- Culturally competent programs for Filipinos, African Americans, Asians and Latinos across the system of care [5 votes].

A total of 33 possible gaps were considered with 18 receiving between one to three votes and 10 receiving no votes. A complete list of gaps considered and the votes received by each is contained in Prioritized System Gaps, in Appendix L.

*Steering Committee Review & Guidance*

On March 24th, between Sessions I and II, the Steering Committee met to review the work conducted by all four Work Groups. Written Work Group Session Reports were distributed to Steering Committee members in advance of this meeting and chairpersons of each Work Group gave presentations. The Steering Committee was given an opportunity to provide feedback to each Work Group. The first such meeting was done in one large plenary comprised of over 60 individuals. Based upon feedback from participants this format was changed for future meetings, with Steering Committee members broken into groups defined by age (child/youth, transition age youth, adult, older adult) to allow for more discussion and debate. Feedback from the Steering Committee was summarized and provided to each Work Group at Session II.

*Adult Work Group Session II*

Session II was comprised of one full-day meeting and one half-day meeting. No priorities were established during Session II as the purpose of Session II was to provide AWG members with a comprehensive training on the wide range of best practice strategies that could be a part of a transformed system and to ask AWG members to identify gaps in the existing system as well as examples of best practice services and supports.

*Reflections on Work Completed & Steering Committee Feedback*

As with all Work Group sessions, the AWG began by reviewing the results of the previous session and in considering input and guidance provided by the Steering Committee. As such, the AWG reviewed and discussed:

- The Session I Work Group report;
- The Rating summaries for Planning Checklist 4;
- A Feedback Report from the Steering Committee;
- The Kick-off Vision Summary; and
- A report on the Outreach Plan which was just getting under way.

*Educational Presentations*

There were a series of presentations regarding service strategies, some including additional materials (referenced with each presentation). After each presentation, the Work Group had a brief Q & A session. This helped deepen AWG members' understanding of a wide range of evidence-based practices and issues related to the delivery of mental health services. The presentations addressed the following areas:

*Integrated Service Agencies (ISA) & Assertive Community Treatment Model Programs*

- Carlos Morales gave a slide show presentation about Assertive Community Treatment (ACT) teams and Kevin Jones discussed the Transitions program as an example of how an ACT program works. The ISA offers a continuum of services that can address a range of clients from those with modest needs for services to those who might be best served by an ACT model.

*Supportive Housing*

- Wendy Goldberg presented a slide show presentation regarding the key elements of a successful supportive housing system and the unique challenges faced by San Mateo County to create such a system.
- The County Continuum of Care plan to end homelessness identified the immediate need for an additional 750 units of affordable housing for individuals and 100 units of affordable housing for families. Additionally, over the next ten years, the plan to end homelessness identified the need for between 5,370-8,370 units over next 10 years.

*Wellness Recovery Action Planning*

- Debra Brasher gave a slide show presentation about Caminar's *Wellness Recovery and Partnership Program* and the process for developing WRAP plans. It is a strength-based, wellness-focused model.
- Carlos Morales gave a slide show presentation about *Illness Management Recovery* plan toolkits that incorporate many of the principles and practices of a wellness recovery action plan.

*Integrated Substance Abuse – Mental Health Services*

- Carlos Morales gave a slide show presentation about integrated substance abuse and mental health services where substance abuse treatment and mental health services are delivered by a single team with a single plan, not by referral to different programs.

*Integrated Services with Law Enforcement, Probation, & the Courts*

- Chris Coppola led a discussion about mental health services and the criminal justice system. She described current partnerships with the police through which 80 police officers per year will receive 40 hours of Crisis Intervention Training.

*Supported Education*

- Debra Brasher of Caminar gave a presentation and led a discussion about supported education services in San Mateo County. Key components to a supported education program are: outreach to engage consumers; case management to support their navigating the college system; and college-based support to help consumers cope with the social and educational demands of a large campus.

*Supported Employment & Benefit Planning Support*

- Robert Manchia of Vocational Rehabilitation Services gave a presentation about the employment support programs in San Mateo County. Key components to a supported education program include: job developers to cultivate jobs among employers; job coaches to support consumers and employers in defining job responsibilities and helping consumers acclimate to job conditions and employment requirements.

*Consumer Self-Help*

- Linford Gayle gave a presentation about consumer self-help. Service/support components required include: drop-in centers with coffee, food, where consumers are not necessarily required to accept services or become engaged.

*Family Education & Support*

- Eunice Kushman and Inge Greenwood gave presentations about National Alliance for the Mentally Ill (NAMI) family support groups. In addition to support groups which operate throughout the County, NAMI also offers a free 12-week "Family to Family Education Program", (2.5 hours per week comprehensive curriculum that covers both the medical knowledge and emotional support for persons coping with a mentally ill loved one). Linford Gayle discussed family support services in the County.

*Active Treatment Models (Cognitive Behavioral Treatment, Trauma, Tool Kits)*

- Evelyn Balancio gave a presentation about Cognitive Behavioral Therapy and Dialectical Behavioral Therapy (DBT). Goals of treatment focus on reducing self-harming behaviors. DBT incorporates weekly psycho-therapy with sessions on: mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness.

*Trauma Services*

- Andrea Aiello gave a slide show presentation about trauma related services and gender sensitive services. She related how it was important to treat mental health and trauma together in a welcoming, non-judging, non-blaming manner. Consumer-survivor staff, focusing first upon safety/security was emphasized.

*Medical / Health Service Integration*

- Chris Coppola gave a presentation about strategies to integrate medical and health services with mental health services. There is a critical need for a large safety net: access to skilled nursing facilities, in-home support, MOUs with dental care providers, and flexible resources to obtain health services that are needed more so because of mental health issues.

*Crisis Service Models*

- Dennis Romano of Caminar gave a presentation on crisis service continuum. To generate an effective system of crisis services would require: crisis phone line; peer drop-in crisis centers with a social model, community-based crisis diversion.

### *Gaps Analysis: Structural, Service and Support Strategies*

Over the course of Sessions II and III, the AWG completed the Transformative Services grid, based upon the Exhibit 4 Gaps Analysis Chart included in the first draft of the DMH planning guidelines (See Appendix L). The AWG assessed the extent to which each structural, service or support strategy was in place in the County. Several of the DMH listings are overlapping and so were combined. The Work Group was asked to complete the Transformative Services grid, considering whether each strategy was needed in the new system and how this strategy would improve access and outcomes for un/under-served populations and what culturally competent elements must be in place for the strategy to be successful. Desirable key elements were described for many of the strategies.

As the AWG discussed the above strategies and supports, it used the Transformative Services grid to record the extent to which each kind of service already existed in the current system, the scope of availability and specific local examples of each kind of service or support. By consensus, the Work Group members rated each type of services as: not available; available, but more needed; or sufficient capacity.

In most all instances, services were identified as either not being evident or being insufficiently available. Prior to Session III, more of this detail was added to the Transformative Services grid so it could be used in the priority setting process.

*Steering Committee*

The Steering Committee met on April 29th and heard reports from all four Work Groups who presented their findings in relation to the transformational structures, services and supports that should be part of the transformed system. The Steering Committee broke into four groups to discuss these reports and to provide feedback to each Work Group.

*Adult Work Group Session III*

Work Group members were provided a written report summarizing findings from the 100 focus groups and community forums. Separate reports were prepared for each Work Group allowing the findings to focus on issues relevant to that Work Group. Session III comprised one half-day and one full-day of deliberations with two distinct parts. First, a slide show summarizing the findings from the focus groups and community forums was presented to ensure that input from un/under-served populations was incorporated in the priority setting process to follow. The second part of Session III focused upon identifying and recommending to the Steering Committee:

- The highest priority target populations for adult services;
- The discrete population to recommend for being served by the Full Service Partnership; and
- The highest priority transformational services, strategies and supports to be funded through the MHSA.

*Review of the Work Completed to Date*

As in other sessions, the AWG Session III began with a review of materials of prior deliberation including the themes from the Kick-off, the Work Group's priority listing of un-served and under-served populations, the Steering Committee discussion of the AWG report and presentation, a summary of an updated Transformative Services grid and utilization data regarding un-served and under-served populations.

*Review of MHSA Essential Elements of Transformation and Potential Outcomes*

The AWG briefly reviewed the MHSA essential elements and outcomes. The AWG expressed concerns that the five essential elements did not sufficiently or specifically address each of the following items:

- The need for integration with the criminal justice system.
- Housing and homelessness issues.
- The extremely narrow eligibility criteria for non-SMI individuals.
- The need for quality programs and continuous quality improvement strategies. Quality is not something explicitly addressed in the State's five essential elements and Work Group members wanted our plan to reflect this as an essential element to San Mateo County's plan.
- Integrated dual diagnosis services.
- That the emphasis upon wellness and recovery addresses stigma, as does anticipated community education efforts on both local and statewide levels.
- Partnerships with private organizations, cultural organizations, faith and business organizations.

- Promoting self-help—a number of Work Group members reiterated that it was critically important that self-help be emphasized as a core value and principle to the system transformation. It was stressed that self-help is not explicitly addressed in the MHSA five essential elements and that these words need to appear as part of the very principles that form the foundation of San Mateo County's plan for transformation.

In relation to the discussion of MHSA outcomes, Work Group members felt that the following outcomes were not captured or emphasized sufficiently:

- Number of consumers hired through MHSA funding and the extent to which a career ladder is developed that provides consumers with opportunities to obtain positions providing higher salaries and benefits;
- Physical health outcomes, specifically relating to premature death; and
- Outcomes that measure the extent to which the proportion of culturally appropriate services is increasing.

*Presentation on Outreach Process*

Louise Rogers presented a slide show and written report summarizing the results of over 100 focus groups and community forums reaching over 1,000 individuals. Work Group members felt that the slide show richly captured the needs of adults and did so in a way that conveyed the human element. Work Group members noted that a number of adult issues became even more compelling after viewing and discussing the presentation, specifically issues of access and community-based services. Please see Appendix G for a copy of the Adult Work Group Community Input and Feedback Report and a presentation in Appendix H for details on the report itself.

*Review and Prioritize the Transformative Services Grid*

The Work Group reviewed the Transformative Services Grid and made two small changes:

- Adding Benefits Planning as an independent service; and
- Redefining 'faith-based services' as neighborhood-based services of which faith based services were but one example.

In addition, when conducting the second level of priorities to identify B and C level services, the group combined a number of services into single, integrated systems of services and supports:

- Created a single service described as "comprehensive support services" (e.g. food, transportation, and child care); and
- Created a continuum of crisis response services that included: 24-hour phone response, mobile crisis teams (station wagon, consumer-friendly crisis intervention), crisis stabilization (e.g. Redwood House), and neighborhood based, peer-focused crisis diversion sites (living room).

The Work Group also utilized a revised voting protocol through which each Work Group member received pairs of four different colored dots:

The group completed the first round of prioritization, with the following strategies in the top third, or A level list:

- Housing continuum;
- Integrated criminal justice-mental health services;

- Peer and family support services and social activities;
- Integrated substance abuse and mental health treatment for dually diagnosed individuals;
- Enhanced collaboration and integration of mental health services at primary care facilities designed to improve primary care services to severely emotionally disturbed (SED) individuals;
- Neighborhood-based, peer-focused multi-service and drop-in centers;
- Primary care-mental health services collaboration to engage under-served and un-served populations that utilize primary care for their health and mental health needs (e.g. Latino, Asian, Pacific Islander);
- Outreach to the homeless and those at-risk of homelessness; and
- Supported employment.

*B and C Priority Services included in order:*

The Work Group declined to distinguish Second and Third tier service priorities, instead creating a bundle of Tier II services that included:

- Comprehensive Continuum of Supports including:
  - Emergency food;
  - Child care;
  - Transportation;
  - Service navigation and personal advocacy, particularly in relation to criminal justice and child welfare systems, as well as in relation to benefits eligibility;
  - Flexible funds;
  - In-home respite; and
  - Benefits planning
- Supported education
- Crisis Services Continuum, including:
  - 24-hour phone line
  - Mobile crisis team (station wagon);
  - Crisis stabilization / diversion (e.g. Redwood House); and
  - Neighborhood based, peer-staffed crisis diversion centers (living room model).
- Evidence-based clinical practice including:
  - Integrated substance abuse (SA) and mental health services;
  - Functional Family Therapy (FFT);
  - Dialectical Behavioral Therapy (DBT);
  - Cognitive Behavioral Therapy (CBT);
  - Trauma Focused CBT;
  - Therapeutic Behavioral Services (behavioral aides); and
  - Motivational Interviewing.

*Review and Discuss Levels of Care Model and Projections & Identify Population for Full Service Partnership*

The Work Group discussed the concept of Full Service Partnerships (FSPs) and the levels of care projections in preparation for identifying the population to be targeted by the FSP. The group never was able to identify a single population by consensus, despite a long and spirited discussion. In the end, a series of votes were taken with each Work Group member being given two votes for the five highest priority

populations identified by members. These populations are listed below in order from top priority to lowest priority. In brackets is the number of votes each population received.

- Adults in the criminal justice system [17];
- Medically fragile adults [15];
- Adults in immediate crisis and at-risk of psychiatric emergency services (PES) [7];
- Homeless [1];
- Individuals at-risk of being placed in locked facilities or individuals in locked facilities for reasons other than criminal justice or primary care issues (i.e. behaviors related to serious mental illness) [0].

The AWG also indicated that across all five of these populations, a strong cultural component was necessary that included culturally sensitive outreach and engagement, a culturally diverse staff, and culturally appropriate services that acknowledge and respect the values of the diverse cultures being served.

While the AWG did not identify exactly how the above FSP would work, a number of ideas were discussed:

- The FSP should provide a fluid structure that allows individuals to move from Assertive Community Treatment-type services delivered by teams staffed at a 1:10 ratio and other team-based services ("FSP-lite") delivered at a 1:20 ratio;
- It would be most likely that separate criminal justice and medically fragile teams would be needed since the expertise involved in serving these populations was significantly different;
- Work Group members hoped that as the plan moved into Year II and Year III, FSPs could be developed for each of the above populations.

*Review Transformative Services Grid and List of Un-served Populations*

The Transformative Services Grid (See Appendix L) provides the ranking of services according to the three priority levels and identifies populations to be targeted for each service. Among the populations called out by the AWG:

- Latino, Asian and Pacific Islander populations;
- Individuals residing in locked facilities because of behaviors related to their mental illness;
- Individuals who are in the criminal justice system;
- Individuals who are homeless; and
- Individuals whose medical conditions required closer integration between mental health and primary care services.

Following the matching of populations to the service grid, there was a final round of voting on the remaining two thirds of services, to put them into clusters B and C. The fact that a service is in List C does not mean it is not needed—it is a description of phasing importance, rather than elimination from consideration (See Appendix L). These priorities were submitted to the Steering Committee. The consultants and Mental Health Services Division staff used this information to construct financial models incorporating only the A priority strategies from each Work Group. This financial model was presented to the joint Steering Committee and Work Group meeting on June 10th and in a facilitated process, the Steering Committee and Work Groups integrated the recommendations from all four Work Groups into one set of priority strategies. This process is described below after the summaries of Sessions I-III for the Older Adult Work Group.

OLDER ADULT WORK GROUP

The Older Adult Work Group (OAWG) met in three series of meetings throughout the spring. Each meeting included a review of current work to date, the presentation of educational materials on mental health, and an identification and prioritization of areas of high need for older adults with mental illness.

*Older Adult Work Group Session I*

The first Work Group Session was a full day meeting designed to provide an intensive orientation to Work Group members, to offer members an opportunity to assess the extent to which qualities and characteristics of a transformed system exist in the current system and to conduct processes through which they prioritized:

- Issues related to untreated mental illness;
- Un-served and under-served populations; and
- Gaps in the existing service system.

*Orientation*

Work Group members were given a wide range of materials selected to orient members and prepare them for the work to come. These materials were presented to Work Group members with the goal of providing a comprehensive picture of mental health needs in San Mateo County, issues relating to access for un/under-served populations, and general considerations for the mental health needs of older adults. Written summaries of the following materials were presented and discussed at the beginning of the first Work Group meeting:

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- Achieving the Promise: Transforming Mental Health Services Care in America (President's New Freedom Commission on Mental Health Services)
- Mental Health: A Report of the U.S. Surgeon General and its supplement Mental Health: Culture, Race and Ethnicity
- Latino Access Study Quality Improvement Committee by San Mateo County mental Health Services Division Latino Access Study Committee
- Being there – Making A Commitment to Mental Health from Little Hoover Commission
- San Mateo County Mental Health Services Division Strategic Plan Adult/Older Adult
- Older Adult System of Care Framework from California Mental Health Director Association
- SAHMSA Targeted Capacity Expansion: Meeting the Mental Health Services Needs of Older Adults

*San Mateo County Data Summary:* A slide presentation with a review of County population, demographic, prevalence and mental health service delivery data (San Mateo County Data Summary for Planning) was also delivered. All Work Group members were also provided copies of the slide show presentation.

*Findings and Conclusions: Discussion of DMH Planning Checklist 4: Wellness/Recovery/Resiliency Services and Support System Planning Checklist*

The DMH Planning Checklist 4 was used to assess the current performance of the public mental health system in San Mateo County, using the Fist of Five scoring method (group showing of hands). A rating scale allowed participants in Adult Work Group to score different qualities of the mental health system 0-5,

with 0 stating that the component or quality is entirely absent. A five (5) would indicate that the service or quality is "a real strength in the system." This Rating Scale was used in the first Work Group meeting to rate a wide variety of qualities identified by the State DMH as being important to an effective mental health system.

Through this exercise the OAWG achieved a better understanding both of the qualities of a transformed system and the extent to which the current system manifested these qualities. The completed DMH Planning Checklist 4 rating results for the OAWG are provided in Appendix M.

The desired qualities identified by a majority of OAWG members as not strongly apparent in the current system included:

- Expectations of recovery are maintained.
- Recovery is in the mission statement, goals, and objectives of the service.
- Resources to meet educational objectives are available.
- Clients have access to and availability of staff who are aware of them 24/7 by phone, in person, or e-mail as appropriate.
- Mechanisms exist to maintain the relationship with persons who graduate and/or drop out so that they can access services if necessary.
- Clients who decline to participate and have demonstrated adverse impacts of untreated mental illness receive frequent outreach and offers of support.

*Conclusions and Findings: DMH-Identified Issues Resulting from Untreated Mental Illness; Un/Under-Served Populations & Gaps in Service System*

*DMH-Identified Issues Resulting from Untreated Mental Illness*

The group considered the State DMH and Steering Committee lists of issues resulting from untreated mental illness. The group identified six issues that were felt by at least three members to be worthy of inclusion with the State DMH issues. After this list was developed, members were asked to vote on each issue. The numbers to the right of each issue listed below represents the number of members who voted to have that issue included with the State DMH list. The OAWG identified issues are listed in order from those receiving the most votes to those receiving the least.

- Preventable/premature death and preventable and treatable medical conditions [18 votes];
- Delusional behavior [17 votes];
- Family instability [15 votes];
- Becoming a victim of abuse [11 votes];
- Caregiver burnout [10 votes]; and
- Social disruption [3 votes].

Items Identified by State DMH of particular importance for Older Adults:

- Cultural sensitivity;
- Safety;
- Family involvement;
- Sensitivity around involuntary treatment; and
- The critical importance of individual treatment plans and the need for consumers to drive their treatment planning.

*Un/Under-Served Populations*
The OAWG was divided into two groups comprised of 10 members each with a blend of consumers, family members, staff, and providers in each small group. The groups were asked to brainstorm an initial list of older adult sub-populations that are un-served or under-served; and a list of gaps in the system of services and supports. Then the two small groups were reassembled to prioritize the populations and the services and supports.

One common theme was that there were many references to sub-populations defined by ethnicity and/or language.
The highest priority sub-populations identified by the OAWG included in order of priority:

- Latino, Pacific Islander, African American, non-English speaking Chinese and Filipino [12 votes];
- Individuals with co-occurring disorders [8 votes];
- Caregivers [5 votes];
- Older adults with diabetes, blindness, disabilities in nursing homes because board and care facilities cannot meet their physical needs [4votes]; and
- Dually-diagnosed individuals with organic brain trauma and mental illness [4 votes].

The Prioritized Sub-populations List is included in Appendix M.

*Gaps in Services*
The OAWG also prioritized gaps in the system of services. Many Work Group members prioritized system performance improvements and services that enhanced overall quality of life, rather than specific services. Most of the gaps identified were related to services that are not traditional mental health services, thus to address these gaps will require coordination with other systems and provision of more practical quality of life support services like transportation, housing, help with chores, money management, and better primary care. The highest priority gaps identified by the OAWG included, in order of priority:

- Transportation with escorts with language interpreter skills [11 votes];
- Appropriate, affordable, accessible housing [10 votes];
- Chore services—shopping, pharmacy visits, housework and repair [5 votes];
- Home medication monitoring [3 votes]; and
- After hours / 24/7 crisis care [3 votes].

A total of 48 possible gaps were considered with eight of these gaps receiving votes. A complete list of gaps considered and the votes received by each is contained in Prioritized System Gaps, in Appendix M.

***Steering Committee Review & Guidance***

On March 24th, between Sessions I and II, the Steering Committee met to review the work conducted by all four Work Groups. Written Work Group Session Reports were distributed to Steering Committee members in advance of this meeting and chairpersons of each Work Group gave presentations. The Steering Committee was given an opportunity to provide feedback to each Work Group. The first such meeting was done in one large plenary comprised of over 60 individuals. Based upon feedback from participants this format was changed for future meetings, with Steering Committee members broken into groups defined by

age (child/youth, transition age youth, adult, older adult) to allow for more discussion and debate. Feedback from the Steering Committee was summarized and provided to each Work Group at Session II.

*Older Adult Work Group Session II*

Session II comprised one full-day meeting and one half-day meeting. No priorities were established during Session II as the purpose of Session II was to provide OAWG members with a comprehensive training on the wide range of best practice strategies that could be a part of a transformed system and to ask OAWG members to identify gaps in the existing system as well as examples of best practice services and supports.

*Reflections on Work Completed & Steering Committee Feedback:*
As with all Work Group sessions, the OAWG began by reviewing the results of the previous session and in considering input and guidance provided by the Steering Committee. As such, the OAWG reviewed and discussed the following, with the note that CYWG members should keep these materials in mind during the deliberations of the Work Group, especially during the third session.

- The Session I Work Group report;
- The Rating summaries for Planning Checklist 4;
- A Feedback Report from the Steering Committee;
- The Kick-off Vision Summary; and
- A report on the Outreach Plan which was just getting under way.

*Training Presentations*:
There were a series of presentations regarding best practice structural and service strategies, some including additional materials (referenced with each presentation). After each presentation, the Work Group had a brief Q & A session.

*Integrated Service Agencies (ISAs)*

- An ISA offers a continuum of services that can address a range of clients from those with modest needs for services to those who might be best served by an Assertive Community Treatment (ACT) model. ISAs provide a personal services coordinator who helps the consumer navigate a range of services that can fluctuate according to the level of need. An ISA either delivers all the services or brokers them for the consumer.

*Integrated Substance Abuse (SA) – Mental Health Services (MH)*

- Carlos Morales gave a slide show presentation about the integration of mental health and substance abuse services for older adults. Integrated services targets consumers where they are in relation to the stages of change. Clinicians can use techniques like motivational interviewing to help consumers through stages of change and help them self-identify the need for abstinence.

*Wellness Recovery Action Planning*

- Carlos Morales gave a slide presentation about Illness Management and Recovery (IMR). IMR Toolkit from SAMHSA - illness management toolkit.
- A Wellness Recovery Action Plan (WRAP) Plan is a structured process through which the consumer identifies supports s/he needs to stay well, identities indicators of destabilization and may specify an "advance directive" which allows the consumer to remain in control of treatment approaches when they are in crisis and unable to make choices.

*Assertive Community Treatment (ACT)*

- Carlos Morales gave a slide show presentation about Assertive Community Treatment. Staff/consumer ratio of 1:10 with one team member from primary care. Daily case review with 70% of treatment in the field with services available 24/7. An ACT Team provides it all: family, health, daily activities, housing. An ACT model is especially appropriate to older adults, the team can keep an older adult at the lowest level of care

*24-Hour 7-Day a Week Response by Personal Service Coordinator*

- Lani Blazer, Aging and Adult Services, spoke about the 24/7 services currently available in the County followed by discussion of need for additional 24/7 services. Staffing patterns that mirror needs of clients; weekend social activities, peer staffed; 24/7 safe, community crisis center; peer-run/operated support social services parallel system - WRAP planning, peer counseling, etc.; respite care needed for 1-7 days.

*Integrated Services with Law Enforcement, Probation, & the Courts*

- Chris Coppola spoke about the integration of mental health services and law enforcement services.

*Specialized Services for Seniors (e.g. support services, etc.)*

- Older Adults have special needs resulting from their age, health conditions, and legal, health, and benefits issues unique to older adults. As such, there is a range of special services related to those needs. Lani Blazer spoke about the senior support services offered by the County, including In-home Support Services (IHSS), Multi-purpose Senior Services Program (MSSP), Linkages, Adult Protective Services (APS), and Probate Conservatorship. Lillian Alfaro spoke about the services at the Menlo Park Senior Center, and Shea Muller spoke about Legal Aid, Foster Grandparents, Nutrition Centers, Volunteer Program. In addition to the services at the Senior Center, Adult Day Care programs provide transportation, assistance with personal needs, sliding scale and structured activities.

*Supportive Housing*

- Childe Abutin spoke about services at Board and Care homes. Peg Morris spoke about Caminar's housing program. Krista Hermawan spoke about the services provided by the Housing Authority. Key elements include: board and care, meals, laundry, Bingo, walks around the block, and in-house activities such as chores, sorting laundry, setting tasks, medication supervision, bathing and 24/7 staffing.

*Integrated Assessment & Care*

- Susan Erhlich spoke about the Ron Robinson Senior Center and the services that they provide. Key elements include outpatient medical care for seniors offering primary care and home visits.

*Peer Support and Self-Help*

- Howard Lader spoke about the Senior Peer Counseling Program. Teresa Hurtado spoke about the Spanish-speaking component of the Senior Peer Counseling Program. This program targets emotionally and physically frail older adults. Services include weekly one-on-one meetings and grief and loss support groups, available in English and Spanish.

*Gaps Analysis: Structural Services and Support Strategies*

Over the course of Sessions II and III, the OAWG completed the Transformative Services grid, based upon the Exhibit 4 Gaps Analysis Chart included in the first draft of the DMH planning guidelines (See Appendix M). The OAWG assessed the extent to which each structural, service or support strategy was in place in the County. Several of the DMH listings are overlapping and so were combined. The Work Group was asked to complete the Transformative Services grid, considering whether each strategy was needed in the transformed system and how this strategy would improve access and outcomes for un/under-served

populations and what culturally competent elements must be in place for the strategy to be successful. Desirable key elements were described for many of the strategies.

As the OAWG discussed the above strategies and supports, it used the Transformative Services grid to record the extent to which each kind of service already existed in the current system, the scope of availability and specific local examples of each kind of service or support. By consensus, the Work Group members rated each type of services as: not available; available, but more needed; or sufficient capacity. In most all instances, services were identified as either not being evident or being insufficiently available. Prior to Session III, more of this detail was added to the Transformative Services grid so it could be used in the priority setting process.

*Steering Committee*

The Steering Committee met on April 29th and heard reports from all four Work Groups who presented their findings in relation to Exhibit 4 and the transformational structures, services and supports that should be part of the transformed system. The Steering Committee broke into four groups to discuss these reports and to provide feedback to each Work Group.

*Older Adult Work Group Session III*

Work Group members were provided a written report summarizing findings from the 100 focus groups and community forums. Separate reports were prepared for each Work Group allowing the findings to focus on issues relevant to that Work Group. Session III comprised one half-day and one full-day of deliberations with two distinct parts. First, a slide show summarizing the findings from the focus groups and community forums was presented to ensure that input from un/under-served populations was incorporated in the priority setting process to follow. The second part of Session III focused upon identifying and recommending to the Steering Committee:

- The highest priority target populations for older adult services;
- The discrete population to recommend for being served by the Full Service Partnership; and
- The highest priority transformational services, strategies and supports to be funded through the MHSA.

*Review of the Work Completed to Date*

As in other sessions, the OAWG Session III began with a review of materials of prior deliberation including the themes from the Kick-off, the Work Group's priority listing of un-served and under-served populations, the Steering Committee discussion of the OAWG report and presentation, a summary of the updated Transformative Services grid, and utilization data regarding un-served and under-served populations.

In its review of the un/under-served populations, the Work Group reaffirmed its commitment to under-served ethnic groups and older adults whose physical health needs, combined with their behaviors resulted in their being 'inappropriately' served, e.g. often living in a more restrictive setting than was necessary. In particular, the OA Work Group is concerned about individuals who live in skilled nursing facilities and board & care facilities that could be living in the community if surrounded by a network of support. The OAWG members also called out the need to address the needs of homebound older adults as another under-served or inappropriately served population.

*Presentation on Outreach Process*

Louise Rogers presented a slide show and written report summarizing the results of over 100 focus groups and community forums reaching over 1,000 individuals. Work Group members felt that the slide show richly captured the needs of older adults and did so in a way that conveyed the human element. Work Group members noted that a number of older adult issues discussed in prior meetings became even more compelling after viewing and discussing the presentation:

- The importance of addressing the isolation and loneliness experienced by older adults;
- The critical need for support in the simplest of daily tasks;
- The need for escort support while older consumers are utilizing the primary care system; and
- The need for a far simpler access system, particularly addressing the barriers of complex phone systems and other technological 'advances' that are challenging for older adults to utilize.

Please see Appendix G for the Older Adult Work Group Community Input and Feedback Report for details on the report itself and a presentation in Appendix H.

*Review of MHSA Essential Elements of Transformation and Potential Outcomes*

The OAWG briefly reviewed the essential elements and outcomes. The OAWG wanted to emphasize that:

- For older adults, outcomes related to improved access to primary care are particularly relevant;
- Wellness and recovery as concepts require redefinition when considering older adults, especially in relation to older, older adults and older adults facing end-of-life issues; and
- Generally, all outcomes and essential elements need to be considered somewhat differently in relation to older adults.

*Review and Prioritize the Transformative Services Grid*

Initially, there was significant resistance to the transformative services grid. After a closer review of the grid and making some changes to remove some strategies, and combine others, the group was reassured with the grid. Changes made included:

- Gero-psychiatric assessment program was deleted, assuming that this would be a component of the integrated mental health and primary care services;
- The 24-hour crisis hotline, mobile crisis response unit, and crisis stabilization services were integrated under the rationale that it made as much sense to link these as it did to create a continuum of housing services that were actually comprised of several housing components;
- Adult day care and adult day health care were combined;
- In-home respite and respite services were combined; and
- The Multi-Services Senior Program (MSSP) was combined with home care assistance since this was viewed as just one of many possible forms of home care support.

Changes were also made in the voting process after the first vote generated an "A" list that did not include any reference to peer services or family supports. The first ballot used nine dots per Work Group member. The second ballot limited voting to only those programs that had received 10 or more votes in the first ballot.

In the second ballot, only four different colored dots with different point values were given to each consumer. The second ballot elicited a significantly different set of priorities than the first ballot. A table in

Appendix M lists both the services, descriptions for each service, and the point total in the first round ballot and the second round ballot.

The 2nd round ballot that resulted was far more aligned with the priorities of the Work Group.

*Resulting Priority A Services included in order:*

- Peer services and supports;
- Integrated mental health and primary care services;
- Continuum of housing services tied with transportation (with escort/companions);
- Family support tied with the continuum of crisis stabilization services (24 -hour phone, mobile crisis teams, neighborhood-based crisis diversion centers, e.g. living room crisis centers);
- Home care assistance including a variety of support for basic home tasks and adherence to medication protocols related to both mental health and primary care; and
- Respite services.

*Resulting Priority B Services included in order:*

- Integrated mental health / substance abuse treatment for individuals with dual disorders;
- Neighborhood-based senior services centers;
- Adult day care and adult day health care;
- Mobile services to reach homebound older adults and older adults living in board & care;
- Outreach to homeless and those at-risk of homelessness;
- Advocacy; and
- Values driven, evidence-based clinical practices:
    - Integrated substance abuse (SA) and mental health services
    - Functional Family Therapy (FFT)
    - Dialectical Behavioral Therapy (DBT)
    - Cognitive Behavioral Therapy (CBT)
    - Trauma Focused CBT
    - Therapeutic Behavioral Services (behavioral aides)
    - Motivational Interviewing
    - Resource of Flexible funds for non-therapeutic needs

*Priority C Services included in order:*

- Senior Legal Aid services;
- Caregiver resource center;
- On site services in faith-based settings;
- Food and emergency food programs;
- Integrated services with the criminal justice system; and
- Senior volunteer program.

*Review and Discuss Levels of Care Model and Projections & Identify Population for Full Service Partnership*

The Work Group discussed the concept of Full Service Partnerships and the levels of care projections in preparation for identifying the population to be targeted by the Full Service Partnership. The OAWG identified the following under-served populations to be included in a Full Service Partnership:

- Older adults living in skilled nursing facilities (SNF)/locked facilities who could live in either board & care or affordable assisted living facilities. It was noted that there were a wide variety of assisted living programs that provided excellent care, but were too costly for many older adults;
- Older adults living in board & care facilities who could live in independent apartments if provided with adequate support;
- Older adults living in senior housing programs who could remain in these programs with more support;
- Older adults at-risk of no longer being able to live in their own apartment without increased home-based support.

*Review Transformative Services List and List of Un-served Populations*

The OAWG worked with the Transformative Services Grid and matched services listed in the grid with the highest priority populations. This is reflected in the final Transformative Services grid (Appendix M). Among the populations called out by the OAWG:

- Latino and Asian populations;
- Individuals residing in locked facilities, SNFs and board & cares where it would be possible to move to a lower level of care if they were provided with more service and support; and
- Individuals whose families were in crisis as a result of 'burn-out' from the stress of providing support and care for an older adult.

The fact that a service is in List C does not mean it is not needed—it is a description of phasing importance, rather than elimination from consideration (See Transformative Services Grid Appendix M). These priorities were submitted to the Steering Committee. The consultants and Mental Health Services Division staff used this information to construct financial models incorporating only the A priority strategies from each Work Group. This financial model was presented to the joint Steering Committee and Work Group meeting on June 10th and in a facilitated process, the Steering Committee and Work Groups integrated the recommendations from all four Work Groups into one set of priority strategies. This process is described below.

JOINT MEETING OF THE STEERING COMMITTEE AND THE FOUR WORK GROUPS

San Mateo County's MHSA Steering Committee and Child/Youth, Transition Age Youth, Adult and Older Adult Work Groups met on June 10th to develop priorities for the $4,972,600 San Mateo County MHSA Community Services and Supports planning estimate as described in the State Department of Mental Health Services letter of June 1, 2005. The consultants and Mental Health Services Division staff worked with the "A" service lists from all four Work Groups and generated program-level cost estimates for each "A" strategy. Strategies were identified that were common across age groups, largely outreach and engagement and crisis services. A separate category was created for these programs. Until the June 10th meeting, Work Group members had not been concerned with the costs involved in the strategies that they had prioritized. At this meeting for the first time, the Steering Committee and Work Groups had to wrestle with the reality of priorities that if funded completely would have exceeded the MHSA budget several times over. Materials included:

- A "big picture" financial model showing the costs of funding all Work Group "A" priority services and supporting FSPs for each Work Group population and funding a number of key 'cross-age'

strategies that addressed stigma, primary care partnerships, outreach and engagement strategies, and crisis services; and
- Financial models depicting the costs of funding "A" strategies for each Work Group organized in a worksheet for small group deliberations.

The goals of the June 10th meeting were:
- To refocus all Steering Committee and Work Group members on the priorities of the MHSA and the input from the un/under-served populations derived from the community outreach process;
- To obtain a final consensus from the Work Group's on their relative priorities in relation to:
  - The specific populations to be served by Full Service Partnerships;
  - The cross-age strategies (outreach, crisis, etc.);
  - The priority "A" strategies, essentially asking the group to additionally prioritize these "A" strategies; and
- To obtain input from the Steering Committee and Work Group members on a set of priorities that integrated "A" strategies from each Work Group, included the 'cross-age' outreach and engagement strategies and incorporated the use of half of the MHSA funding for Full Service Partnerships.

*Review of Prior Work*

As with other meetings, the session began with a review of the core values and priorities framing the MHSA. Each attendee had copies of the MHSA essential elements and outcome requirements and these were reviewed and discussed briefly. Participants were reminded that other elements of the transformation would be addressed with future MHSA components, e.g. capital facilities and technology, prevention and early intervention, education and training, and innovative programs. A slide show presentation titled Community Input and Feedback was presented to ensure that all members had at their forefront the perceptions and priorities of the un/under-served populations. This slide show synthesized the findings that were presented in age-specific Work Group presentations.

*Priority Setting*

After the slide show presentation, Steering Committee and Work Group members worked in small groups. Three page summaries were distributed to all members of the four age-defined groups. Each handout identified both the 'cross-age' Outreach and Engagement Strategies and the "A" list Transformative Services and Strategies for that Work Group. The lists included cost estimates that incorporated cost offsets and potential revenue and a final MHSA funding cost. In these small groups, the first task was to affirm that all members understood the strategy descriptions, cost and the target populations of each of the strategies.

After a presentation to the entire group on the total costs of all the "A" list priority strategies which totaled over $16 million in desired "A" services, the outreach and engagement strategies, and the Full Service Partnerships, the small groups reconvened to attempt to prioritize the "A" list strategies and the outreach and engagement strategies as well as relative allocation of funding.

Mental Heath Services Division staff and consultants provided a consolidated ranking of outreach and engagement strategies that reflected the collective priorities of the four age-defined groups. After the presentation, the entire group was asked to vote using the 'fist of five' to provide a gauge of the degree of consensus across age groups. Mental Health Services Division staff then drafted all the input and

recommendations from the Work Groups and Steering Committee and developed a draft budget of strategies and Full Service Partnerships that reflected those priorities while adhering to the fiscal limitations of San Mateo County's MHSA Community Services and Supports planning estimate. The draft Pan was next forwarded to the Mental Health Board and the Steering Committee for further review and input before releasing the draft Plan for a 30-day public comment period and a public hearing of the Plan. During the 30-day public comment period, the Work Groups were reconvened to consider the Plan in half-day sessions designed to ensure that staff adjustments to the budget and list of strategies honored the priorities expressed both by the Work Groups and by consumers and representatives of the un/under-served populations reached through the community outreach process.

Through all of the above described planning steps, the intent was to support a process that generated genuine involvement of consumers, family members, staff, partnering agencies, and individuals who have been historically un/under-served by the mental health system. As a result of this process, we have a set of prioritized strategies that reflect both the values and priorities of the MHSA and the input and direct involvement of dozens of San Mateo County consumers, family members, and providers. The process required a significant investment of time on the part of Steering Committee members and especially of Work Group members who devoted over 30 hours in meetings and untold hours reviewing reports, research, data and summaries. In the end, the inclusiveness of the process was intended to enable stakeholders to have a sense of ownership and authorship of that plan. Achieving this sense of shared authorship was one of the primary goals of San Mateo County's MHSA planning process.

## 1.3 DESCRIPTION OF ETHNIC & CULTURAL DISPARITIES WITHIN EACH SELECTED ISSUE BY AGE GROUP

To understand the experience of our un/under-served populations, we analyzed historic service utilization data to better understand patterns of service use among different populations (see Section 2 that follows). This data describes who is served and who is under-served, but it does not provide answers as to why certain populations are accessing services and why other populations remain un-served. To achieve a better understanding of *why* specific populations were unable to access services, we conducted over 100 focus groups and community forums with representatives of these populations. Below is a summary organized by age-group of the perceptions of those un/under-served populations. The discussion is organized around four themes that resonated throughout the focus group process: access, consumer-focus, cultural competence, and service integration.

### *Ethnic / Cultural Disparities Relating to Children / Youth Issues*

#### Community Input: Community Forums and Focus Groups

The community input phase of the MHSA planning provided valuable insight regarding service gaps among under-served communities. The following feedback was received from focus groups and community forums relevant to Children and Youth.

#### Access:

- Stigma remains a major barrier to care for many under-served ethnic groups. For families, stigma is an especially powerful deterrent to seeking mental health services. Families reported that children are often ostracized and teased for their mental illness.

- Lack of understanding of mental illness was also a barrier to care. Members of many un-served groups reported knowing little about mental illness, the signs, and symptoms, and where to go for help. Many said that children's ability to get services depends largely on how their families respond to mental illness.
- Among historically under-served populations, there was a common feeling that the largely Western/European approach to mental health was incongruent with how members of non-European cultures understand themselves and solve their problems. Many felt that family and community systems play important roles in health and healing in their culture, a perspective that needs to be better integrated into outreach and service provision.
- Many immigrant groups reported reluctance to use mental health services for fear of endangering their legal status in the United States. More education was needed on this issue, especially among Latinos.
- Lack of availability of mental health services within the schools and health clinics used by families was often cited as a primary barrier to care among children. Many immigrant families rely on schools for supports and information about other services. A lack of information about mental illness and the mental health system among school staff further contributed to this barrier.
- The 1-800 number, the Access Team and other access points were identified as systems that failed to serve as a point of entry and were more often described negatively than any other component of the system

Consumer Focus:

- Families wanted mental health services to be more customer-friendly, especially around appointments, returning phone calls, wait times, length of consult and directions and side effects of medications. Non-English speaking families wanted increased bilingual capacity among all staff.
- Family members wanted extended hours of operation, while some providers felt that employers need to grant employees leave to take their children to appointments during working hours.
- Family members and providers both wanted a personal service coordinator or advocate to help support them in navigating mental health services. Family members whose children were receiving services attributed their success at penetrating the system to persistence and luck. For many, advocating for their children felt like a full time job.
- Most consumers and family members and many providers identified a strong need for building peer and family capacity to be involved in treatment planning and services and supports.
- Among families for whom English is a second language, many felt that doctors did not adequately explain treatment and medication plans. They emphasized the need for bilingual providers because the child consumer may speak English, but the parents often do not.

Cultural Competence:

- Many members of un-served communities felt that their experiences and realities were not well understood by providers. Many participants expressed the desire for broader availability of providers who not only shared their cultural and linguistic background, but who also understood and legitimized their experiences.
- Members of under-served communities expressed a desire to have therapeutic and psychiatric services delivered in their primary language, e.g. Spanish, Tagalog, Chinese, or Tongan. A need for bilingual pharmacists was also expressed.

- Family members of children from immigrant communities wanted parenting education and support around acculturation issues and the cultural gap between themselves and their children. For many populations, the family system needed to be respected and integrated into treatment plans for children.

Service Integration:

- The need for integrated services was described differently by providers, consumers and family members, but it amounted to the same thing: more co-located services, in neighborhoods, facilitating access and reducing fragmentation.
- Many providers and family members cited the need for better coordination between mental health and primary care systems. Families and providers alike advocated strongly for comprehensive school-based health services.
- The treatment team for children, many family members felt, should include the child, family, teacher, counselor, and provider. School staff needed more education around behavioral therapies.
- Care is not continuous as children get older and transition out of child services. Such transitions need to be better coordinated and older youth need additional support regarding life skills, education, treatment options, and independent living.

Services:

- Family members caring for children with mental illnesses also need more information on obtaining benefits and services and their legal rights, as well as peer support.

*Ethnic / Cultural Disparities Relating to Transition Age Youth Issues*

Community Input: Community Forums and Focus Groups

The community input phase of the MHSA planning provided valuable insight on service gaps among under-served communities. The following feedback was received from focus groups and community forums relevant to Transition Age Youth.

Access

- Stigma remains a major barrier to care for many under-served ethnic groups. For youth and families, stigma is an especially powerful deterrent to seeking mental health services. Many youth we spoke with reported that shame about their mental illness prevents them from seeking help, even within their own families. The youth respondents talked about the negative association between mental illness and weakness and vulnerability. There were comments about the term "mental health' and preferred alternatives such as "wellness," "counseling," "stress resource." The level of stigma among transition age youth is so great, that many youth were reluctant to speak on the issue.
- Lack of understanding of mental illness was also a barrier to care. Members of many un-served groups reported knowing little about mental illness, the signs, and symptoms, and where to go for help. According to many participants, TAY may self-medicate with street drugs and do not receive any type of diagnosis until they enter the juvenile justice system.
- Among historically under-served populations, there was a common feeling that the largely Western/European approach to mental health was incongruent with how members on non-European cultures understand themselves and solve their problems. The concept of "mental"

versus "physical" health is seen as an artificial Western construct. Family and community systems played important roles among many under-served populations, a perspective that needed to be better integrated into outreach, education and service provision.

- Many immigrant groups reported reluctance to use mental health services for fear of endangering their legal status in the United States. More information was needed on this issue, especially among Latinos.
- Lack of availability of mental health services in other languages within the schools and health clinics used by TAY and families was often cited as a primary barrier to care. Families rely on schools for many supports and information about other services. Lack of information about mental illness and the mental health system among school staff was an additional barrier mentioned.
- Families need access to services after-hours and weekends. In addition, families need assistance with childcare and transportation. Lack of access, especially in Coast regions from Pacifica to Pescadero, combined with lack of transportation is a major barrier to access in the County.
- More than expected, TAY and providers raised the issue of lack of medical coverage for uninsured as a problem and barrier, especially among immigrant consumers.
- Transitions between programs were not simple. Movement from child/youth system to adult was challenging. There is a need for more continuity of care, e.g. juvenile hall to community, between public and private providers, between school-based psychologist/counselor and public when hospitalized, etc. Loss of trust is one of the issues discussed as an impact of the lack of continuity of care as well as the disruptiveness of switching providers.
- The 1-800 number, the Access Team and other access points were identified as systems that failed to serve as a point of entry and were more often described negatively than any other component of the system

Consumer Focus:

- Many TAY were viewed as at-risk of slipping through the cracks, particularly foster care youth, immigrant youth, and those involved in the juvenile justice system. At-risk youth, many suggested, needed additional support and tracking. For some youth on medications, this transition is also combined with increasing independence/less parent monitoring regarding taking medications, and they may stop suddenly and experience repercussions from that.
- Family members and youth both wanted a personal service coordinator or advocate for youth, though youth wanted more "quality of life" focus, while immigrant family members wanted support in navigating mental health services.
- Family members and TAY of under-served ethnic groups felt that transportation issues could be better addressed with services being delivered in natural settings in neighborhoods rather than through taxi vouchers. TAY wanted service provision to occur in teen clinics, while families emphasized the importance of school-based services.

Cultural Competence:

- Many members of un-served communities felt that their experiences and realities were not well understood by providers. Many participants expressed the desire for broader availability of providers who not only shared their cultural and linguistic background, but who also understood and legitimized their experiences. Some TAY wanted providers to come to their communities so they could better understand their lives. Others wanted providers who "looked and talked" like them.

- Members of un-served communities expressed a desire to have therapeutic and psychiatric services delivered in their primary language, e.g. Spanish, Tagalog, Chinese or Tongan. A need for bilingual pharmacists was also expressed.
- Family members of TAY from immigrant communities wanted parenting education and support around acculturation issues as well as the cultural/generational gap between themselves and their children. For many populations, the family system needed to be respected and integrated into treatment plans for TAY.

Service Integration:

- The need for more integrated services was described differently by providers, consumers and family members, but it amounted to the same thing: co-located services in communities, facilitating access and reducing fragmentation.
- Many providers and family members cited the need for better coordination between the juvenile justice, criminal justice and primary care systems. Transition services for TAY were viewed as critical by all parties, including TAY themselves.

*Ethnic / Cultural Disparities Relating to Adult Issues*

Community Input: Community Forums and Focus Groups

The community input phase of the MHSA planning provided valuable insight on service gaps among under-served communities. The following feedback was received from focus groups and community forums relevant to Adults.

Access

- Stigma remains a major barrier to care for many under-served ethnic groups. Many participants suggested that shame about mental illness keeps many people from getting the supports and services they need. Participants felt that stigma could be reduced and access improved if community leaders including the faith community were engaged by Mental Health Services Division leadership and became more informed about mental health issues.
- Lack of understanding of mental illness was also a barrier to care. Among under-served communities, conceptions of mental health were incongruent with those held by providers in the mental health system. Participants indicated that people in their communities often do not view mental health problems as a medical issue and as a result do not seek medical services for those problems.
- Members of some un-served groups said there was confusion in their communities around the difference between mental health problems and mental retardation.
- Many immigrant groups reported reluctance to use mental health services for fear of endangering their legal status in the United States. More information was needed on this topic, especially among Latinos.
- Many participants noted that services were located at distant and not easily accessible locations. Traveling to another city for services was seen as a major barrier to care by many, especially in Coastside communities.
- The 1-800 number, the Access Team and other access points were identified as systems that failed to serve as a point of entry and were more often described negatively than any other component of the system. Providers, consumers, and family members alike suggested that

Access's primary goal was to prevent people from entering the system, rather than to facilitate entry.

- For some under-served communities, interactions with County agencies were described as negative and alienating. African Americans, homeless, and veteran participants, for example, felt that few agencies had their best interests in mind and at times felt discriminated against. Negative previous experiences with government institutions kept many members from accessing services.
- Many participants felt that peer-led workshops on mental health at community centers and churches could also effectively address the knowledge gap and decrease stigma. Latino participants were especially enthusiastic about the "navigator" model in which potential clients receive assistance in navigating the system from a peer "guide." Similar ideas were expressed by participants of other cultures. Others felt that such workshops should occur within people's homes in under-served communities.
- Some participants expressed the need for community support for people experiencing social and economic stresses, especially among immigrant communities. Increased social supports would prevent greater mental health issues.

Consumer Focus:

- Consumers, family members, providers and community members all wanted mental health services to be more customer-friendly, especially around appointments, returning phone calls, wait times, length of consult and directions and side effects of medications. The current system, many felt, was alienating and time consuming to navigate.
- Family members, consumers, and providers all concurred on the need for a personal service coordinator (PSC) or advocate for consumers. The PSC, many felt, should have a clearly defined role and support consumers during transitions.
- While some consumers advocated for expanded transportation services, many felt that this issue could be better addressed through neighborhood and community-based services, staffed by consumers of diverse backgrounds.

Cultural Competence:

- Members of un-served communities felt that their experiences and realities were not well understood by providers, including African American, Latino, Filipino, Chinese, and Tongan participants. Many participants expressed the desire for broader availability of providers who not only shared their cultural and linguistic background, but who also understood and legitimized their experiences.
- Among historically under-served populations, there was a common feeling that the largely Western/European approach to mental health was incongruent with how members of non-European cultures understand themselves and solve their problems. According to many participants, family and community systems play important roles in health and healing among many under-served populations, a perspective that needs to be better integrated into outreach and service provision.
- Many providers and members of under-served communities concurred on the need for more bilingual and culturally competent services. Providers recommended professional development for all staff. Consumers emphasized the need for therapeutic and psychiatric services to be delivered in their primary language, e.g. Spanish, Tagalog, Chinese or Tongan. A need for bilingual pharmacists was also expressed.

Service Integration:

- Many participants also suggested that services be better coordinated between different systems, especially during times of transition, including during entry and discharge from the criminal justice system, discharge from the hospital, and during any changes in provider or program.
- Consumers, family members, and advocates of adult consumers all wanted drop-in and walk-in services that addressed the needs of the whole person. Many suggested drop-in clinics with comprehensive health and quality of life services. Consumers wanted to be able to go to one place to get a physical health and housing problem addressed.

Services:

- Crisis services were in need of improvement and expansion, according to many participants. Many would like to see expanded 24/7 services, with immediate crisis response. The current system was described as an "answering service" and difficult for people in crisis to navigate, especially for consumers with limited English proficiency.
- Some consumers and advocates would like to see more home-based services and supports; this perspective was especially important to Filipino and Tongan participants.

*Ethnic / Cultural Disparities Relating to Older Adult Issues*

Community Input: Community Forums and Focus Groups

The community input phase of the MHSA planning provided valuable insight on service gaps among under-served communities. The following feedback was received from focus groups and community forums relevant to Older Adults.

Access:

- Stigma and embarrassment remains a major barrier for many under-served ethnic groups. Many older adults expressed fear about being negatively judged by their peers and family members or being discriminated against in employment because of mental illness. Participants felt that stigma could be reduced and access improved if community leaders including the faith community were engaged by Mental Health Services Division leadership and became more informed about mental health issues.
- Older adults fear hospitalization, overmedication and the loss of independence/interference from others. They also expressed fear over the loss of confidentiality.
- Lack of information and understanding of mental health and services was also a barrier to care. Members of many un-served groups reported knowing little about mental illness, the signs, and symptoms, and where to go for help. Some participants noted that many older people ignore late onset mental illness and attribute symptoms to age instead.
- Family member and caregiver's knowledge of mental health and services plays an important role in whether or not some older adults access services. Other participants also indicated that older adults without caregivers and families are a highly under-served population.
- Many participants noted that services were located at distant and not easily accessible locations. Traveling to another city for services was seen as a major barrier to care by many. Older adults overwhelmingly expressed the need for accessible hospitals, doctors, specialists and medication.
- The 1-800 number, the Access Team and other access points were identified as systems that failed to serve as a point of entry and were more often described negatively than any other

component of the system, especially among consumers with limited English proficiency. Providers, consumers, and family members alike suggested that Access's primary goal was to prevent people from entering the system, rather than facilitating entry.

- Older adults indicated the paperwork associated with accessing care was overwhelming, especially to those with limited educational background.
- More information is needed regarding the services available. They also indicated a need for "one place to call for info" or a "guide" to help navigate the services.

Consumer Focus:

- Older adult consumers, family members, and community members all wanted mental health services to be more individualized, customer-friendly, especially around appointments, returning phone calls, wait times, length of consult and directions and side effects of medications. Many felt it was unreasonable to expect older adults to navigate complex menu options to leave a message for their provider.
- Family members, older adult consumers, and providers all concurred on the need for a personal service coordinator (PSC), guide, or advocate for older adults. The PSC, many felt, should have a clearly defined role, support consumers during transitions, and have the power to do placements.
- While some consumers advocated for transportation services to be integrated into mental health services for older adults, many felt that this issue could be better addressed through neighborhood and community-based services. Others suggested home-based services, especially for medically fragile adults.
- Most consumers and family members and many providers identified a strong need for building family capacity to be involved in treatment planning, services and supports. Caregiver education was also mentioned as a key component of improving overall quality of care to older adults. Support groups for family members and caregivers are important to older adults to promote understanding and patience.

Cultural Competence:

- Many providers and members of under-served communities concurred on the need for more bilingual and culturally competent services. Providers recommended professional development for all staff. Consumers emphasized the need for therapeutic and psychiatric services to be delivered in their primary language, e.g. Spanish, Tagalog, Chinese or Tongan or at the availability of translators. A need for bilingual pharmacists was also expressed.
- Among historically under-served populations, there was a common feeling that the largely Western/European approach to mental health was incongruent with how members of non-European cultures understand themselves and solve their problems. Family and community systems played important roles in health and healing among many under-served populations, a perspective that needed to be better integrated into outreach and service provision.

Service Integration:

- The need for integrated services was described differently by providers, consumers and family members, but it amounted to the same thing: more co-located services, in neighborhoods, facilitating access and reducing fragmentation.
- Some older adults expressed the need for spirituality and religion to be integrated in treatment and co-locating services in inter-faith settings.

Services:

- Many older adults were reasonably satisfied with the quality of care they received upon accessing mental health services. Even among under-served communities, many expressed a high degree of satisfaction with psychiatric and therapeutic services. Latino participants were especially pleased with their individual and group therapy experiences.
- However, consumers, providers, and family members widely agreed that broader availability of services and support groups are needed to meet the needs of older adults in San Mateo County.
- Crisis services were in need of improvement and expansion, according to many participants. Many would like to see expanded 24/7 services, with immediate crisis response. The current system was described as an "answering service" and difficult for older adults to navigate. The need for a crisis line that has a live, bilingual person was mentioned.
- Some consumers and advocates would like to see more home-based services for older adults, this perspective was especially important to Filipino and Tongan participants.

## 1.4 RATIONALE FOR SELECTING ANY ISSUES NOT IDENTIFIED BY MHSA

As noted throughout, the San Mateo County planning process was not driven by "issues" as much as it was driven by a focus on un/under-served populations, gaps in services and qualities of a transformed system. A review of the strategies selected by the stakeholders shows that they address the MHSA issues as well as the other concerns identified by those engaged in the planning process. Key issues identified by age-specific Work Groups and through the community outreach process were consistent with issues identified within MHSA requirements. There was a heavier emphasis on outreach and engagement strategies than specific mental health services particularly in light of concerns about disparities in access.

# SECTION 2: ANALYZING MENTAL HEALTH SERVICES NEEDS IN THE COMMUNITY

## 2.1 NARRATIVE ANALYSIS OF UN-SERVED POPULATIONS BY AGE GROUP

The first component of our analysis of un-served populations in San Mateo County uses the State DMH website data regarding prevalence projections as factored by 200% of poverty. However, as acknowledged in DMH Letter No: 05-02, 200% of poverty is not an adequate predictor of need in counties where there is a higher cost of self-sufficiency. While we were unable to factor the details of the State DMH prevalence predictions to incorporate the higher cost of self-sufficiency and the larger base of potential users of public mental health services in San Mateo County, it is worth noting that the San Mateo County self-sufficiency adjustment factor for one adult with two children is 1.9476—a factor that could double the potential population to be served. Two hundred percent of poverty prevalence also does not account for the need or mandate under AB3632 for mental health (MH) services for special education students with an Individual Education Plan (IEP) specifying MH services, including psychiatric emergency services. Under these circumstances, comparisons by percentage of the population projected and population served rather than the numbers themselves, as is demonstrated in Table 1 below, is a more conservative approach to calculation of the un-served.

Another feature of the State DMH prevalence projections is that the age breaks do not support a clean analysis of the Transition Age Youth population (age 16-25) or of the Older Adult population when defined as those over 60, as has been the practice in San Mateo County. The DMH data also does not crosswalk the prevalence by age with prevalence by ethnicity. When possible, other sources have been used to describe these factors in the narrative discussions that follow (throughout this narrative, data sources are identified).

The following observations about percentages of populations that were un-served/served by the Mental Health Services Division can be made from Table 1. The fact that services were provided is not meant to imply that all individuals receiving services were adequately or appropriately served—the discussion of under-service follows later in this section.

- More people were actually served by the Mental Health Services Division than projected by state prevalence methods when restricted to 200% of poverty.
- Fewer females and more males were served than projected.
- Slightly fewer children/youth were served than projected.
- About the same number of transition age youth were served as projected.
- More adults were served than projected.
- Fewer older adults were served than projected.
- Significantly more Whites and African Americans were served than projected.
- Significantly fewer Latinos and Asian/Pacific Islanders were served than projected.
- Significantly fewer people were served in their primary language than may need it.

Table 1

## Comparisons of Prevalence Estimates and 03/04 Actual Consumers Served

(Note that DMH prevalence data does not show age breaks at 16 for transition age or at 59 for older adults)

| | | Prevalence Estimates <200% poverty | | | Mental Health Consumers | |
|---|---|---|---|---|---|---|
| | | 2004 | Subtotal | % | FY2003/04 | % |
| **Total Population** | | **9,166** | | | **11,154** | |
| ***Gender Distributions*** | | | | | | |
| Male | | 3,627 | | 40% | 5,258 | 47% |
| Female | | 5,537 | | 60% | 5,896 | 53% |
| ***Age Distributions*** | | | | | | |
| 00-05 | | 945 | | | | |
| 06-11 | | 1,007 | | | | |
| 12-17 | | 827 | | | | |
| | **00-17** | | **2,778** | **30%** | **3,127** | **28%** |
| **Transition Age** | **18-25** | | **1,522** | **17%** | | |
| | **16-25** | | | | **2,030** | **18%** |
| 18-20 | | 739 | | | | |
| 21-24 | | 782 | | | | |
| 25-34 | | 1,311 | | | | |
| 35-44 | | 1,383 | | | | |
| 45-54 | | 716 | | | | |
| 55-64 | | 562 | | | | |
| | **18-64** | | **5,493** | **60%** | | |
| | **18-59** | | | | **7,071** | **63%** |
| | **65+** | **894** | **894** | **10%** | | |
| | **60+** | | | | **956** | **9%** |
| ***Ethnic Distributions*** | | | | | | |
| **White-NH** | | **2,434** | **2,434** | **27%** | **4,734** | **42%** |
| **African Am-NH** | | **417** | **417** | **5%** | **1,151** | **10%** |
| Asian-NH | | 1,275 | | | | |
| Pacific I-NH | | 209 | | | | |
| **Asian/PI** | | | **1,484** | **16%** | **774** | **7%** |
| **Hispanic** | | **4,320** | **4,320** | **47%** | **3,014** | **27%** |
| Native-NH | | 43 | | | | |
| Other-NH | | 58 | | | | |
| Multi-NH | | 408 | | | | |
| **Other** | | | **510** | **6%** | **1,481** | **13%** |

**Data Sources:** DMH Website and SMCMH 03/04 Data Book

| ***Language Distributions (not available for prevalence subpopulation analysis)*** | | | | |
|---|---|---|---|---|
| | Total Population > 5 Years (a) | | FY 03/04 Consumers (b) | |
| ***Language Spoken at Home*** | **Count** | **%** | **Count** | **%** |
| English only | 387,594 | 59% | 9,158 | 82% |
| Non- English | | 40% | 1,996 | 18% |
| Spanish | 119,972 | 18% | | |
| Asian/PI | 102,970 | 16% | | |
| Other | 44,044 | 7% | | |
| Total | **662,509** | | | |

**Data Sources:**
(a) San Mateo County Cultural Competence Plan (2000 Census Data)
(b) SMCMH 03/04 Data Book

Additionally, we looked at data regarding homeless status, disability status, seasonal and migrant farm workers and projected demand, but we were not always able to factor age cohorts. We were also not able to compare these forecasts of possible need to the numbers of individuals served by the Mental Health Services Division in FY 03/04 because these are not data elements that are currently available; we have had to use proxy data. The forecasts and potential un-served populations include:

- At any point in time in 2004 there were 1,429 homeless individuals in San Mateo County; the unduplicated count over the year was 4,500 people (Data Source: San Mateo County). The populations identified as most at-risk of becoming homeless are Latinos and African Americans. The Federal Task Force on Homelessness and Severe Mental Illness estimates that 33% of those that are homeless have a serious mental illness (SMI), and of these, 40-60% have a co-occurring substance abuse (SA) disorder. In San Mateo County, this would result in almost 1,500 homeless individuals per year that require mental health/co-occurring disorder services. While this population is mostly adult, there are also transition age youth and older adults in the homeless population. In San Mateo County, the Transitions (AB2034) program has been focusing on the homeless population, serving 71 adults and 11 older adults in FY 03/04. We conclude that a substantial proportion of the homeless population is un-served.
- In regard to those with a sensory, physical, mental or self-care disability (Data Source: San Mateo County 2000 Census Data), there are over 100,000 individuals in San Mateo County. The breakdown by age group is listed below and prevalence assumptions from the U.S. Surgeon General's Report (9-13% of children have a serious emotional disturbance (SED) and 5.4% of adults and older adults have a SMI) are applied to calculate the number that would need mental health services.

| | | | |
|---|---|---|---|
| 5-20 | 3,969 | @ 13%= | 516 |
| 21-64 | 73,274 | @5.4%= | 3,957 |
| 65+ | 30,397 | @5.4%= | 1,641 |

- If we assume that some portion of the total children/youth (3,127 in FY 03/04) and adults (7,071 in FY 03/04) served by the Mental Health Services Division fall into the disability population, it is the older adult population that stands out as un-served. In FY 03/04, 956 older adults were served, and only 141 of these were served by the Elder Outreach program, designed to reach isolated, disabled and home-bound elderly.
- Few people think of San Mateo County as having seasonal and migrant farm workers, but the western portion of the County has an active agricultural component and is geographically isolated by coastal foothills and distributed along the coastline. At any given point in time in 2004 (Data Source: San Mateo County 2000 Census Data) there were 3,183 farm workers and/or their families. Again using the Surgeon General's prevalence numbers, we might expect to have served 172 of these individuals. However, in FY 03/04, our Coastside clinic served a total of 225 individuals and only 65 were identified as Latino. The farm workers and their families are significantly un-served.
- It should be noted that Native Americans comprise approximately one half of one percent of the population of San Mateo County (information from 2000 Census). An online search did not yield any results for Native American cultural or advocacy organizations in the County.

Children / Youth

Based on the data summarized in Table 1 above, it can be concluded that the current Mental Health Services Division does not serve the Latino, Asian and Pacific Islander populations at the levels we would expect to see them in our consumer population. We assume this is true across the age span. In addition, we know that:

- By grade 9, 1.2% of San Mateo County Pacific Islanders and 1.4 % of Latinos have dropped out of school, compared to an overall San Mateo County rate of 0.8% (Data Source: California Department of Education).
- In 2004, 812 unduplicated San Mateo County children/youth were in out-of-home placements both in-county and out-of-county (Data Source: San Mateo County). Based on the work of the San Mateo County Child Welfare System Improvement group, up to 50% of these children/youth, or 406 annually, require mental health services. In FY 03/04 the current system was able to serve 286 children/youth in the child welfare system (and an additional 15 in the Wrap Around program), leaving about one third un-served. According to a report recently prepared for the Peninsula Preteen Alliance, a disproportionate number of African Americans (41% of 2003 foster care children, while only 3% of the population) and Latinos (more than half of the child abuse cases) suffer from child abuse and neglect and are placed in the foster care system.
- In the San Mateo County juvenile justice system, there were about 239 youth at any point in time in 2004 in the juvenile justice facility, with 1,831 duplicated bookings (Data Source: San Mateo County). According to 2003 San Mateo County data, African Americans (80 arrests per 1,000 African American youth) and Latinos (14 arrests per 1,000 Latino youth) have higher rates of felony arrests than the remainder of the population (8.1 arrests per 1,000 Caucasian youth and 8.9 arrests per 1,000 for all other youth) and so are over-represented in the juvenile justice population (Data Source: San Mateo County Children's Report).
- Projections based on reports from the U.S. Department of Justice suggest that, at any point in time, there would be at least 143 youth requiring mental health services. The current system provided service in FY 03/04 to 870 youth involved with the juvenile justice system, including youth in camps and on probation (these individuals were 17 or younger and more than one third were Latino). The current system provides for crisis services in juvenile hall and the camps, with more intensive services available only to those that are already in mental health service prior to admission to the facility. Further, the anecdotal information available from juvenile justice staff indicates that there is a serious problem in developing and implementing mental health aftercare plans and services for youth exiting juvenile justice facilities and placements.
- 4.2% of 7th graders in San Mateo County report binge drinking and 6% report trying marijuana (Data Source: Preteen Alliance Report). The Surgeon General's report tells us that 2% of SED youth also have a substance abuse disorder.
- 23% of 7th graders in San Mateo County report feeling so sad and hopeless almost every day for two weeks that they stopped doing some usual activities. Girls were more likely than boys to report feeling sad and hopeless, and Latina girls were more likely than any other group to report at 33% (Data Source: Preteen Alliance Report).
- In San Mateo County, at any point in time (Data Source: California Health Interview Survey 2003), there are 14,589 children/youth that are uninsured. Using the Surgeon General's prevalence forecasts, this suggests that at least 1,800 children/youth in San Mateo County are uninsured but

require mental health services. The current system served 1,031 children/youth in FY 03/04 that had no known source of insurance coverage, leaving the remaining portion of the projected population that is uninsured without services.

Transition Age Youth

Based on the data summarized in Table 1 above, it can be concluded that the current Mental Health Services Division does not serve the Latino, Asian and Pacific Islander populations at the levels we would expect to see them in our consumer population. We assume this is true across the age span. In addition, we know that:

- By grade 9, 1.2% of San Mateo County Pacific Islanders and 1.4% of Latinos have dropped out of school, compared to a San Mateo County average of 0.8%. By grades 9-12 (4 year summary), these numbers have grown to 10.3% of Pacific Islanders and 11.8 % of Latinos, compared to an overall San Mateo County rate of 6.1% (Data Source: California Department of Education).
- In San Mateo County, from 2000-2002, 14 youth aged 15-24 committed suicide, making suicide the third leading cause of death in this age group, after unintentional injury and motor vehicle accidents. Gay, lesbian, bisexual and transgender teens are more likely to seriously consider and attempt suicide than heterosexual teens (Data Source: San Mateo County Children's Report).
- In 2004, nearly 33% of 9th and 11th graders in San Mateo County reported using alcohol in the last month, and 17% reported using marijuana (Data Source: San Mateo County Children's Report).
- The National Comorbidity Survey Replication, reported in the June 2004 issue of Archives of General Psychiatry, focused on studying the prevalence of mental health need in those 18 and above, and found that mental disorders "gain the strongest foothold" by attacking youth—50% of all cases start by age 14 and 75% by age 24.
- As noted earlier, in 2004, 812 San Mateo County children/youth were in out-of-home placements both in-county and out-of-county (we are unable to break this out between child/youth and TAY). Based on the work of the San Mateo County Child Welfare System Improvement group, up to 50% of these children/youth, or 406 annually, require mental health services. In FY 03/04 the current system was able to serve 286 children/youth in the child welfare system, leaving about one third un-served. Most of the current system services provided in the San Mateo County juvenile justice system were for those 17 or younger. For those aged 16-25, the problem is expanded due to youth leaving foster care or other out-of-home placements with no community supports. In FY 03/04, the San Mateo Youth Transition to Adult Committee (YTAC) program served 60 transition age SED youth. The Support and Advocacy for Young Adults in Transition (SAYAT) program, targeted at homeless or at-risk of homeless SED youth, served 40 individuals.
- An issue identified by youth serving on the TAY planning group is young SED parents in the TAY age group, who may or may not have their children with them. There are very limited services available to this population, especially if the children are placed elsewhere. The Mental Health Services Division Pre-to-Three program served 308 parents and 251 children in FY 03/04. Of the parents, 131, or almost half, were ages 16-25. More than half of the population served by this program was Latino.
- Another group identified as un-served in the planning process is very difficult to quantify in terms of the numbers needing services and those actually served—youth that are gang-involved. We know

that 9% (13% Latino, 11% African American and an unknown percentage of Asian/Pacific Islander youth) of San Mateo County 7th graders reported gang involvement (Data Source: Preteen Alliance Report). There is an overlap with the juvenile justice and adult justice system numbers. Both youth and families raised this group frequently as an example of the lack of service from the present system.

Adults

Based on the data summarized in Table 1 above, it can be concluded that the current Mental Health Services Division does not serve the Latino, Asian and Pacific Islander populations at the levels we would expect to see them in our consumer population. We assume this is true across the age span. In addition, we know that:

- At any point in time in 2004, 1,101 adults were in the San Mateo County jail system, with 13,208 total duplicated bookings (Data Source: San Mateo County). African Americans (19% of bookings) and Latinos (34% of bookings) are overrepresented in the jail population compared to their proportions in the general population; males represent 81% of bookings. The U.S. Department of Justice estimates that 16% of jail inmates have serious mental illness and that 40-60% of these individuals also have a co-occurring substance abuse disorder. This suggests there are 176 individuals in jail at any point in time who may require mental health/co-occurring services. In many communities, there has been an effort to divert individuals with SMI from the criminal justice system through the use of Mental Health Courts and booking diversion methods. Currently, there is no Mental Health Court in San Mateo County; however, the San Mateo County Mental Health Services Mentally Ill Offender project did serve 57 individuals in FY 03/04.

- In San Mateo County, at any point in time there are 58,036 adults that are uninsured (Data Source: California Health Interview Survey 2003). Using the Surgeon General's prevalence forecasts, this suggests that at least 3,134 adults in San Mateo County are uninsured but require mental health services. The current system served 804 adults in FY 03/04 that had no known source of coverage, leaving the remaining portion of the projected population that is uninsured without services.

- According to the National Comorbidity Survey Replication, over a 12 month period, 60% of those with a mental disorder got no treatment at all. Groups such as the elderly, racial/ethnic minorities and those with low income or without insurance had the greatest unmet need for treatment. Those who did get treatment were more likely to be seen by a primary care physician (22.8%) than by a psychiatrist (12%) or a non-psychiatrist mental health specialist (16%). We also know from substance abuse treatment providers that there are high numbers of individuals treated through with dual mental health and drug and alcohol disorders served in substance abuse treatment programs.

- The National Comorbidity Survey Replication also reports that in any given year, 9.5% of the population age 18 and older will experience a mood disorder (e.g., depression, bipolar), and that 45% of those with mood disorders are severely affected. The median age of onset is 30 years of age, but the delay in initial treatment contact ranges from six to eight years. The cost of depression in healthcare and the workforce has been well documented—among the five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) that account for 49% of total healthcare costs and 42% of illness-related lost wages, mood disorders rank third in healthcare costs, first in work loss costs and second in total costs. Yet it is under-recognized and under-treated in primary care settings (30-40% not identified and about 10% only on benzodiazepines). (Data Source: Integrating Behavioral Health and Primary Care Services, NASMHPD, 2005).

Older Adults

Based on the data summarized in Table 1 above, it can be concluded that the current Mental Health Services Division does not serve the Latino, Asian and Pacific Islander populations at the levels we would expect to see them in our consumer population. We assume this is true across the age span. In addition, we know that:

- As noted above, older adults are found in the San Mateo County un-served homeless population and are among the disabled population that is un-served.
- There has been a decline in the number of older adults served by the San Mateo County mental health system over the last four years. The Elder Outreach team went from an annual caseload of 196 to 141, the clinics went from 542 to 372, and the network went from 235 to 133.
- Nationally, in the recently completed *PRISMe* study of patients 65 and older, 20% scored positive for psychological distress, 8% for at-risk drinking, and 5% had suicidal thoughts. With "the best referral process imaginable", only 49% of the patients referred actually were engaged in specialty behavioral health services, compared to 71% in a primary care integrated model. Specifically, the engagement rate for depression in the integrated model was 76%, in the referral model, 55%; the engagement rate for alcohol in the integrated model was 72%, in the referral model, 29%. Findings also included greater engagement for more severe symptoms and worse functioning, high engagement among suicidal elderly and engagement demonstrated across different clinics and ethnicities. (Data Source: Integrating Behavioral Health and Primary Care Services, NASMHPD, 2005). We believe that there are many un-served older adults in primary care, but based on national research findings, they may not be identified and referred for treatment.

## 2.2 ANALYSIS OF FY 03/04 MENTAL HEALTH SERVICES DIVISION UTILIZATION DATA: THOSE CURRENTLY FULLY SERVED OR UNDER/INAPPROPRIATELY SERVED

This discussion of utilization data begins with an overview of the process of initiating and engaging people in services. During analysis of Mental Health Services Division FY 03/04 utilization data, we saw that 27% of all individuals known to the system had two or fewer hours of service. Wanting to better understand this phenomenon, we utilized an emerging standard for measuring initiation and engagement in services (Source: 2nd Forum on Performance Measures, Carter Center, April 2004).

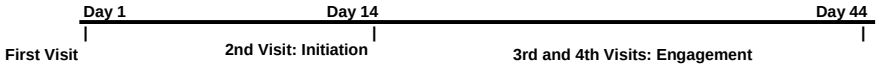
As demonstrated in the diagram below, we found that only 31% of the Mental Health Services Division client episodes met the full initiation and engagement standard—many of the individuals who sought services from our mental health system did not return for a 2nd visit or the 2nd visit was not timely; for those that met the initiation standard, many did not get a 4th visit or a timely 4th visit. This pattern varied by age groups, with 44% of children/youth episodes fully meeting the standard, 27% of adults, and only 11% of older adults. There was no significant difference by payor source or language status; however, there were a larger proportion of Latino client episodes that met the standard (41%) than the overall average. This data, combined with the information collected from the community during the outreach forum and focus group process, tells us that not only is the mental health system difficult to understand in terms of how to enter it, there are barriers in the entry process itself that need to be identified and addressed.

**Definitions**

**Episode:** Services provided to a client where there wasn't a break in service longer than 119 days. If a longer break occurred, a new episode began.

**Initiation Standard:** A client must have a second visit within 14 days after the first visit to meet the Initiation Standard.

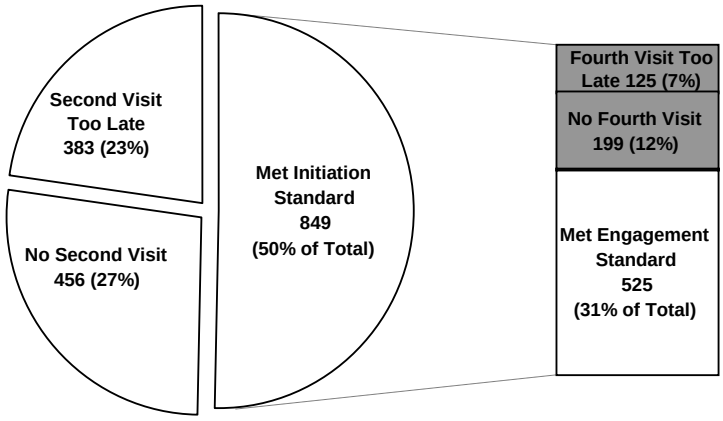
**Engagement Standard:** A client who met the Initiation Standard must have a 3rd and 4th visit within 30 days after the 2nd visit (4 visits in 44 days).




**Episode Data Analysis**

| | Total Episodes | | Met Initiation Standard (2nd visit, 14 days) | | Didn't Meet Initiation Standard | | | | Met Engagement Standard | | Didn't Meet Engagement Standard | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | No Second Visit | | Second Visit Too Late | | | | No Fourth Visit | | Fourth Visit Too Late | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| **All Ages** | **1,688** | **100%** | **849** | **50%** | **456** | **27%** | **383** | **23%** | **525** | **31%** | **199** | **12%** | **125** | **7%** |

**Note:** The 1,688 episodes were for 1,576 clients; 3 clients had 3 episodes, and 106 clients had 2 episodes (per Episode definition).




Additional information from the overall analysis of our FY 03/04 utilization data includes:

- Most people (10,085) were served in the outpatient system, including psychiatric emergency and Access Team contacts.
- Over 2,000 adult clients (or 59% of all adult clients) were served with less than 15 hours of service per year. Of these, 17% received only medication related services.
- About 2,500 people also used San Mateo Medical Center Psychiatric Emergency Services (PES) for crisis services. Of these, most were adults, followed by children/youth and then older adults. Between 20% (older adults) and 35% (children/youth) had received services from the mental health system prior to the first PES visit. Post the PES visit, 76% of children/youth received services compared with only 37% of adults and 36% of older adults.
- Just over 700 people had inpatient episodes, most of them adults. There were 89 transition age youth and 70 older adults. The number of consumers with five or more inpatient episodes dropped from 23 in FY 02/03 to 11 in FY 03/04. A review of these 11 cases indicated the investment of a minimum of 47 hours of outpatient services to a top of 312 hours of outpatient service in addition to the inpatient stays.
- Over 500 adults received residential services in addition to outpatient services; 109 people were served in SNF/locked facilities; 12 of these individuals were older adults.

- Slightly over half of the people served by San Mateo County were Medi-Cal beneficiaries (56.5%), although this varied by age group. About 7% of the people served were on and off of Medi-Cal during the year of service.
- There is a range in the percentage of Medi-Cal consumers served by sub-region (countywide average, 12.13%, ranging from 8.63% in East Palo Alto to 14.48% in Central). Sub-regions also show variance in the percentages by ethnicity of the Medi-Cal population served.
- The diagnostic mix of San Mateo County consumers was:

| | |
|---|---|
| ADHD | 2% |
| Anxiety | 6% |
| Bipolar | 5% |
| Conduct Disorder | 1% |
| Deferred | 26% |
| Depression / Mood Disorder | 20% |
| Other | 14% |
| Schizophrenia / Psychotic | 25% |

The mix of diagnoses is representative of most public mental health systems. The number of deferred diagnoses may reflect capacity issues, in terms of time and availability of staff to develop more detailed diagnostic analyses, but is a serious barrier to adequate treatment planning.

A key utilization issue that Mental Health Services Division has been tracking is the amount of service received in relationship to clinical need. During FY 03/04, on average, a consumer received 20 hours of service per year. Children got slightly more service (average hours, 24.8), while adults (average hours, 18) and older adults (average hours, 15.3) got less service. As Table 2 below demonstrates, these trends have been steady over the last four years.

San Mateo County contracted providers reported higher levels of service (average hours, 29) than the County clinics (average hours, 18.8) which is predictable given that new, more intensive programs have been contracted through community-based providers. The managed care network served Medi-Cal consumers with lower needs for services (average hours, 4).

Table 2

**Standardized Service Hour (clinician hour) Trend View**

| | 2000-2001 | 2001-2002 | 2002-2003 | 2003-2004 |
|---|---|---|---|---|
| **Percent of Cases Grouped by Total Clinical Hours and AGE** | | | | |
| **All Ages** | | | | |
| Low: 0-15 (white) | 69% | 70% | 70% | 68% |
| Med: 16-60 (gray) | 23% | 22% | 22% | 23% |
| High: 61+ (black) | 8% | 8% | 9% | 9% |
| **Children** | | | | |
| Low: 0-15 (white) | 59% | 61% | 60% | 60% |
| Med: 16-60 (gray) | 29% | 27% | 27% | 28% |
| High: 61+ (black) | 13% | 13% | 13% | 11% |
| **Adults** | | | | |
| Low: 0-15 (white) | 73% | 73% | 73% | 72% |
| Med: 16-60 (gray) | 21% | 20% | 19% | 21% |
| High: 61+ (black) | 6% | 7% | 8% | 7% |
| **Older Adults** | | | | |
| Low: 0-15 (white) | 75% | 75% | 77% | 74% |
| Med: 16-60 (gray) | 22% | 22% | 19% | 20% |
| High: 61+ (black) | 3% | 3% | 4% | 6% |
| **Average Clinician Hours per Case within Groupings** | | | | |
| **All Ages** | | | | |
| Low: 0-15 | 4.9 | 4.3 | 4.4 | 4.3 |
| Med: 16-60 | 33.8 | 30.1 | 30.9 | 30.3 |
| High: 61+ | 143.0 | 127.4 | 121.4 | 118.0 |
| All Cases | 19.8 | 20.1 | 20.4 | 20.0 |
| **Children** | | | | |
| Low: 0-15 | 5.0 | 4.0 | 4.5 | 4.3 |
| Med: 16-60 | 36.1 | 30.7 | 32.4 | 31.4 |
| High: 61+ | 159.2 | 133.4 | 123.3 | 116.0 |
| All Cases | 30.2 | 27.4 | 27.0 | 24.8 |
| **Adults** | | | | |
| Low: 0-15 | 4.9 | 4.3 | 4.2 | 4.2 |
| Med: 16-60 | 32.6 | 29.5 | 29.8 | 28.9 |
| High: 61+ | 133.5 | 123.2 | 120.3 | 119.7 |
| All Cases | 16.7 | 17.8 | 17.9 | 18.0 |
| **Older Adults** | | | | |
| Low: 0-15 | 5.1 | 5.1 | 5.4 | 5.5 |
| Med: 16-60 | 33.0 | 32.1 | 32.5 | 34.4 |
| High: 61+ | 38.1 | 88.1 | 82.9 | 75.7 |
| All Cases | 12.6 | 13.6 | 13.9 | 15.3 |

Overall, many people connecting with the Mental Health Services Division receive a very modest amount of service. This pattern is common in the public mental health system nationally, spreading too little service over too many people. The system has fixed capacity and allocates everyone some level of service, but that level may not be aligned with recovery goals; this lack of system capacity can undermine the commitment to individualized service planning for recovery.

To address the issue of under/inappropriate service, San Mateo County initiated a pilot project in late 2003 to consistently assess clinical need for level of care, using the LOCUS and CALOCUS (national tools developed by the American Association of Community Psychiatrists). These tools have seven levels of care based on assessment of multiple domains; levels 1-4 represent low to high levels of outpatient mental health services:

LOCUS/CALOCUS Levels of Care

| | |
|---|---|
| < 10 | = Level 0: Basic Services |
| 10-13 | = Level 1: Recovery Maintenance |
| 14-16 | = Level 2: Low Intensity Community Based Services |
| 17-19 | = Level 3: High Intensity Community Based Services |
| 20-22 | = Level 4: Medically Monitored Non-Residential Services |
| 23-27 | = Level 5: Medically Monitored Residential Services |
| 28+ | = Level 6: Inpatient Services (Medically Managed Residential Services) |

Since early 2004 all new San Mateo consumers and existing consumers having an annual review have been scored on these tools, and these scores have been compared to actual amounts of services delivered. FY 03/04 data suggested that:

- For children/youth, the median hours of service rise with the lowest to highest level of outpatient care (from 30.7 to 57.6 hours). However, for children with Individualized Education Plans (IEPs) the rise in median hours is much greater (from 29.6 to 84.6 hours of care) than for children that do not have an IEP (from 30.4 to 32.6).
- For adults and older adults, median hours are relatively flat, no matter the level of care (adult, from 12.9 to 17.6) and older adults (12.4 to 12.3).

We believe that system transformation, MHSA funding and the use of these tools will enable us in the future to better match clinical need to an appropriately intensive level of service, although sufficient capacity will continue to be an issue.

CHART A: SERVICE UTILIZATION BY RACE/ETHNICITY

The planning guidelines define fully served as "people who have been diagnosed with serious mental illness and children/youth who have been diagnosed with serious emotional disorders and their families, who are receiving mental health services through an individual service plan where both the client and their service provider/coordinator agree that they are getting the services they want and need in order to achieve their wellness/recovery goals. Examples of people who may be fully served include individuals in AB 34 or AB2034 programs and children and families receiving Wraparound services within a comprehensive Children's System of Care."

Of those served in the San Mateo County Wrap Around program from 2000-2003:

- There were a total of 72 youth, 63% male and 37% female.
- Forty-two percent were white, 32% Latino, 17% African-American, and 9% other.
- Fifty-seven percent were 16 or older, 43% were younger than 16, the youngest was 8.

Of those served in the AB2034 program in FY03/04:

- Eight-two individuals were served, 61% male and 39% female.
- Sixty-seven percent were white, 17% African-American, 6% Latino, 6% Asian/Pacific Islander, and 4% other.
- Eighty-seven percent were between 18-59 (however, 11% were transition age youth under the age of 25), 13% were older adults.

Given that over 8,600 people were served in the outpatient system in FY 03/04, these programs represent a very small component of the San Mateo service delivery system. To broaden our understanding of the under/inappropriately served, we utilized the LOCUS and CALOCUS scores combined with an analysis of actual service hours provided to each client to approximate whether each client was fully served or under/inappropriately served, based on the following algorithm:

- In Fiscal Year 2003/2004 11,154 clients received some type of mental health service from San Mateo County; this was the starting point.
- 2,460 persons received services at the Access Team or through Psychiatric Emergency Services and did not receive ongoing mental health services. These individuals were subtracted from the 11,154 total because they were not brought into service; this resulted in 8,694 clients that were considered "served".
- Of the 8,694 clients served, 1,385 were assessed as needing brief treatment and were triaged to and served by the network of private providers. Because of the relatively low level of need and the services provided, 100% of these clients were assumed to be fully served. 7,309 clients required further analysis.
- Of the remaining 7,309 clients served, 3,464 had LOCUS/CALOCUS scores that placed their level of need at Level 0 through 6 (see above for a description of the levels). Based on clinical design work that accompanied the implementation of the LOCUS/CALOCUS instruments, the following assumptions were made about these individuals:

| Locus Level | Range of Hours | Expected Average | Fully Served Level |
|---|---|---|---|
| Level 0 | N/A | N/A | 6 hours |
| Level 1 | 0 – 15 hours | 6 hours | 6 hours |
| Level 2 | 16 – 40 hours | 25 hours | 25 hours |
| Level 3 | 41 – 99 hours | 60 hours | 60 hours |
| Level 4 | 100 – 400 hours | 150 hours | 100 hours |
| Level 5 | N/A | N/A | 100 hours |
| Level 6 | N/A | N/A | 100 hours |

  Hours were calculated as clinician hours. If a client received two hours of group services and there were for clients in the group and one clinician, the calculated hours were 0.5 (two clinician hours divided by four clients). Clients who received services that were greater than or equal to the "fully served" level, were considered fully served; clients who received fewer hours were considered underserved.

  The expected average for each level was used to estimate "fully served", except for Level 4, which was based on the SAMHSA Assertive Community Treatment fidelity scale of two hours of service per week, rounded to 100 hours. Ranges were not set for LOCUS Level 0 and Locus Level 1 hours (six hours) were used to determine if a given client was fully served. Ranges were also not set for Locus Level 5 and 6 (residential/inpatient) and LOCUS Level 4 hours were used to estimate fully served.

- After the LOCUS/CALOCUS and Managed Care Network calculations were made, there were 3,845 clients that did not have a LOCUS/CALOCUS score and thus, fully/under-served status.

These clients were placed in one of the 56 race/ethnicity-gender-age cohorts (seven race/ethnicity categories, two gender categories, four age cohorts) and compared with the fully/under-served status of the clients in those 56 cohorts who were assigned a status based on their LOCUS/CALOCUS Level.

- These calculations resulted in the fully served, under-served/inappropriately served figures in the following tables.
- The County Population and Poverty information is taken from the DMH Website (same source used for Table 1 in Section 2.2). As noted in the discussion of Table 1, the data does not break out specifics for transition age youth or older adults. For the purposes of this analysis, we will assume that the 0-17 percentages on ethnicity and poverty are a proxy for transition age youth and that the 18+ percentages on ethnicity and poverty are a proxy for older adults.

| Children & Youth | Fully Served | | Under-served/ Inappropriately Served | | Total Served | | County Poverty Population | | County Population 0-17 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 748 | 400 | 470 | 371 | 1989 | 100% | | | | |
| RACE/ETHNICITY | | | | | | | | | | |
| African American | 84 | 51 | 56 | 29 | 220 | 11% | 1,163 | 4% | 5,397 | 3% |
| Asian/PI | 40 | 25 | 19 | 15 | 99 | 5% | 4,861 | 15% | 32,943 | 20% |
| Latino | 261 | 143 | 209 | 159 | 772 | 39% | 18,005 | 56% | 49,753 | 31% |
| Native American | 3 | 1 | 0 | 3 | 7 | 0% | 162 | 1% | 295 | 0% |
| Other | 31 | 15 | 13 | 9 | 68 | 3% | 1,978 | 6% | 9,988 | 6% |
| Unknown | 71 | 53 | 68 | 59 | 251 | 13% | | | | |
| White | 258 | 112 | 105 | 97 | 572 | 29% | 5,723 | 18% | 63,724 | 39% |

| Transition Age Youth | Fully Served | | Under-served/ Inappropriately Served | | Total Served | | County Poverty Population | | County Population 0-17 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 565 | 573 | 260 | 318 | 1716 | 100% | | | | |
| RACE/ETHNICITY | | | | | | | | | | |
| African American | 56 | 55 | 34 | 19 | 164 | 10% | - | 4% | - | 3% |
| Asian/PI | 61 | 46 | 22 | 29 | 158 | 9% | - | 15% | - | 20% |
| Latino | 184 | 277 | 96 | 135 | 692 | 40% | - | 56% | - | 31% |
| Native American | 1 | 0 | 0 | 0 | 1 | 0% | - | 1% | - | 0% |
| Other | 18 | 18 | 10 | 14 | 60 | 3% | - | 6% | - | 6% |
| Unknown | 28 | 22 | 29 | 25 | 104 | 6% | | | | |
| White | 217 | 155 | 69 | 96 | 537 | 31% | - | 18% | - | 39% |

| Adult | Fully Served | | Under-served/ Inappropriately Served | | Total Served | | County Poverty Population | | County Population 18+ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 1091 | 1462 | 651 | 961 | 4165 | 100% | | | | |
| RACE/ETHNICITY | | | | | | | | | | |
| African American | 111 | 121 | 80 | 137 | 449 | 11% | 3,755 | 5% | 18,381 | 3% |
| Asian PI | 78 | 101 | 58 | 81 | 318 | 8% | 13,567 | 18% | 116,482 | 21% |
| Latino | 165 | 403 | 96 | 231 | 895 | 21% | 31,827 | 42% | 104,955 | 19% |
| Native American | 3 | 7 | 3 | 5 | 18 | 0% | 454 | 1% | 1,251 | 0% |
| Other | 52 | 60 | 34 | 41 | 187 | 4% | 2,920 | 4% | 15,361 | 3% |
| Unknown | 58 | 82 | 38 | 57 | 235 | 6% | | | | |
| White | 624 | 688 | 342 | 409 | 2063 | 50% | 23,920 | 31% | 288,631 | 53% |

| Older Adult | Fully Served | | Under-served/ Inappropriately Served | | Total Served | | County Poverty Population | | County Population 18+ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 137 | 334 | 98 | 255 | 824 | 100% | | | | |
| RACE/ETHNICITY | | | | | | | | | | |
| African American | 12 | 24 | 11 | 34 | 81 | 10% | - | 5% | - | 3% |
| Asian/PI | 9 | 27 | 8 | 34 | 78 | 9% | - | 18% | - | 21% |
| Latino | 19 | 81 | 18 | 45 | 163 | 20% | - | 42% | - | 19% |
| Native American | | 1 | | 2 | 3 | 0% | - | 1% | - | 0% |
| Other | 13 | 17 | 10 | 13 | 53 | 6% | - | 4% | - | 3% |
| Unknown | 7 | 26 | 4 | 10 | 47 | 6% | | | | |
| White | 77 | 158 | 47 | 117 | 399 | 48% | - | 31% | - | 53% |

## 2.3 DESCRIPTION OF UNDER-SERVED AND INAPPROPRIATELY SERVED POPULATIONS BY AGE GROUP AND ETHNIC DISPARITIES

### Children / Youth

In considering the data above, the following can be observed about this age group:

- The African American population is represented in a greater proportion (11%) than they are represented in either the general San Mateo County population (3%) or the poverty population (4%).
- The Asian/Pacific Islander population (5%) is under-represented both in regard to the general population (20%) and the poverty population (15%).
- The Latino population (39%) is greater than the general population (31%) but under-represented in regard to the poverty population (56%).
- The White population (29%) is over-represented in regard to the poverty population (18%) while under-represented in regard to the general population (39%).
- Males were more likely than females to be fully served (males 61%, females 52%).
- Overall, 42% of the clients were under-served—this ranged from 34% of the Asian/Pacific Islander population to 47% of the Latino population (Whites were 35%).

Transition Age Youth

In considering the data above, the following can be observed about this age group:

- The African American population is represented in a greater proportion (10%) than they are represented in either the general San Mateo County population (3%) or the poverty population (4%).
- The Asian/Pacific Islander population (9%) is under-represented both in regard to the general population (20%) and the poverty population (15%).
- The Latino population (40%) is greater than the general population (31%) but under-represented in regard to the poverty population (56%).
- The White population (31%) is over-represented in regard to the poverty population (18%) while under-represented in regard to the general population (39%).
- Males were more likely than females to be fully served (males 68%, females 64%).
- Overall, 33% of the clients were under-served—this ranged from 30% of the White population to 33% of the Latino population.

Adults

In considering the data above, the following can be observed about this age group:

- The African American population is represented in a greater proportion (11%) than they are represented in either the general San Mateo County population (3%) or the poverty population (5%).
- The Asian/Pacific Islander population (8%) is under-represented both in regard to the general population (21%) and the poverty population (18%).
- The Latino population (21%) is slightly greater than the general population (19%) but under-represented in regard to the poverty population (42%).
- The White population (50%) is over-represented in regard to the poverty population (31%) while slightly under-represented in regard to the general population (53%).
- Males were more likely than females to be fully served (males 63%, females 60%).
- Overall, 38% of the clients were under-served—this ranged from 36% of the White and Asian/Pacific Islander populations to 48% of the African American population.

Older Adults

In considering the data above, the following can be observed about this age group:

- The African American population is represented in a greater proportion (10%) than they are represented in either the general San Mateo County population (3%) or the poverty population (5%).
- The Asian/Pacific Islander population (9%) is under-represented both in regard to the general population (21%) and the poverty population (18%).
- The Latino population (20%) is slightly greater than the general population (19%) but under-represented in regard to the poverty population (42%).
- The White population (48%) is over-represented in regard to the poverty population (31%) while slightly under-represented in regard to the general population (53%).
- Males were slightly more likely than females to be fully served (males 58%, females 57%).
- Overall, 43% of the clients were under-served—this ranged from 36% of the Latino population to 55% of the African American population.

## 2.4 OBJECTIVES RELATED TO THE NEED FOR AND PROVISION OF CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES

The San Mateo Cultural Competence Plans and our recent Latino Access Study demonstrate that we have been working on improving our performance in regard to culturally and linguistically competent services. (see Section 5 for an analysis of our strengths and limitations in capacity to meet the needs of racially and ethnically diverse populations.) From the beginning of the MHSA planning process in San Mateo County, we provided data to the Steering Committee and Work Groups regarding the cultural and linguistic gaps in our service delivery system (see Section 2.1). The feedback from our community forums and focus groups underlined the messages in the data. These new analyses in Section 2.2 and 2.3 provide even more detail about the gaps in our system—not just whether populations were served, but the degree to which they were or were not fully served.

Our objectives, which are embedded in our proposed programs (see Section 6), are intended to continue improvement in addressing gaps for cultural and linguistic populations. They include:

- *Develop outreach and engagement strategies with the Latino, Asian and Pacific Islander communities, which are historically under-represented among consumers served by the mental health system, and the African American community, which has expressed concerns that services for their community are not culturally responsive*.

  These strategies include the use of navigator/outreach workers that will be community-based and linked to the organizations and people that are trusted and used by the members of the specific cultural/linguistic community. Grants will be used with the Latino, Filipino, Chinese, Pacific Islander and African American communities for needs assessment, training, materials development, specific service design and building of linkages into the mental health system. We know from our outreach forums and focus groups that these communities have differing needs and differing ways of talking about mental health issues. We need to work collaboratively with them to find the messages and partnerships that will support identification of SMI and SED populations and their inclusion in the mental health service system.

  Other components of the outreach and engagement strategies include the placement of mental health clinicians in primary care clinics, where diverse populations present for care, rather than seeking mental health services, and improvement of the crisis and after-hours system with criminal justice and other key agencies via a process that will include diverse community representation.

- *Focus all Full Service Partnership programs on cultural and linguistic populations that have not been served or have been under/inappropriately served in the past.*

  For children/youth and transition age youth, the Latino and Asian/Pacific Islander populations are not served to the extent expected in the poverty population. Additionally, the Latino population, along with the African American population is overrepresented in the juvenile justice and child welfare system, has a higher rate of school dropouts, and is more likely to report gang involvement. These are the individuals that we hope to identify through our outreach and engagement activities to include in Full Service Partnership services for young people.

For adults and older adults, the emphasis will also be on Latino, Asian/Pacific Islander and African American participants. Asian/Pacific Islander and Latino populations are under-represented in our current service population, and African Americans, Pacific Islanders and Latinos are over-represented in the criminal justice system. As shown in the data above, the older adult population is generally the most under-served of all age groups, with over 50% of African Americans and Asian/Pacific Islanders being under-served. These are the individuals that we hope to identify through our outreach and engagement activities to include in Full Service Partnership services for adults and older adults.

- *Prioritize all new positions, clinicians, peers and parent partners to be filled with people that are bilingual and bicultural, in addition to seeking to fill vacant existing positions with bilingual, bicultural or culturally competent staff.*

  As will be noted throughout the proposed programs, there is the intent to "mirror" the service population by hiring staff that will bring a new level of cultural competence and awareness into the entire system. To support this intent, we have proposed the creation of an Academy for the new peer and parent partner positions so we can focus on recruiting bilingual/bicultural community-based individuals who are then trained with the skills needed for these new positions, which are all priced at a living wage.

  Similarly, we are expanding our clinical internship program, also focused on bilingual/bicultural individuals, in order to address our long term need for more bilingual and bicultural clinical staff. Our current psychiatric residency program also is structured to recruit diverse populations.

- *Assure that all providers serving populations of all ages, whether County or community-based contractor employees, are provided with cultural competence training.*

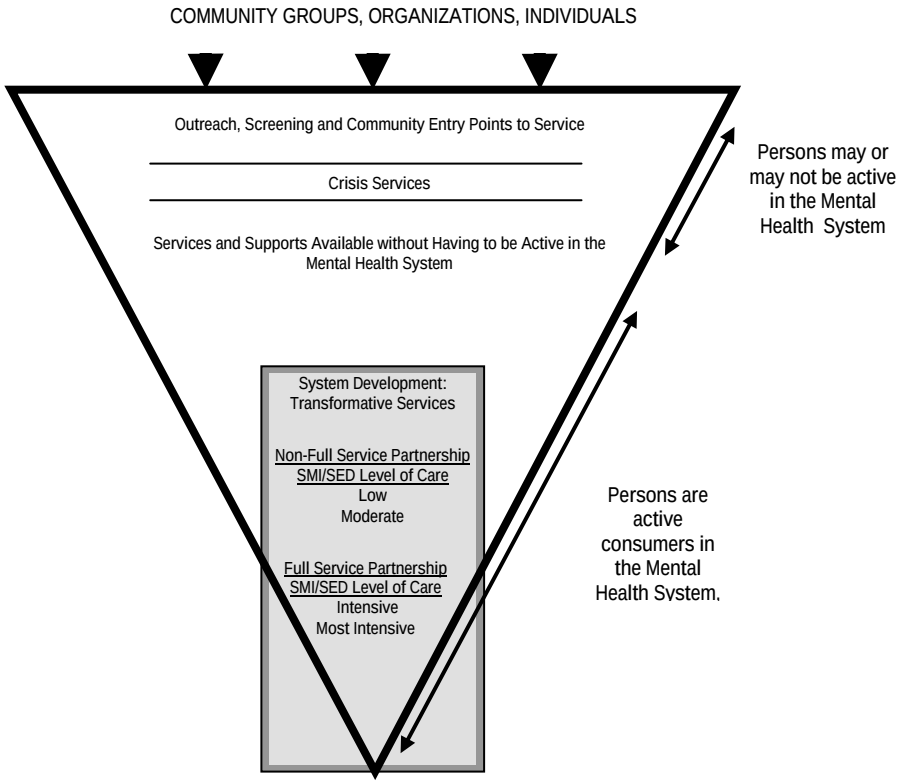
  Another component of our training initiative is system wide training on a number of issues that are critical for system transformation: cultural competence, integrated co-occurring disorder services, sexual orientation and gender differences, wellness and recovery and a variety of other evidence based practices.

# SECTION 3: IDENTIFYING INITIAL POPULATIONS FOR FULL SERVICE PARTNERSHIPS

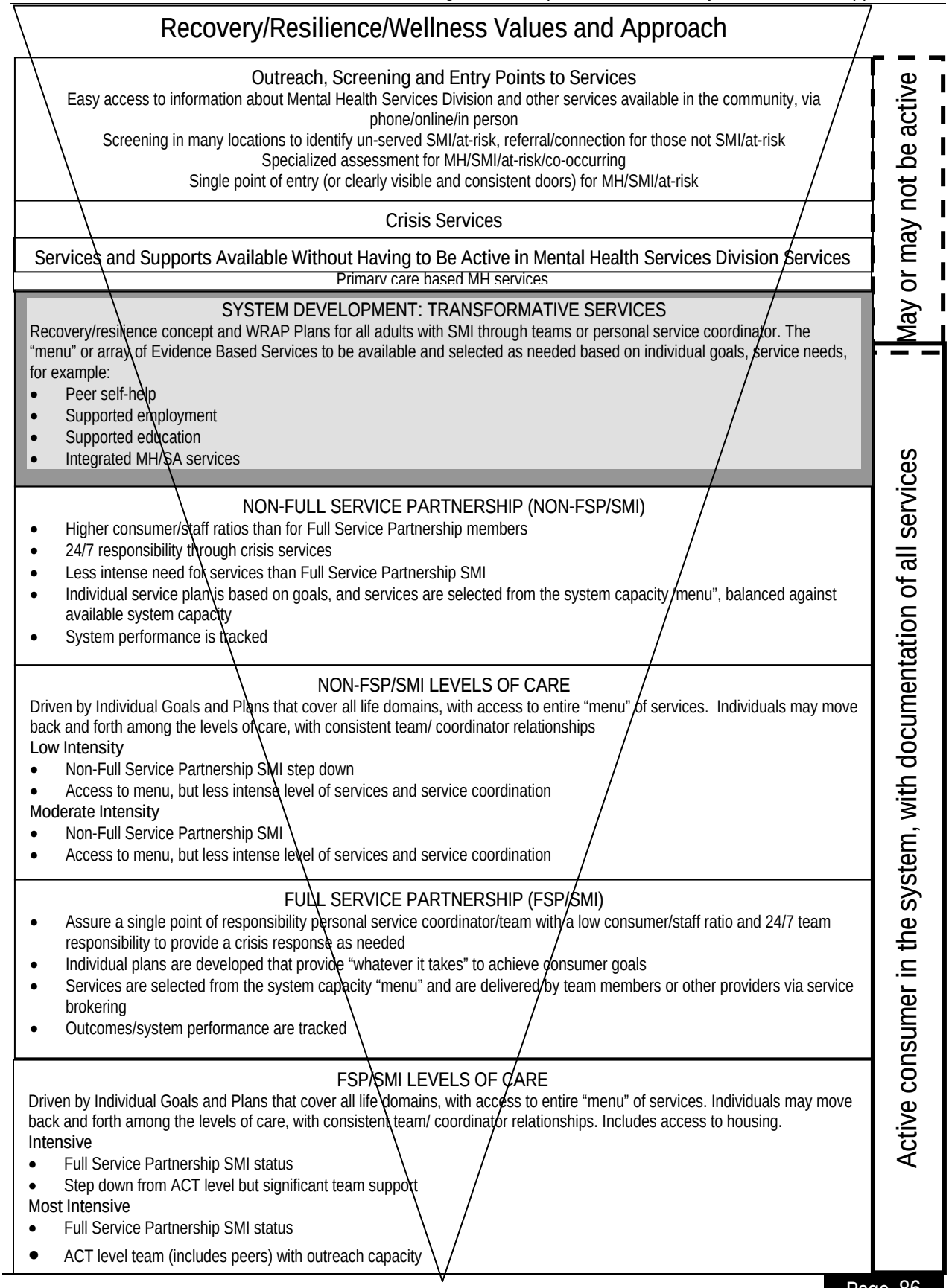
## CONTEXT

In light of the discussions that occurred in the Work Groups as well as the community feedback, it became important to provide context for all stakeholders regarding how the MHSA services, including Full Service Partnerships, will fit together and integrate with the current system as it is transformed. The diagram below was developed with feedback from the co-chairs and Work Groups as it evolved. It is a high level picture of all the system components and where Full Service Partnerships fit into a transformed system. The triangle suggests that larger numbers of people will be served at less intensive levels of service. To find and serve people with SMI or SED that are now un-served, we will have to expand our outreach and screening activities in partnership with other community systems. This will also provide a strong foundation for future prevention and early intervention services.

Recovery/Resilience/Wellness throughout the System—the Levels of Care Model




The diagram also introduces the concept of making some services available for people without having to be actively enrolled in the system—this is intended to support recovery, resilience, and ease of access for the community. The expanded diagram that follows is a more detailed version that uses examples from the adult system.


Recovery/Resilience/Wellness Values and Approach
Outreach, Screening and Entry Points to Services
Easy access to information about Mental Health Services Division and other services available in the community, via phone/online/in person
Screening in many locations to identify un-served SMI/at-risk, referral/connection for those not SMI/at-risk
Specialized assessment for MH/SMI/at-risk/co-occurring
Single point of entry (or clearly visible and consistent doors) for MH/SMI/at-risk
Crisis Services
Services and Supports Available Without Having to Be Active in Mental Health Services Division Services
Primary care based MH services
SYSTEM DEVELOPMENT: TRANSFORMATIVE SERVICES
Recovery/resilience concept and WRAP Plans for all adults with SMI through teams or personal service coordinator. The "menu" or array of Evidence Based Services to be available and selected as needed based on individual goals, service needs, for example:
Peer self-help
Supported employment
Supported education
Integrated MH/SA services
NON-FULL SERVICE PARTNERSHIP (NON-FSP/SMI)
Higher consumer/staff ratios than for Full Service Partnership members
24/7 responsibility through crisis services
Less intense need for services than Full Service Partnership SMI
Individual service plan is based on goals, and services are selected from the system capacity "menu", balanced against available system capacity
System performance is tracked
NON-FSP/SMI LEVELS OF CARE
Driven by Individual Goals and Plans that cover all life domains, with access to entire "menu" of services. Individuals may move back and forth among the levels of care, with consistent team/ coordinator relationships
Low Intensity
Non-Full Service Partnership SMI step down
Access to menu, but less intense level of services and service coordination
Moderate Intensity
Non-Full Service Partnership SMI
Access to menu, but less intense level of services and service coordination
FULL SERVICE PARTNERSHIP (FSP/SMI)
Assure a single point of responsibility personal service coordinator/team with a low consumer/staff ratio and 24/7 team responsibility to provide a crisis response as needed
Individual plans are developed that provide "whatever it takes" to achieve consumer goals
Services are selected from the system capacity "menu" and are delivered by team members or other providers via service brokering
Outcomes/system performance are tracked
FSP/SMI LEVELS OF CARE
Driven by Individual Goals and Plans that cover all life domains, with access to entire "menu" of services. Individuals may move back and forth among the levels of care, with consistent team/ coordinator relationships. Includes access to housing.
Intensive
Full Service Partnership SMI status
Step down from ACT level but significant team support
Most Intensive
Full Service Partnership SMI status
ACT level team (includes peers) with outreach capacity
May or may not be active
Active consumer in the system, with documentation of all services

In regard to Full Service Partnerships, we will prioritize those who have been un-served; however, we also assume there will be a mixture of new consumers and existing consumers—those that have been un-served (for example, adults and youth in the justice system) as well as those that have been clinically under-served (for example, those at high risk for homelessness or involvement in the criminal justice system). See the previous section for a full discussion of those un-served and under/inappropriately served.

It should be noted that the Level of Care Model corresponds to the three types of available funding: Full Service Partnerships, System Development, and Outreach and Engagement. Our planning for MHSA Community Supports and Services focused on assuring System Development of Transformative Services that will make a difference in the lives of people—the System should have an expanded "menu" of Transformative Services that is available to those served in Full Service Partnerships as well as other consumers served at moderate levels of intensity. In the past, access to a menu of services has been a problem with the way specialty programs have been funded and organized.

The intent is to build the Full Service Partnerships on our learning from our current Wrap Around program for children/youth and our current AB2034 program, Transitions, for adults, as well as on integrated service agencies such as The Village in Long Beach. For example, in the Child/Youth and Transition Age Youth Work Groups, it was agreed that Wrap Around is not just a program—the philosophies, values and service standards should guide all services for children, youth and families. Therefore, we want to be sure that all consumers with SMI and SED (not just those in the Full Service Partnerships) have access to a wider array of community-based services—a "menu" that can be used in developing an individualized service plan. The major difference will be in the amount of service received. Using the LOCUS/CALOCUS clinical assessment tool, we can establish "levels of care" in which everyone has access to a "menu" to develop a service plan based on their level of care. This will be a flexible system in which people may move into more intensive levels of care, or to moderate to low intensity services, depending on their clinical needs.

The diagram reflects services that were identified as desirable during the planning process (see the prioritized Transformative Services grids). Few of the services identified as desirable can be financed at the levels required with the current amounts of MHSA funding that is available, but the diagram and the Transformative Services grids are a "road map" for system development over time, using new resources as they become available.

## 3.1 IDENTIFICATION OF POPULATIONS FOR FULL SERVICE PARTNERSHIPS

### Children / Youth

The Full Service Partnership program will build on the current Wrap Around Program, which has 15 slots. The total number of child/youth/transition age youth slots proposed is 80, including the current capacity of 15 Wrap Around slots and 15 additional Wrap Around authorized slots. One team with 40 slots will focus on SED children/youth, at-risk of out-of-home placement (either through child welfare or the juvenile justice system). The emphasis will be on Latino, Asian/Pacific Islander or African American youth, with staffing that reflects those populations.

### Transition Age Youth

The transition age youth Full Service Partnership component also has 40 slots. This team will focus on SED youth aged 16-25 emancipating from family or out-of-home placement (either through child welfare or the juvenile justice system). The emphasis will be on Latino, Asian/Pacific Islander or African-American youth, with staffing that reflects those populations. Housing supports will be a part of the services offered. Note that it is the intent of Mental Health Services Division to apply SED criteria for TAY services through the age of 25, as the application of SMI criteria has been a barrier to providing services to many at-risk youth leaving the child/youth system.

### Adults

The adult Full Service Partnership will create 60 new slots, targeting un-served seriously mentally ill adults in the criminal justice system, under/inappropriately served adults with SMI in locked facilities, and un-served individuals with SMI at-risk of incarceration or institutionalization (due to homelessness, involuntary hospitalizations, etc). The majority of these individuals are projected to need integrated services for co-occurring AOD and SMI because of the overwhelming evidence in the criminal justice, mental health, and drug and alcohol systems that the majority of SMI individuals have co-occurring drug and alcohol problems.The emphasis will be on Latino, Asian/Pacific Islander and African American populations with staffing mirroring this population mix. Housing supports will be a part of the services offered.

### Older Adults

The new Older Adult Full Service Partnership will be one that targets 50 older adults with SMI who are medically fragile, living in skilled nursing or locked facilities or who would otherwise require acute or skilled nursing/institutional care, as well as transition age adults with SMI who meet these criteria. It is expected that the majority of consumers served by this partnership will be older adults and the array of services and supports would be constructed to address older adults' unique needs. However, the services will also be available to adults whose physical health needs mirror those of older adults. The partnership will focus upon African American, Latino, and Asian/Pacific Islander populations with staffing recruited to reflect this population. Housing supports will be a part of the services offered.

## 3.2 DESCRIPTION OF CRITERIA LEADING TO SELECTION OF POPULATIONS

### Children / Youth

As noted in the discussion of un-served and under-served populations, the Latino and Asian/Pacific Islander populations are not served to the extent expected in the DMH prevalence forecasts. Additionally, the Latino population, along with the African American population is overrepresented in the juvenile justice and child welfare system, has a higher rate of school dropouts, and is more likely to report gang involvement. The staffing and outreach methods will be developed so as to engage these populations in intensive Full Service Partnership services. Youth and families that served on the Work Group ascribed receiving this level of intensive services to their current success in the community.

Transition Age Youth

As noted in the discussion of un-served and under-served populations, the Latino and Asian/Pacific Islander populations are not served to the extent expected in the DMH prevalence forecasts. Additionally, the Latino population, along with the African American population is overrepresented in the juvenile justice and child welfare system, has a higher rate of school dropouts, and is more likely to report gang involvement. The staffing and outreach methods will be developed so as to engage these populations in intensive Full Service Partnership services. Youth and families that served on the Work Group ascribed receiving this level of intensive services to their current success in the community.

Adults

As noted in the discussion of un-served and under-served populations, the Latino and Asian/Pacific Islander populations are not served to the extent expected in the DMH prevalence forecasts. Additionally, the Latino population, along with the African American population is overrepresented in the criminal justice system. The staffing and outreach methods will be developed so as to engage these populations in intensive Full Service Partnership services.

Older Adults

As noted in relation to other age groups, the Mental Health Services Division has historically under-served older adults as well as the Latino and Asian/Pacific Islander populations. These groups are not necessarily over-represented in the acute or skilled nursing facilities that will be the primary sites from which consumers are recruited. However, staffing for this Full Service Partnership will anticipate increased numbers of these populations as the rest of the system becomes more responsive and targets outreach and engagement for individuals from these sub-populations.

## 3.3 DESCRIPTION OF HOW SELECTION OF INITIAL POPULATIONS WILL REDUCE ETHNIC DISPARITIES

Children / Youth

As noted above, the initial populations selected are those that demonstrate the most disparities in the current Mental Health Services system. To successfully address these priority populations and reduce both the numbers of un-served and under-served in these ethnic/linguistic populations, this strategy must incorporate culturally competent elements:

- Goal setting and planning process are culturally sensitive.
- Teams include bilingual staff and all members would be trained in culturally competent practices.
- Services would be delivered by bilingual, culturally competent staff.

With the appropriate staff and program components in place, we expect that:

- Focusing on child and family goals empowers them to engage in services.
- Successful teams engage and empower children and families (and, as appropriate, kinship and community resources) with plans that are appropriate to their needs, thus reducing under-service that puts the child at-risk of out-of-home placement.

Transition Age Youth

As noted above, the initial populations selected are those that demonstrate the most disparities in the current Mental Health Services system. To successfully address these priority populations and reduce both the numbers of un-served and under-served in these ethnic/linguistic populations, this strategy must incorporate culturally competent elements:

- Goal setting and planning process are culturally sensitive.
- Teams include bilingual staff and all members would be trained in culturally competent practices.
- Services would be delivered by bilingual, culturally competent staff.

With the appropriate staff and program components in place, we expect that:

- Focusing on youth and family goals empowers them to engage in services.
- Successful teams engage and empower youth with plans that are appropriate to their needs, thus reducing under-service that puts the youth at-risk of out-of-home placement.

Adults

As noted above, the initial populations selected are those that demonstrate the most disparities in the current Mental Health Services system. To successfully address these priority populations and reduce both the numbers of un-served and under-served in these ethnic/linguistic populations, this strategy must incorporate culturally competent elements:

- Goal setting and planning process are culturally sensitive.
- Teams include bilingual staff and all members would be trained in culturally competent practices.
- Services would be delivered by bilingual, culturally competent staff.

With the appropriate staff and program components in place, we expect that:

- Focusing on goals that empower consumers and their families to engage in services.
- Successful teams engage and empower consumers with plans that are appropriate to their needs, thus reducing under-service that puts the consumers at-risk of out of incarceration or institutionalization.

Older Adults

As noted above, the initial populations selected are those that demonstrate the most disparities in the current Mental Health Services system. To successfully address these priority populations and reduce both the numbers of un-served and under-served in these ethnic/linguistic populations, this strategy must incorporate culturally competent elements:

- Outreach targeting un-served populations.
- Goal setting and planning process are culturally sensitive.
- Teams include bilingual staff and all members would be trained in culturally competent practices.
- Services would be delivered by bilingual, culturally competent staff.

With the appropriate staff and program components in place, we expect that:

- Focusing on goals that empower consumers and their families to engage in services.
- Successful teams engage and empower consumers with plans that are appropriate to their needs, thus reducing under-service that puts the consumers at-risk of out of placement in acute or skilled nursing or institutional care .

# SECTION 4: IDENTIFYING PROGRAM STRATEGIES

## CONTEXT

Throughout the planning process, the five elements identified in the DMH planning guidelines as fundamental to the MHSA were key premises for the Work Group and Steering Committee discussions. The planning documents and the priority strategies that emerged from the process demonstrate the alignment with these fundamental concepts. The proposed programs described in Section 6 are shown here in relationship to the five elements.

| Fundamental Elements<br><br>Proposed Programs | Community collaboration | Cultural competence | Client- and family-driven | Wellness/ recovery /resiliency focus | Integrated service experiences for clients and families |
|---|---|---|---|---|---|
| Full Service Partnerships | | | | | |
| 1. Full Service Partnership, Child/Youth/Transition Age Youth | X | X | X | X | X |
| 2. Full Service Partnership, Adults | X | X | X | X | X |
| 3. Full Service Partnership, Older Adults (and Medically Fragile Transition Age Adults) | X | X | X | X | X |
| Outreach and Engagement | | | | | |
| 4. Community Outreach and Engagement | X | X | X | X | X |
| System Development: Transformation | | | | | |
| 5. School Based Services | X | X | X | X | X |
| 6. Criminal Justice Initiative | X | X | | X | X |
| 7. Older Adult System of Care Development | X | X | X | X | X |
| 8. System Transformation | X | X | X | X | X |

The planning process utilized Planning Checklists 3 and 4 to assess current operations, as described earlier in the Work Group processes. The Transformative Services Grids were developed throughout the process, based on draft DMH Guidelines; they reflect the listings of strategies found under Section IV of the Final Guidelines, as those lists were refined and prioritized by the Work Groups. The three types of funding are reflected in the Level of Care Model.

As noted above, we want to be sure that all consumers with SMI and SED (not just those in the Full Service Partnerships) have access to a wider array of community-based services—a "menu" that can be used in developing an individualized service plan.

A high priority is to expand family support/education services for children/youth/transition age youth and peer supports for adults/older adults and make these available for consumers that are not served in Full

Service Partnerships. Bringing peers and family members in as full partners in the delivery system will not only change the experience of our clients, but will support the shift and transformation of the entire system of care towards the recovery/resilience vision.

In Connecticut, from 2001-2003, a rigorous study of the Peer Engagement Specialists Program was conducted. This study compared outcomes and service satisfaction for people who received support and counseling from Peer Engagement Specialists and clinicians compared to those who received clinical services alone. Participants in the Peer Engagement Specialists study reported perceiving at six month's time significantly more positive relationship elements, including empathy, positive regard, and acceptance from their care providers as compared to those who received standard care; at six month's time, among those initially rated as the most "unengaged" in treatment, persons in the peer-based condition showed more attendance at their treatment meetings than those receiving standard care.

| | Child/Youth | Transition Age Youth | Adult | Older Adult |
|---|---|---|---|---|
| Peers are: | Age 15 or younger and have been or are currently served in the mental health system—peers are a source of support in both informal and formal locations in the mental health system | Between 16-25 and have been or are currently served in the mental health system—peers are a source of support in both informal and formal locations in the mental health system | Between 25 and 59 and have been or are currently served in the mental health system—peers are a source of support in both informal and formal locations in the mental health system | Over 59 and have been or are currently served in the mental health system—peers are a source of support in both informal and formal locations in the mental health system |
| Peer Partners are: | Less likely to be developed for children/youth age 15 or younger | Peers as defined above, or other young adults (peers with knowledge of youth culture, if it is not possible to find users of the mental health system in this age group) that are employed by the mental health system to provide support to consumers, peer counseling, assistance navigating the system and co-lead groups | Peers as defined above that are employed by the mental health system to provide support to consumers, peer counseling, benefits counseling, assistance navigating the system and co-lead groups | Peers as defined above that are employed by the mental health system to provide support to consumers, peer counseling, benefits counseling, assistance navigating the system, and co-lead groups |
| Parent/Caregiver Partners are: | Parents that have had services from the mental health system for their children—they are peers to other parents of children/youth now receiving services and formally employed by the mental health system to focus on engagement, education and support for family members | Parents that have had services from the mental health system for their children—they are peers to other parents of youth now receiving services and formally employed by the mental health system to focus on engagement, education and support for family members. | Parents that have had services from the mental health system for their families—they are peers to other parents of adults now receiving services and formally employed by the mental health system to focus on engagement, education and support for family members. | People (adult children or those with other relationships to older adults) that are experienced as caregivers—they are peers to other caregivers for older adults now receiving services and are formally employed by the mental health system to provide education and support for caregivers |

Peers, peer partners and parent/caregiver partners will fulfill a variety of roles in our transformed mental health system. Peer partners and parent/caregiver partners will be formally employed by the mental health system, either as County employees or as employees for community-based organizations that contract with the County. We have proposed a significant expansion of these positions, priced at a living wage. Please see Section 6 proposed programs for details regarding the number and type of the positions. The chart below summarizes the ways in which these resources are included in the program strategies.

| | Child/Youth | Transition Age Youth | Adult | Older Adult |
|---|---|---|---|---|
| Outreach and Engagement | Navigator/outreach workers to provide community-based outreach to un-served populations (Latino, Asian/PI, African American). Could be peer partners or parent partners, but principal requirement is bilingual, bicultural and connected to the community. | | | |
| System Development: Transformation | Parent partners are supports to other families of children/youth actively being served in the system, providing self help groups, social activities, assistance navigating the system, peer counseling | Parent partners are supports to other families of seriously emotionally disturbed youth, providing self help groups, social activities, assistance navigating the system, peer counseling | Peer partners are located in all County clinics to provide support to consumers, peer counseling, benefits counseling, assistance navigating the system | Peer partners will provide supports including home visits, assistance with transportation, accompany to appointments and training of peer counselor volunteer corps (senior peer counseling) |
| | | | Pathways-Court Mental Health Program staff includes a peer partner and a parent partner | |
| | | | Neighborhood based peer-run self help center is staffed by peer partners that help recruit and organize peers to provide self help groups, social activities and other supports | |
| Full Service Partnerships | Parent partners are team members (as is true in current Wrap Around program) and provide supports to other families of children/youth including self help groups, social activities, assistance navigating the system, peer counseling | Parent partners are team members, but could also convert a position to a peer partner | Peer partners are team members and provide support to consumers, peer counseling, benefits counseling, assistance navigating the system | Peer partners and caregiver partners are team members and provide support to consumers, peer counseling, benefits counseling, assistance navigating the system |
| | | Peer-run self help center is staffed by peer partners, including 5 part time work study positions, that help recruit and organize peers to provide self help groups, social activities and other supports | | |

There are two other examples of transformative initiatives that cut across the specific program strategies described in Section 6: housing and co-occurring disorder services. The tables below summarize their presence in the program strategies. The expansions of housing capacity are a start, but minimal compared

to the needs of mental health consumers. The release of the MHSA Capital Facilities funding component will provide additional opportunities for expansion.

| Proposed Programs | New Housing Capacity | Existing Mental Health Services Division Housing Capacity (as distinct from residential program capacity) | Other Housing Related Initiatives and Opportunities for Coordination |
|---|---|---|---|
| Full Service Partnerships | | | |
| 1. Full Service Partnership, Child/Youth/Transition Age Youth | 20 slots (for Transition Age Youth) | 6 slots | HSA Transitional Housing and Placement Program operated by Youth and Family Enrichment Services |
| 2. Full Service Partnership, Adults | 50 slots | 392 slots - Federal rent subsidies and support.<br>189 slots - Site based supportive housing.<br>265 slots - Adult residential care. | County Housing Authority<br>Human Services Shelter Plus Care |
| 3. Full Service Partnership, Older Adults | 20 slots | A subset of above. | Senior Housing Site Based Section 8<br>Mid Peninsula Housing Corporation |

The emphasis on co-occurring disorders begins with training of all Mental Health Services Division and AOD staff and provider agencies in appropriate assessment (based on the 1998 consensus document for mental health and substance abuse/addiction service integration, as initially conceived by state mental health and substance abuse directors (NASMHPD/ NASADAD) and further articulated by Ken Minkoff and his colleagues).

| Proposed Programs | Co-occurring Training for Providers | Co-occurring Treatment Services Included in Program |
|---|---|---|
| Full Service Partnerships | | |
| 1. Full Service Partnership, Child/Youth/Transition Age Youth | X | X |
| 2. Full Service Partnership, Adults | X | X |
| 3. Full Service Partnership, Older Adults | X | X |
| Outreach and Engagement | | |
| 4. Community Outreach and Engagement | X | |
| System Development: Transformation | | |
| 5. School Based Services | X | X |
| 6. Criminal Justice Initiative | X | X |
| 7. Older Adult System of Care Development | X | X |
| 8. System Transformation | X | X |

# SECTION 5: ASSESSING CAPACITY

## 5.1 ANALYSIS OF STRENGTHS AND LIMITATIONS OF CAPACITY TO MEET THE NEEDS OF RACIALLY AND ETHNICALLY DIVERSE POPULATIONS

San Mateo's mental health services system capacity and workforce has strengths and limitations for meeting the needs of racially, ethnically, and linguistically diverse populations. The challenges of overcoming the limitations have been the focus of multi-year efforts to more closely align the system capacity with the diversity of the population.

Strengths:

- *Recruitment and hiring of bilingual and bicultural staff.*
  The Mental Health Services Division has developed slightly improved competence in recruiting, hiring and retaining direct service staff who are Hispanic/Latino and Spanish-speaking. When we surveyed in March 1998, 22 direct service employees (14% of total number) were Hispanic/Latino. In our most recent survey in May 2005, 30 direct service employees (20% of total number) were Hispanic/Latino and 44% of the direct service employees were Spanish speaking. There is still significant room for improvement given that Hispanics/Latinos are 27% of the Mental Health Services Division client population. We have also shown improvement in Spanish language capacity in direct service staff. In FY 02-03, there were 41 bilingual Spanish-speaking clinicians. In May 2005, there were 67 (45% of total number) bilingual Spanish-speaking clinicians.

  Several factors contribute to the Mental Health Services Division's improvement. The Mental Health Services Division has targeted vacancies to bilingual/bicultural staff even during periods of hiring freezes and designates some positions as eligible for a language differential or enhanced wage based on job functions. Recruitment for bilingual clinical staff remains "open" at all times to maximize the number of candidates for positions. The Mental Health Services Division has improved Hispanic/Latino and African American representation in leadership roles in the mental health system.

- *Workforce development.*
  The Mental Health Services Division operates a graduate student culturally/linguistically focused trainee stipend program that offers $5,000 stipends to students working in the Mental Health System in hopes they will pursue careers in public mental health. A coordinator conducts outreach to graduate schools to identify a diverse pool of trainees and works with mental health programs to develop placements and provide ongoing training. This year, there are 43 training interns of whom 18% are either bilingual/bicultural Spanish; 5% are bilingual/bicultural Filipino; 14% are bilingual/bicultural Chinese; 5% are bicultural African American; 5% are bilingual/bicultural Indian; and 2% have competence in American Sign Language. The Mental Health Services Division's psychiatric residency program, one of only two public community mental health residencies in California, includes 16 psychiatric residents a year, four in each year of residency. The diversity of language in the residency group in FY 05-06 is 19% Tagalog, 6% Chinese, 12% Spanish, and 6% (South Asian) Indian. The ethnicity of the group is also diverse including: 19% Filipino, 19% Latino, 13% African American, 19% Chinese, 6% (South Asian) Indian. More than 80 percent of graduates from the program continue with careers in the public sector.

- *Program development.*
  San Mateo County's mental health services system has demonstrated experience developing culturally appropriate mental health services. Staff characteristics and competencies are critical aspects of capacity for addressing the needs of racially, ethnically, linguistically diverse populations, as is program development that focuses on the specific cultural context of mental health consumers. Examples of services that demonstrate this experience include: Filipino and Latino family groups, women's depression group in Spanish, Lesbian/Gay/Bisexual/Transgender group, Spanish-speaking Parent's Project, and La Esperanza Vive (Spanish speaking) senior peer counseling.

- *Capacity for self-assessment.*
  The Mental Health Services Division has strong capacity for self-assessment and data gathering for monitoring and improving system capacity to meet the needs of racially, ethnically and linguistically diverse populations. The Mental Health Services Division has conducted two self-assessments of its organizational capacity and that of its subcontracted providers to serve a racially, ethnically, and linguistically diverse population. In addition to identifying the racial/ethnic characteristics and linguistic capabilities of the workforce, the Division has collected information about workforce training competencies and gaps, perceptions of barriers to access for racially, ethnically, and linguistically diverse populations. The Latino Access Study demonstrates the Mental Health Services Division's ability to carry out an extensive qualitative and quantitative process and analysis to understand and develop strategies for addressing barriers to access and retention for the Latino population. This year, the Mental Health Services Division will be participating as part of the Health Department in a comprehensive assessment of community need for linguistic accessibility and self-assessment of linguistic capacity at access points to health and mental health services.

- *Coordination with Health Plan of San Mateo.*
  Outreach and access to the diverse population of San Mateo County residents with mental health needs is a challenge, but the Mental Health Services Division is fortunate to have a strong collaboration with the Health Plan of San Mateo, the health plan that covers all Medi-Cal beneficiaries (in the County organized health system structure), and Healthy Families and Healthy Kids so that insurance is available to all children up to 400% of federal poverty. The Health Plan is in the process of developing a specialty Medicare Advantage Plan for all Medi-Medi beneficiaries. The Healthy Families (over 8,000) and Healthy Kids (over 5,000) populations are over 80% Hispanic/Latino.

Limitations:

- As will be seen from the following tables, San Mateo's Asian (including Tagalog, Cantonese and Mandarin) and Pacific Islander language capacity within direct services (both County-operated and contracted) should be strengthened to mirror the population of the County.

## 5.2 ASSESSMENT OF PERCENTAGES OF PROVIDERS COMPARED TO THOSE NEEDING SERVICES AND TOTAL COUNTY POPULATION

The following tables illustrate the significant disparities between the percentages of mental health providers and other staff of racial, ethnic and linguistic groups, Mental Health Services Division client population, prevalence estimates less than 200% poverty and the total San Mateo County population.

## County Employees by Ethnicity Compared to Clients, Prevalence Estimates, and County Population

| | County Employees | White | | Latino | | African American | |
|---|---|---|---|---|---|---|---|
| Administrative management | 51 | 26 | 51.0% | 12 | 22.6% | 1 | 2.0% |
| Direct services | 153 | 73 | 48.0% | 30 | 19.9% | 10 | 6.5% |
| Support services | 44 | 13 | 30.7% | 15 | 33.7% | 1 | 2.3% |
| Interpreter | 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 8 | 5 | 62.5% | 1 | 12.5% | 1 | 12.5% |
| Total | 257 | 118 | 45.9% | 58 | 22.5% | 13 | 5.3% |
| Mental Health Services Division clients | | 4,734 | 42.0% | 3,014 | 27.0% | 1,151 | 10.0% |
| Prevalence estimates <200% poverty | | 2,434 | 27.0% | 4,320 | 47.0% | 417 | 5.0% |
| County Population | | 338,109 | 50.8% | 151,554 | 22.8% | 23,616 | 3.6% |

| | County Employees | Filipino | | Chinese | | Other Asian | | Pacific Islander | | Total Asian / Pacific Islander | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Administrative management | 51 | 7 | 13.7% | 2 | 3.9% | 1 | 2.0% | 0 | 0.0% | 10 | 19.6% |
| Direct services | 153 | 4 | 2.6% | 4 | 2.9% | 7 | 4.9% | 2 | 1.3% | 18 | 11.8% |
| Support services | 44 | 9 | 20.5% | 0 | 0.4% | 0 | 0.0% | 1 | 2.7% | 10 | 23.5% |
| Interpreter | 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 8 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Total | 257 | 20 | 7.8% | 7 | 2.6% | 8 | 3.3% | 3 | 1.2% | 38 | 14.9% |
| Mental Health Services Division clients | | | | | | | | | | 774 | 7.0% |
| Prevalence estimates <200% poverty | | | | | | | | | | 1,484 | 16.0% |
| County population | | | | | | | | | | 148,032 | 22.3% |

| | County Employees | American Native | | Other | | Total Amer Native / Other | |
|---|---|---|---|---|---|---|---|
| Administrative management | 51 | 0 | 0.0% | 3 | 6.9% | 3 | 6.9% |
| Direct services | 153 | 3 | 2.0% | 18 | 11.5% | 21 | 13.5% |
| Support services | 44 | 1 | 1.5% | 2 | 5.7% | 3 | 7.2% |
| Interpreter | 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 8 | 1 | 12.5% | 0 | 0.0% | 1 | 12.5% |
| Total | 257 | 5 | 1.9% | 24 | 9.6% | 28 | 11.0% |
| Mental Health Services Division clients | | | | | | 1,481 | 13.0% |
| Prevalence estimates <200% poverty | | | | | | 510 | 6.0% |
| County population | | 1,496 | 0.2% | 2,190 | 0.3% | 3,686 | 0.6% |

## Contractors by Ethnicity Compared to Clients, Prevalence Estimates and Population

| | Contractors | White | | Latino | | African American | |
|---|---|---|---|---|---|---|---|
| Administrative management | 72 | 46 | 64.4% | 7 | 10.2% | 4 | 5.6% |
| Direct services | 322 | 198 | 61.4% | 25 | 7.8% | 14 | 4.2% |
| Support services | 46 | 21 | 44.6% | 6 | 12.7% | 6 | 13.0% |
| Interpreter | 3 | 1 | 33.3% | 1 | 33.3% | 0 | 0.0% |
| Peer / self-help services | 11 | 6 | 59.1% | 1 | 4.6% | 2 | 18.2% |
| Unknown | 10 | | 5.0% | | 35.0% | | 30.0% |
| Total | 464 | 272 | 58.8% | 40 | 9.3% | 26 | 6.2% |
| Mental Health Services Division clients | | 4,734 | 42.0% | 3,014 | 27.0% | 1,151 | 10.0% |
| Prevalence estimates <200% poverty | | 2,434 | 27.0% | 4,320 | 47.0% | 417 | 5.0% |
| County population | | 338,109 | 50.8% | 151,554 | 22.8% | 23,616 | 3.6% |

| | Contractors | Filipino | | Chinese | | Other Asian | | Pacific Islander | | Total Asian / Pacific Islander | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Administrative management | 72 | 5 | 6.9% | 0 | 0.0% | 1 | 1.4% | 1 | 1.4% | 7 | 9.7% |
| Direct services | 322 | 20 | 6.1% | 13 | 4.2% | 9 | 2.7% | 3 | 1.0% | 45 | 14.0% |
| Support services | 46 | 5 | 10.5% | 1 | 2.2% | 2 | 4.3% | 0 | 0.7% | 8 | 17.7% |
| Interpreter | 3 | 0 | 0.0% | 0 | 0.0% | 1 | 33.3% | 0 | 0.0% | 1 | 33.3% |
| Peer / self-help services | 11 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Unknown | 10 | 0 | 0.0% | 1 | 10.0% | 0 | 0.0% | 0 | 0.0% | 1 | 11.0% |
| Total | 464 | 29 | 6.3% | 14 | 3.3% | 13 | 2.8% | 4 | 0.1% | 61 | 13.2% |
| Mental Health Services Division clients | | | | | | | | | | 774 | 7.0% |
| Prevalence estimates <200% poverty | | | | | | | | | | 1,484 | 16.0% |
| County population | | | | | | | | | | 148,032 | 22.3% |

| | Contractors | American Native | | Other | | Total Amer Native / Other | |
|---|---|---|---|---|---|---|---|
| Administrative management | 72 | 1 | 2.1% | 6 | 8.1% | 7 | 10.2% |
| Direct services | 322 | 8 | 2.5% | 33 | 10.2% | 41 | 12.6% |
| Support services | 46 | 1 | 2.2% | 4 | 9.8% | 5 | 12.0% |
| Interpreter | 3 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 11 | 1 | 4.6% | 2 | 13.6% | 2 | 18.2% |
| Unknown | 10 | 0 | 0.0% | 2 | 20.0% | 2 | 22.0% |
| Total | 464 | 11 | 2.4% | 45 | 10.0% | 55 | 12.0% |
| Mental Health Services Division clients | | | | | | 1,481 | 13.0% |
| Prevalence estimates <200% poverty | | | | | | 510 | 6.0% |
| County population | | 1,496 | 0.2% | 2,190 | 0.3% | 3,686 | 0.6% |

## County Employees and Contractors Spoken Language Capability

| | County Employees | Spanish | | Tagalog | | Other Pacific Islander | |
|---|---|---|---|---|---|---|---|
| Administrative management | 51 | 20 | 39.2% | 7 | 13.7% | 0 | 0.0% |
| Direct services | 153 | 67 | 43.8% | 4 | 2.6% | 1 | 0.7% |
| Support services | 44 | 20 | 45.5% | 8 | 18.2% | 0 | 0.0% |
| Interpreter | 1 | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 8 | 1 | 12.5% | 0 | 0.0% | 0 | 0.0% |
| Total | 257 | 109 | 42.4% | 19 | 7.4% | 1 | 0.4% |

| | County Employees | Cantonese | | Mandarin | | Other Chinese | |
|---|---|---|---|---|---|---|---|
| Administrative management | 51 | 0 | 0.0% | 1 | 2.0% | 1 | 2.0% |
| Direct services | 153 | 1 | 0.7% | 3 | 2.0% | 7 | 4.6% |
| Support services | 44 | 0 | 0.0% | 0 | 0.0% | 2 | 4.6% |
| Interpreter | 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 8 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Total | 257 | 1 | 0.4% | 4 | 1.6% | 10 | 3.9% |

| | Contractors | Spanish | | Tagalog | | Other Pacific Islander | |
|---|---|---|---|---|---|---|---|
| Administrative management | 72 | 20 | 27.8% | 5 | 6.9% | 2 | 2.8% |
| Direct services | 324 | 115 | 35.5% | 17 | 5.3% | 2 | 0.6% |
| Support services | 47 | 13 | 27.7% | 3 | 6.4% | 1 | 2.1% |
| Interpreter | 3 | 2 | 66.7% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 11 | 2 | 18.2% | 0 | 0.0% | 1 | 9.1% |
| Unknown | 11 | 3 | 27.3% | 0 | 0.0% | 0 | 0.0% |
| Total | 468 | 155 | 33.1% | 25 | 5.3% | 6 | 1.3% |

| | Contractors | Cantonese | | Mandarin | | Other Chinese | |
|---|---|---|---|---|---|---|---|
| Administrative management | 72 | 0 | 0.0% | 1 | 1.4% | 0 | 0.0% |
| Direct services | 324 | 15 | 4.6% | 12 | 3.7% | 4 | 1.2% |
| Support services | 47 | 1 | 2.1% | 1 | 2.1% | 1 | 2.1% |
| Interpreter | 3 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Peer / self-help services | 11 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Unknown | 11 | 1 | 9.1% | 1 | 9.1% | 0 | 0.0% |
| Total | 468 | 17 | 3.6% | 15 | 3.2% | 5 | 1.1% |

Section 2 of this proposal contains an analysis of mental health needs in the community including estimates of unmet need by ethnic group. We find that while our ability to recruit and retain a diverse, bilingual staff has improved, we have not achieved the most desirable balance.

At the time of the 2000 Census, 22.8% of San Mateo residents were Hispanic and 22.3% were Asian/Pacific Islander. These populations are under-served according to the earlier analysis. Based on a May 2005 survey of Mental Health Services Division employees, 22.5% are Hispanic/Latino, and 14.9% are Asian/Pacific Islander. However, the percentages of direct service staff are 20% Hispanic/Latino and 11.8% Asian/Pacific Islander. Of the direct service staff, only 2.6% are Filipino and 2.9% are Chinese, the two largest Asian population groups in the County. We surveyed contract providers as well and found only 7.8% of their direct service staff and 9.3% overall are Hispanic/Latino. Asian/Pacific Islander staff capacity was 13.2% overall, and 14.0% within direct services. The 2000 Census also tells us that 18.0% of San Mateo's population over age five speaks Spanish at home, 8.5% speak an Asian/Pacific Islander language, and 6.4% speak Tagalog. Of the County staff, 42.2% speak Spanish, 7.4% speak Tagalog, and 0.4% speak a Pacific Islander language.

We know these populations are growing. The State Department of Finance projects that by the year 2040, Hispanics/Latinos will comprise 40% and Asians 36% of San Mateo County's population. In addition, the portion of the population aged 60 and older is projected to increase from 17% in 2000 to 24% in 2020. The senior population is expected to become increasingly Asian and Latino over time. San Mateo County's youth population is more diverse than the adult population and is comprised of Latinos 30%, Asian/Pacific Islander 23%, and African American 5%.

While a relatively small percentage of the total population is African American (3.6%), African Americans are 10.8% of the mental health client population. African Americans are only 5.3% of the Mental Health Services Division workforce, and 6.9% of the direct services workforce.

We find significant variations in the concentrations of ethnic and linguistic groups in different regions of the County and therefore variations in the mental health services capacity necessary to meet the needs of ethnically, racially, linguistically diverse population. For example, in the northern region, 36.6% of the population is Asian/Pacific Islander, and 24.7% is Hispanic. In the northern region, 15.4% speak Tagalog at home, 11.5% another Asian/Pacific Islander language, and 18.4% speak Spanish. In Daly City, 31.6% of the population is Filipino, and 13.6% of the population is Chinese. Farther south, in the East Palo Alto region the population is 60.0% Hispanic, 23.0% African American, and 9.8% Asian/Pacific Islander. In East Palo Alto, 54.4 % of the population speaks Spanish at home. Spanish is also prevalent in the southern region where it is 24.3% of the population and the Coast, where it is 16.1%. We have a goal that we have not yet achieved that mental health system capacity in these regions should mirror the population needing mental health services.

## 5.3 DISCUSSION OF BARRIERS IN IMPLEMENTATION

Recruitment and hiring of bilingual and bicultural staff at all levels of the organization: While the Mental Health Services Division has improved somewhat in its recruitment and retention of Hispanic/Latino bilingual and bicultural staff, the challenge of recruiting/retaining for this and African American, Filipino, Chinese and Other Asian/Pacific Islander populations cannot be overstated. The high cost of living in the

Bay Area, commute congestion, and other quality of life issues combined with the shortage of bilingual and bicultural mental health practitioners require workforce development strategies and a long term approach to shift the composition of the workforce to more closely correspond to the diverse population and serve the population more appropriately. In addition, there are specific workforce development challenges for bilingual and bicultural consumer and family member positions. We are proposing to develop a training Academy to develop more capacity over time for consumer and family member positions. San Mateo County is an active participant in the Bay Area Director's Workforce Development Collaborative that is attempting to leverage Bay Area resources to approach these issues on a regional basis.

Competition for bilingual and bicultural staff will be strong in the Bay Area as counties mobilize to implement their MHSA proposals. San Mateo County intends to initiate recruitment activities in the fall in order to identify candidates. In addition, San Mateo County proposes to add 10 bilingual/bicultural stipend internships a year to its training program in hopes some trainees will agree to pursue longer term employment with San Mateo County.

# SECTION 6: DEVELOPING WORK PLANS, TIMEFRAMES AND BUDGETS/STAFFING

## 6.1 SUMMARY INFORMATION ON PROGRAMS TO BE DEVELOPED OR EXPANDED

1) Please see Exhibits 1, 2, and 3.

2) *Full Service Partnership Funding*: The majority of San Mateo County's total three-year MHSA CSS funding is dedicated to Full Service Partnerships: $8,025,861 out of $15,994,990or 50.18%. We have developed a one page spreadsheet to show the distribution of Full Service Partnership funding. This is attached in Appendix P. Consumers participating in Full Service Partnerships will also be able to use services funded under System Development (for example, the adult peer run center).

It should be noted that we have tried, wherever possible, to leverage MHSA funds with other funding resources, either Medi–Cal or by partnering with other funding initiatives. Three-year costs for the proposed new services are $23,333,102, offset by projected revenues of $7,338,109 and the MHSA CSS funding of $15,994,993.

3) *System Development Funding*: The number of individuals estimated to receive services through System Development funds for each of the three fiscal years is summarized in the table that follows. Consumers being served in Full Service Partnerships will be able to use services funded under System Development, and we anticipate that System Development will lead to identification of individuals requiring Full Service Partnership services.

| | Existing (non MHSA) | Year 1 MHSA | Year 2 MHSA | Year 3 MHSA |
|---|---|---|---|---|
| School Based Services | 0 non 26.5 | 15-25 | 200 | 200 |
| Criminal Justice Initiative | 0 | 40-56 | 225 | 225 |
| Older Adult System of Care Development | 100 for peer<br>0 for RN | 70-90<br>10 | 396<br>50 | 396<br>50 |
| System Transformation | 6,864 | 70 | 374 | 374 |

4) *Outreach and Engagement Funding*: The estimated unduplicated count of individuals expected to be reached through Outreach and Engagement strategies for each of the three fiscal years is summarized in the table that follows. We anticipate that up to 10% of those served in Outreach and Engagement will be referred for Full Service Partnership enrollment.

| | Existing (non MHSA) | Year 1 MHSA | Year 2 MHSA | Year 3 MHSA |
|---|---|---|---|---|
| Community Outreach and Engagement | 0 outreach<br>872 primary care | 200 outreach<br>150 | 1,300 outreach<br>900 primary care | 1,300 outreach<br>900 primary care |

## 6.2 PROGRAMS TO BE DEVELOPED OR EXPANDED

### 1. Full Service Partnership, Child/Youth/Transition Age Youth

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

This program has the goal of helping our highest risk children and youth with serious emotional disorders remain in their communities, with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. This program will also provide community-based intensive services to transition age youth with serious emotional disorders to assist them in remaining or returning to their communities in safe environments, transitioning from foster care, and continuing their education or obtaining employment. The program will reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system. Consistent with the Human Services Agency System Improvement Plan, permanence as broadly defined, is a goal for these children and youth, many of whom experience multiple transitions through one temporary placement and relationship after another.

Priority populations to be served by the program are SED children and 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, and SED and dually diagnosed transition age youth at risk of or returning from residential placement or emancipating, with juvenile justice or child welfare involvement. SED children and youth and transition age youth with multiple psychiatric emergency services episodes and/or frequent hospitalizations and extended stays will also be 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 will also serve newly identified transition age youth that are experiencing a “first break”. The programs will be 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 our current service population.

There will be 80 slots in this contracted Full Service Partnership (FSP) program, staffed to reflect ethnic/cultural/linguistically diverse populations. The slots will be divided between two 40 slot teams, one for children/youth and one for transition age youth. The teams will operate under the Wrap Around philosophy, being family and person centered. Teams will have 24/7 availability.

Staff:
1.0 FTE Supervising Mental Health Clinician
1.0 FTE Mental Health Program Specialist
2.0 FTE Mental Health Counselors
4.25 FTE Mental Health Clinicians, certified or skilled in AOD assessment and treatment
2.37 FTE Parent/Caregiver Partner (Community Worker)
0.5 FTE Psychiatrist

Drop-in Center:
1.5 FTE Community Workers
1.5 FTE Work Study Peer Partners
+admin support, housing, flex funds and vehicles

Supported Education:
1.25 FTE Mental Health Counselors

Each team will have specific expertise in working with their population; however, supervision of both teams by a single person will assure consistent vision across both teams and collaboration between teams—this is a system enhancement intended to create a more seamless relationship between services for children and services for adults. Enrollees will not experience multiple transitions between programs as they age. They will 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 will benefit from the shared resources across the program including the cultural and linguistic diversity of staff, parent partners, the existing collaborative relationships with Juvenile Justice and Justice, Child Welfare, Education, Housing and Employment Services, and the expertise of individual clinicians in co-occurring disorders and other evidence based practices.

The program will reflect the core values of Wrap Around: to partner with families and other important people 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 of the family, a source of resilience, and an integral component of service delivery.

The transition age youth team will also emphasize the individual consumer's role in developing their own wellness and recovery plan. It is anticipated that a substantial portion of the transition age youth served by this FSP team will be emancipating and may not have strong family involvement in planning for the future. However, the FSP team will have a goal of consistent involvement of significant adults to provide continuity and support during youth transition to adulthood. There will also be a focus on assisting transition age youth, some of whom may have no family members, to become "interdependent," as we use the term in San Mateo County. This means that these youth will build on or develop the skills to become independent through their continued education and/or employment and their own housing, but recognizing that they need to sustain continued relationships with family (if they choose) and other adults in their lives who provide ongoing support.

During the first weeks of enrollment, FSP staff will meet with the child/youth/transition age youth and family to conduct an orientation and strengths assessment and set the groundwork for the first Child/Youth/Family Multidisciplinary Team (MDT) meeting. They will consult also with the system of care staff involved with the family (e.g., Mental Health Services Division, child welfare, juvenile justice, and education). Planning and services will be coordinated with those provided (including housing) by the Adolescent Services Unit of Human Services. The Child/Youth/Family Multidisciplinary Team develops the comprehensive action plan,

which identifies the highest priority needs in at least three life domains. Action steps are developed and responsibility for completing those steps is assigned. The Team meets on an as needed basis while the child/youth is enrolled.

Referrals will come from probation officers, child welfare social workers, and mental health professionals. The current Wrap Around Program is a joint effort of the following San Mateo County agencies: the Human Services Agency (Children and Family Services), the Health Services Department (Mental Health Services Division), and the Probation Department (Juvenile Probation Division). Because this program will be an expansion of the Wrap Around Program, the entry points for enrollment of children/youth in the program will continue to be through the Interagency Placement Review Committee (IPRC), which is comprised of representatives from the three collaborative agencies as well as Education, Alcohol and Other Drug Services, and the Placement Aftercare Committee, which reviews referrals on youth ready to step down from Residential Care Facilities.

With the creation of the transition age youth team, it is likely that many of the residential step down referrals will be directed towards that team. While referrals to the transition age youth team may come from these groups, pre-authorization of enrollment by the groups will not be required. FSP enrollment to the transition age youth team will be reviewed by the Youth to Adult Transition Committee (YTAC), an inter-agency collaboration including the Mental Health Services Division, Alcohol and Other Drug Services, Probation, and Education, in order to coordinate services and resources as the 40 transition age slots will be fully funded with MHSA funding.

The FSP will also offer a drop-in center and supported education to engage transition age youth—this component will serve the FSP participants as well as other SED transition age youth in the community that are receiving mental health services. The focus will be 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. There will be special outreach to lesbian/gay/bisexual/transgender/questioning SED youth.

The program will contract through a community organization for a drop-in center that provides self-help groups, recreational and social activities, lesbian/gay/bisexual/transgender/questioning groups, Double Trouble (co-occurring disorder self-help) groups, living skills classes, and other supports identified as needed by those using the center. It will be staffed by 1.5 FTE young adults (Community Workers) with 1.5 FTE work study peer positions, bicultural/bilingual to mirror the service population. Mental Health Services Division clinical staff can also come on site to offer services—it provides an informal place to connect rather than formal, office based services. The drop-in center is a service that youth participants frequently mentioned as needed—targeted specifically to this age group (e.g., not part of a program for adults with SMI), staffed by people close to this age group. The center would be located in a community location or possibly near or on a community college campus and co-located with the supported education program, providing linkage to training of the work-study peers.

The supported education program was also frequently mentioned by youth participating in the planning process—they talked about the need for assistance when entering into the confusing world of college, an enormous transition for individuals that have been supported in school based programs. We would build on the existing supported education program for adults, expanding the current contracted program by 1.25

FTEs mental health counselors to create a focus on transition age youth. Again, youth provided clear feedback about not wanting to be served in the same program as adults with SMI, so this would have to be presented as a distinct program offering to be responsive to the needs of transition age youth.

Several existing initiatives will coordinate with this new FSP program. These include the San Mateo Youth Transition to Adult Committee (YTAC) described earlier, which served 60 transition age SED youth in FY03/04, the Support and Advocacy for Young Adults in Transition (SAYAT) program, targeted at homeless or at-risk of homeless SED youth, which served 40 individuals, and the Young Adults Independent Living program (YAIL), which served 23 individuals. The Human Services Agency has been developing programs and supports for youth that are emancipating from the child welfare system. These include services offered by the Adolescent Services Unit and activities carried out under the System Improvement Plan. Our MHSA programs will coordinate closely with their activities, to avoid duplication of service and to assure that the overall system is clear about which services are available for youth coming from a variety of settings.

*3) Housing or employment services to be provided*

Safe, permanent, and affordable housing is critical to maintaining stability in the community. The FSP enrollees in both teams will have access to flexible funds. Those served by the team for transition age youth will also have access to housing subsidies to insure they have housing and linkages to resources to meet their housing needs. The FSP budget includes funds for 20 housing subsidies for TAY. This will be available for youth whose needs are not met through resources available from the Human Services Agency for emancipated foster care youth. Emancipated foster care youth have access to monthly housing stipends for up to one year after emancipation through the Transitional Housing and Placement Program operated by Youth and Family Enrichment Services through the Human Services Agency.

The supported education program will be designed to address the specific interests and goals of transition age youth. The work-study peer positions related to the drop-in center described above will be available for FSP enrollees. In addition, FSP enrollees will be linked with the array of Human Services program designed to support emancipating youth. FSP enrollees will be linked as appropriate to the Independent Living Skills Program (ILSP) that provides educational assistance, employment, classes in life skills training, financial aid workshops, computer classes, transportation, mentoring, housing, and tutoring. The ILSP Aftercare Program offers planning, resources and referrals for housing, employment readiness, health insurance and financial assistance, transportation, and aid in resolving legal and debt issues. Foster Care Youth Employment Services offers one-to-one intensive employment and educational services. Services include filling out job applications, resume writing, interviewing techniques, networking methods, scholarships, and assistance pursuing higher education.

*4) Average cost for each Full Service Partnership participant*

*$27,841*

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

As noted above, the program is founded on the values of Wrap Around, which is strengths based and seeks to maintain and build resiliency for the children/youth and families that are served.

When the pilot Wrap Around Program was created, a training plan was implemented during the first year of project operation (CY 2000). These 12 formal training sessions will be updated and utilized to train new staff in the expanded FSP. A key part of the training sessions is the involvement of family members at every session and the inclusion of system of care staff, so that all individuals have the same sets of values and assumptions about the program.

The concept of self-help is one of the foundational ideas of recovery/resiliency. The drop-in center and its services and supports will be organized around self-help and independence, building the skills needed to be successful. By locating the center on or near a community college campus, there will be an emphasis on using the natural opportunities and supports in the community.

*6) If expanding an existing program, describe the program and how it will change*

This program expands the current Wraparound Program (15 slots) by adding another 15 Wraparound slots through the existing funding mechanism (authorized limit) and 50 MHSA funded slots. Existing Mental Health Services Division staffing for the Wrap Around Program includes 1.75 metal health clinicians, and 0.87 FTE parent partner. As of 9/05, there will also be 1.0 FTE mental health program specialist. These positions will be combined with the new positions to create expanded teams with expanded capacity. There is an existing assigned probation officer serving as the primary probation officer for all Wrap Around youth that are wards of the court.

*7) Describe which services and supports clients or family members will provide*

Parent Partners are part of the team and are assigned to a family to provide support in identifying strengths, pinpointing areas of growth, and creating plans that will promote positive change. This is a significant component of the program as it provides a connection to the parents or caregivers and a unique outlook on the family's perspective that helps maintain the family-focused nature of the program. The person that fills this role must have personal knowledge and experience as a caregiver for a special needs child in order to fully relate to the child/youth and family. Since we anticipate that a proportion of the transition age youth in this FSP may have minimal family involvement, we will weigh the benefits of using some of the parent partner FTE for peer membership in the transition age team.

The drop-in center will be staffed and run by young adults and include work study peer positions. An added bonus is that the program will help identify and train peers for a potential mental health services career path.

*8) Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

The current Wrap Around Program is the joint effort of the Human Services Agency (Children and Family Services), the Health Services Department (Mental Health Services Division), the Probation Department (Juvenile Probation Division), and Education. There is a long history of collaboration among these agencies and with community agency partners. These collaborations will be enhanced by the focus on a specific enrolled FSP population and the emphasis and accountability for producing positive outcomes for these children and youth. By definition, the children/youth/transition age youth and families participating in this program will have been served by multiple agencies. The intent is to bring together all of the systems involved with the family around a single Child/Youth/Family plan, which will assure coordination of services and supports and contribute to the achievement of the goals/outcomes identified in the Plan.

Over the past year, the Health Department including the Mental Health Services Division, Public Health and the Human Services Agency including Alcohol and Other Drug Services and Child Protective Services have developed Partners for Safe and Healthy Children, a systemic, coordinated, integrated approach to providing high-risk and vulnerable young children and their families with evidence-based public health and behavioral health assessment, case management and treatment services. This effort in addition to the historical collaboration establishes the inter-departmental communication and accountability so important to successful partnerships.

Supported education and the drop-in center will require close coordination with the community college system, where we now have a successful supported education program for adults. In the past, San Mateo County operated a grant-funded supported education program for transition age youth, called Stepping Stones; unfortunately, the program was not viable once grant funding ended. Relationships were created that will be helpful in re-establishing these services.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities*

The initial populations selected are Latino, Asian, Pacific Islander, and African American that demonstrate the greatest numbers in the juvenile justice and child welfare populations and the most disparities in the current mental health services system. To successfully address these priority populations and reduce both the numbers of un-served and under-served in these ethnic/linguistic populations, this strategy must incorporate culturally competent elements:

- Goal setting and planning process are culturally sensitive, incorporating cultural values that provide children, youth and families with faith, hope, recovery and resiliency.
- Teams include bilingual staff and all members would be trained in culturally competent practices.
- Services would be delivered by bilingual, culturally competent staff.
- Staff will identify individual child, youth and family culturally focused community supports and integrate those in planning.

With the appropriate staff and program components in place, we expect that:

- Focusing on child/youth/family goals empowers them to engage in services.

- Successful teams engage and empower youth with plans that are appropriate to their needs, thus reducing under-service that puts the youth at-risk of out-of-home placement.

The staffing of the teams and the drop-in center will mirror the populations served. As our community outreach and school based programs reach culturally and linguistically diverse communities, they will be able to refer youth to the drop-in center and supported education program.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

As a part of the System Transformation Program, there will be system-wide training for staff in County and contract programs that will include sexual orientation and gender differences so that they can be addressed with knowledge and sensitivity. Child and youth staff will be trained in cognitive behavioral approaches, including Trauma Focused CBT.

The issue of supports and services for lesbian/gay/bisexual/transgender/questioning youth were clearly identified by the transition age youth participating in our MHSA planning process. Among the services to be offered by the new transition age drop-in center would be lesbian/gay/bisexual/transgender/questioning groups.

Since the Child/Youth/Family Plan is driven by the needs of the child/youth/family, specific issues related to sexual orientation or gender can be addressed as a part of the Plan, assuring that the services are appropriate to the specific needs of the child/youth/family.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

The program is available to children/youth/transition age youth that have been in residential placement out-of-county, as a step down and return to their home community. If a youth enrolled in a FSP requires placement (after other alternatives have been fully explored), their personal services coordinator will maintain contact and will assist in transitioning the youth back to the community and full participation in the FSP.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above.

*13) Timeline for this work plan*

| | |
|---|---|
| November 2005 | Draft RFP |
| December 2005 | Release RFP |
| January 2006 | Review proposals, make initial selection of vendor by late January. |
| February 2006 | Make award of contract to start March 15 contingent on State approval of proposal |
| March 2006 | Identify potential space, draft outreach and enrollment materials, identify children/youth/transition age youth who meet Wrap Around criteria |

| | |
|---|---|
| March 15, 2006 | Contract start date |
| April 1, 2006 | Fully staffed |
| April 15, 2006 | Fully trained |
| April 15-May 31 | Outreach and Enrollment, achieve 50% enrollment |
| June 30, 2006 | Achieve 60% enrollment |
| August 30, 2006 | Achieve 100% enrollment |

*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

### 2. Full Service Partnership, Adults

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

The Full Service Partnership for Adults will offer "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 will be non-coercive, and focused on engaging people on their terms, in the field and in institutions. While services provided through this initiative will address the individual's underlying mental health and behavioral health problems that may have led to or contributed to involvement in the criminal justice system and institutionalization, a wide range of strategies and supports beyond mental health services will be 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 following categories of seriously mentally ill and dually diagnosed individuals will be addressed by the partnership:

1) Those eligible for diversion from criminal justice incarceration if adequate multi-agency community supports can be provided;
2) those currently incarcerated for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization;
3) individuals placed in locked mental health facilities who can succeed in the community with intensive supports; and
4) 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 will be designed to be appropriate to the issues and needs of Latino, African Americans and Pacific Islander populations that are over-represented in the criminal justice system and under-represented in the mental health system.

This program is grounded in research and evaluation findings of California's Mentally Ill Criminally Ill Crime Reduction (MIOCR) program and national effectiveness research through the national GAINS Center for

People with Co-occurring Disorders in the Justice System. These 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. San Mateo's Options Program was one of the State's successful MIOCR projects, and mental health services staff from Options remain in County employment and will function as consultants and motivators for the new Full Service Partnership. 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 program will have 60 slots.

Staff:
1.0 FTE Supervisor (Mental Health Program Specialist)
0.5 FTE Psychiatrist
1.0 FTE Nurse
2.0 FTE Mental Health Clinicians
1.0 FTE Peer Partner (Community Worker)
0.5 FTE Vocational Counselor
+admin support, housing, flex funds and vehicles

The program will be contracted to a community-based agency identified through a Request for Proposal. A high priority will be placed upon bidders that recruit a culturally and linguistically diverse staff to operate this program and address the cultural and linguistic needs of the population to be served. Bidders experience in working with the FSP target population using assertive community treatment and other intensive evidence based approaches will be critical in the selection process.

Referrals to the adult Full Service Partnership will come from:

- The Pathways Court Mental Health Program and Criminal Justice System. Consumers will be referred from the criminal justice system, including the jail and the newly established Pathways Program. The mental health clinician assigned to Pathways, will identify non-violent offenders whose criminal justice involvement has resulted from mental health issues. The liaison to the Pathways Program will also work with the Correctional Mental Health and Probation Staff to identify incarcerated individuals who are approaching their release date and would benefit from a collaborative discharge plan and referral into the Full Service Partnership.
- The Full Service Partnership team will work with mental health case managers to identify individuals who are either in sub-acute and locked facilities or who are at immediate risk of being placed at those levels of care, but who have the potential to live safely in the community with sufficient support and structure.
- The Full Service Partnership team will work with mental health case managers, alcohol and other drug services providers, and the outreach and support team to identify individuals whose mental illness results in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of criminal justice or institutional placement.

Substantial time and resources will be devoted to the process of engaging individuals to want services provided by this program. Services will be provided in the field, in natural settings where people conduct their lives as opposed to a clinic setting. Staff members of this program will have a "can do" approach to identifying what approach or resource will make a difference to a particular individual in engaging them in treatment. Staff will have access to flexible funds so that resources that are needed immediately may be purchased without delay. Transportation, medical care, food, shelter may be critical to some people. For others, establishing communication and a relationship may be more important. The program will follow a housing first approach focusing on access to safe, affordable, and individual housing options.

Consumers will work with team members to develop their own individual service and Wellness and Recovery plans which will specify individual action steps in relation to employment, education, housing, medication, peer relations, social activities, and education. Consumers and team members will work together to tailor and "stage" or phase the type and amount of services. All services will be voluntary, guided by individual choice, and the delivery of all services will be guided by the principles of cultural competence, recovery and resiliency with an emphasis on building consumer strengths and natural resources in the community, with family, and with their peer/social network. Should psychiatric inpatient care be necessary and appropriate, it will be provided as it is now, though MHSA funds will not be necessary. The program will be designed to allow a greater or lesser degree of support and structure, depending on the needs of the consumer at any given time.

The Full Service Partnership will provide the full range of mental health services including medication support with a focus on co-occurring mental health and drug and alcohol problems. Staff will be trained in motivational interviewing and will develop dually focused programming including groups. There will be a harm reduction focus and drug/alcohol use will not be used as a reason for program termination. Medication services will include psychiatry and nursing support for ongoing dialogues with consumers about their psychiatric medication choices, symptoms, limiting side effects, and individualizing dosage schedules. Full Service Partnership team members will work with individual consumers to arrange for delivery if necessary and to help them take their medications on a regular schedule.

The Full Service Partnership team members will work with consumers to identify and access other medical, substance abuse treatment, and dental services that may be needed as well as support for healthy lifestyles such as incentives for healthy eating, exercise, and smoking cessation.

The Full Service Partnership will be supported by existing mental health services relationships with all aspects of the criminal justice community including Probation, Parole, Sheriff's Department and municipal Police Departments. Staff of the FSP will participate in an existing monthly collaborative meeting which addresses consumers at-risk in the community, communication barriers within the committee membership, collaborative structures and approaches to make treatment more accessible and incarceration less likely.

Staff will be available to consumers 24/7 and service plans will be designed to utilize exceptional community relationships that are already well developed and in place. The inclusion of a mental health nurse on the team, a model long supported by San Mateo County, along with dedicated psychiatric staff will allow consistent medication evaluation and rapid linkage to physical health providers. The peer partner will 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.

*3) Description of housing or employment services to be provided*

Both housing and employment services are central to the Full Service Partnership serving adults. The vocational counselor will be an integral member of the treatment teams, working with each consumer to develop action steps to build job-readiness, linking consumers to the job coach and job developer established through the Human Services Agency but also working with FSP consumers and staff to develop a supported employment vision for the Full Service Partnership. Operating with the philosophy that the best prep for a job is a job, the vocational counselor will work with the Human Services Agency Vocational Rehabilitation Services (VRS) job developer to tailor positions to FSP enrollees. The vocational counselor will build on existing strong ties to prevocational and vocational providers in the community, such as non-profit contractors such as Good Will Industries Recycling Centers, to develop the employment component within individual service plans and to help consumers identify, obtain, and retain employment opportunities. Existing benefit counselors will be utilized to provide guidance and reassurance as possibilities for gainful employment arise. The vocational counselor will work with employers with a history of employing mental health consumers, to match consumers to the most appropriate job opportunities and to support both the consumer and the employer in helping that match to work.

Significant housing resources will be available to enrollees in this program in the form of rental subsidies. The goal is to provide permanent independent housing in scattered sites throughout the community. However, it is recognized that it will be important to provide temporary housing for some consumers as rapidly as possible, to avert incarceration or to shorten or prevent a sub-acute inpatient stay. Specific beds have been identified and dedicated at two sites: newly remodeled apartments with onsite property management, activities and supports (5-6 beds) and; added bed capacity has been arranged through a contracted provider of transitional housing.

For consumers who can benefit from community housing, existing long-standing excellent relationships with County Housing Authority will facilitate locating and financing community housing. Additionally, the Mental Health Services Division has excellent relationships with community-based housing managers and owners who are currently renting to mental health consumers and who are willing to continue to do so. At intake, a housing stability assessment will be conducted with the consumer to assess the extent to which housing subsidies are needed to sustain the consumer in housing. A funding pool adequate to support 50 housing subsidies will be available to this Full Service Partnership.

*4) Average cost for each Full Service Partnership participant*

$22,000

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

The Full Service Partnership for adults will foster and promote the values of recover/resiliency through its emphasis upon a strength-based approach to services and individual service planning. Service plans will

be used to help consumers identify, cultivate and sustain relationships with peers, family members, neighbors, landlords, employers, and others to create a network of support that will build the resiliency of consumers. Its emphasis on gainful employment and independent lease-held housing will demonstrate an abiding belief in the reality of recovery. Peer partners, on staff and volunteer/stipended partners, will play a critical role in demonstrating success in their own personal recovery. Peers employed in other County mental health units will be utilized, as appropriate, as mentors or role models, including peers who successfully completed the MIO Options Program and who are now mental health employees.

*6) If expanding an existing program, describe the program and how it will change*

This will be a new program, however, it is expected that two current providers of Full Service Partnerships for adults (Caminar and Telecare) will both bid to operate this program. In the event that either of these providers is selected, it is likely that this Full Service Partnership would be integrated into the pre-existing program.

*7) Describe which services and supports clients or family members will provide*

One of the primary roles to be performed by Peer Partners will be to establish peer relationships among members of the Full Service Partnerships. These peer relationships will be designed to build on natural common interests to promote peer involvement in social, recreation and entertainment activities. Peer support groups will be developed to further foster healthy peer relationships and to build consumer capacity to address challenges to their recovery. The Full Service Partnership will also provide training and education to criminal justice personnel, including the Probation Department and the court, to build a deeper understanding of the principles of wellness and recovery as well as an appreciation of the prevalence of relapse as a natural part of mental health recovery.

*8) Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

By working closely with the Probation Department and the criminal justice system, this Full Service Partnership will generate a shared commitment to reducing incarceration resulting from untreated mental illness. Improved recidivism outcomes resulting from the integration of community-based mental health services with housing, vocational and peer support will inform policy makers from the criminal justice system about the value of these interventions and their importance to efforts to improve criminal justice outcomes. The use of comprehensive, consumer-driven individual service plans that include strategies related to housing, employment, education, recreation and self-help will engender increased collaboration with those systems and sectors.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities*

The initial populations selected are those that demonstrate the most disparities in the current mental health services system. To successfully address these priority populations and reduce both the numbers of un-served and under-served in these ethnic/linguistic populations, this strategy must incorporate culturally competent elements:

- Goal setting and planning process are culturally sensitive and build on an individual's cultural community resources.
- Teams include bilingual staff and all members are trained in culturally competent practices.
- Services are delivered by bilingual, culturally competent staff.

With the appropriate staff and program components in place, we expect that:

- Focusing on consumer-generated goals that are culturally relevant empowers consumers to engage in services and maintain that engagement;
- Successful teams engage and empower consumers with plans that are appropriate to their needs, maximize the benefits derived from use of culturally appropriate strategies and supports and thus reduce under-utilization of services that puts the consumers at-risk of placement in more restrictive settings, including incarceration.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

As part of the System Transformation Program, training in gender differences and sexual orientation will be offered system-wide to both Mental Health Services Division staff and contractors. Mental Health Services Division staff, including staff of the Full Service Partnership will also be trained in cognitive behavioral approaches, including trauma focused CBT. Individual service plans will allow consumers to easily identify issues relating either to gender differences or sexual orientation and services and supports will be designed to address those issues on an individual basis.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

The Adult Full Service Partnership will be explicitly targeting individuals living in sub-acute locked facilities located outside the county as a step-down enabling them to return to their community.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above.

*13) Timeline for this work plan*

| | |
|---|---|
| December 1, 2005 | Publish Request for Proposals (contingent on state awarding funding) |
| December 12, 2005 | Bidder's Conference |
| January 6, 2006 | Responses Due |
| January 12, 2006 | Panel Review |
| January 20, 2006 | Tentative Awards (contingent on state awarding funding) |
| Pre-notice from State | Identify potential space, draft outreach and enrollment materials, identify potential clients for recruitment |
| April 1, 2006 | Contract start date |
| April 15, 2006 | Fully hired |
| April 15-May 31 | Outreach and Enrollment, achieve 50% enrollment |

| | |
|---|---|
| June 30, 2006 | Achieve 60% enrollment |
| July 30, 2006 | Achieve 80% enrollment |
| September 2, 2006 | Achieve 100% enrollment |

*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

### 3. Full Service Partnership, Older Adults (and Medically Fragile Transition Age Adults)

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

The Full Service Partnership for older adults will serve seriously mentally ill older adults and medically fragile transition age adults 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 will particularly seek to "enroll" Asian, Pacific Islander and Latino individuals as these populations are under-represented in the current service population. We know that many of the diverse populations that are now un-served will more likely appear in Emergency Departments or general healthcare settings or may come to the attention of social services agencies including Adult Protective Services. We expect that this program will substantially impact the ability of the mental health system to identify and serve these seriously mentally ill and medically fragile older adults/transition age adults through an integrated services approach both in primary care settings and in the individual's community living environment. The FSP team will both directly provide services and ensure connection/access to other specialty mental health services, human/social services, and primary medical care based on each individual's needs.

Similar to the Adult FSP, 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. Staff will be recruited to ensure ethnic/cultural and linguistic diversity and will be trained in cross-cultural counseling approaches.

Staff:
1.0 FTE Supervisor (Mental Health Program Specialist)
0.5 FTE Psychiatrist
1.0 FTE Nurse
2.0 FTE Mental Health Clinicians
1.0 FTE Peer or Family/Caregiver Partner (Community Worker)
+admin support, housing, flex funds and vehicles

The program will target seriously mentally ill older adults and medically fragile transition age adults 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 will work 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 will be 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. The program will have 60 slots with staff available 24/7. 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. The full-time nurse will enable the 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 role of the nurse in providing education and monitoring of medications would increase compliance and enable the consumer to maintain their community placement. The licensed clinicians will 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. The Peer Partner will 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 will work with the family to build their capacity to support the consumer.

With these strategies, the Full Service Partnership will help to mobilize natural supports in the consumer's system and build those natural strengths to maintain the consumer in the least restrictive setting. In addition to the FSP staff, each FSP member will receive 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 will be identified and integrated into the consumer's individual service plan which will be developed in the first weeks of enrollment in the program. This plan will define the roles and responsibilities of the team, as well as those of the consumer, the family, and peers.

The program will collaborate extensively with the Health Services Agency (Aging and Adult Services), Health Services Department (Primary Care) and a variety of contract agencies that provide board and care and acute care. The Full Service Partnership will engage and empower natural community supports that will extend the impact of the partnership staff. The program will serve as a step down program for acute care, locked placements, and skilled nursing facilities in order to avoid prolonged institutional placements that often hasten the loss of an individual's sense of wellness, independence, and overall quality of life.

*3) Description of housing or employment services to be provided*

Housing services are central to the Full Service Partnership serving older adults and medically fragile transition age adults. At intake, a housing stability assessment will be conducted with the consumer and, where appropriate, with family members, to assess the supports and wraparound services needed to maintain the greatest possible level of community living and to identify whether housing subsidies are needed to sustain the consumer in independent housing. There will be 20 housing subsidies in addition to funding for an emergency shelter bed and a dedicated respite bed in a board and care facility.

*4) Average cost for each Full Service Partnership participant*

*$23,796*

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

The Full Service Partnership is a strengths-based program that will work with peers and with family members when possible to build a network commitment focused on promoting the highest quality of life and independence possible. As is consistent with the principles of wellness and recovery, the consumer will be primarily responsible for defining the specific goals that define his/her desired quality of life. Consumer-driven service planning and goal setting will be specifically targeted for consumers whose declining health compromise their capacity and require consideration of how quality of life coincides with facing end-of-life issues.

*6) If expanding an existing program, describe the program and how it will change*

This Full Service Partnership is a new initiative.

*7) Describe which services and supports clients or family members will provide*

A full time Peer Partner or a full time Family/Caregiver Partner will be an important member of the Full Service Partnership, engaging peers and family members to provide a range of supports and services to promote consumer wellness. While the specific services and supports to be provided by clients and family members will vary according to the needs and capacities of each client and their relationship with their family, consumers and family members will be considered first to provide a wide range of supports, including:

- Transportation and escort services to assist at medical appointments and with other transportation needs.
- Monitoring and/or arranging for home-based support with routine tasks and personal care needs (e.g. meal preparation, house cleaning, laundry, shopping, bathing and other hygiene needs), and coordinating with involved agencies such as In-Home Supportive Services.
- Providing social supports and facilitating access to supports to address isolation and loneliness.

*8) Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

This program will work closely with other San Mateo County agencies, including the Health Plan of San Mateo, the Health Services Agency's Aging and Adult Services; Department of Human Services; the San Mateo Medical Center including the Ron Robinson Senior Center and County-operated primary care clinics (all of which are Federally Qualified Health Centers, or FQHCs); the Ravenswood Family Health Center, a community-based FQHC that serves East Palo Alto; and, private practitioners that have a high proportion of Medi-Cal/Medicare older adults in their patient populations. The FSP will also link with a range of city and non-profit adult day health programs and recreational services. Finally, this Full Service Partnership will also collaborate with board and care, acute care, locked placements, and skilled nursing facilities, serving as a step down and a step up program for all of them, as the needs of consumers served by this program change.

The Full Service Partnership for older adults and transition age adults will identify a range of ways in which peers and families can be engaged and supported to provide vital services and supports for individuals who are medically fragile. As our population continues to age, the proportion of aging and medically fragile adults will increase proportionately, magnifying the importance of identifying cost effective strategies for reducing reliance on skilled nursing and acute care facilities and other restrictive settings.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities*

The ethnic/linguistic populations that are emphasized for FSP enrollment are those that have experienced the greatest disparities in access and services utilization in San Mateo County's Mental Health Services Division system. To successfully address these priority populations and reduce both the numbers of un-served and under-served in these ethnic/linguistic populations, this strategy must incorporate culturally competent elements:

- Outreach and engagement strategies that reach diverse communities where there are populations of older or medically fragile transition age adults who are at significant risk due to psychiatric and co-occurring conditions
- Goal setting and planning processes that acknowledge and respect each individual's cultural history and context
- Teams include bilingual staff and all members would be trained in culturally competent practices
- Services would be delivered by bilingual, culturally competent staff
- Services plans will reflect and respect the healing traditions and healers of each individual enrollee
- The FSP team and services design will respect and engage each individual's family, extended family and community contingent on his/her wishes

With the appropriate staff and program components in place, we expect that:

- Focusing on consumer-generated goals that are culturally respectful and relevant will empower consumers and their families to engage in services and maintain that engagement extending the time the consumer can live in a community setting.

- Successful teams will engage and empower consumers with plans that are appropriate to their needs, maximize the benefits derived from use of culturally appropriate strategies and supports and thus reduce under-utilization of services that puts the consumers at risk of placement in more restrictive settings.
- In addition, culturally diverse and culturally informed staff is more likely to incorporate culturally relevant strategies, including alternative therapies and the use of families and extended families to provide natural supports for consumers. The use of these culturally relevant strategies also builds consumer commitment to treatment and their individual service plans.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

As part of the System Transformation Program, there will be system wide training for staff in County and contract programs that will include considerations of sexual orientation and gender differences. This will include staff from this Full Service Partnership.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

The program will serve as a step down and step up program for consumers residing in locked facilities/skilled nursing facilities located outside the county.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above.

*13) Timeline for this work plan*

| | |
|---|---|
| December 1, 2005 | Publish Request for Proposals (contingent on state awarding funding) |
| December 12, 2005 | Bidder's Conference |
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*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

### 4. Community Outreach and Engagement

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

The goal is to identify individuals that are currently un-served that require Full Service Partnership or other mental health services. This program will build bridges with ethnic and linguistic populations that currently do not access mental health services or find the services responsive to their needs. It will utilize community-based workers and population based community needs assessment, planning and materials development as well as primary care based services to identify and engage diverse populations in services.

The community-based workers (navigator model) will provide outreach to Latino, Chinese, Filipino, Pacific Islander and African American populations of all ages with emphasis on differing groups in differing parts of the County. For example, in the coast region the focus will be on Latino populations, in north county the focus will be on Filipino and Chinese populations, in south and central county the focus will be on African American, Latino, and Pacific Islander populations. These outreach workers may be peers or parent partners, but the principal requirement is that they be bilingual, bicultural and connected to the community. We have allocated 2.5 FTEs to this program, but hope that the community-based contractor(s) awarded this program will fill these positions with part-time individuals, to get the broadest ethnic, linguistic and geographic coverage possible.

Staff:
1.0 FTE Community Worker, Asian/Latino focused in northern region
1.0 FTE Community Worker, Latino/African American/Pacific Islander focused in southern region
0.5 FTE Community Worker, Latino focused on Coast
+ admin support and vehicles

Outreach workers can demystify the mental health system, reduce stigma, and engage community leaders in supporting and directing people towards mental health services. The outreach workers will also assist/navigate access for specific individuals into the mental heath system, but their reach will be extended by collaborating with and training other systems' outreach workers. These include the health outreach workers associated with the children's health initiative, many of whom work in school settings. They will also collaborate with and train individuals that are part of local community services and resources (such as the faith community) that are trusted and used by the diverse populations that need improved access to mental health services.

A cultural disparity grant process using one-time funds commencing in FY 05-06 and recurring the next two fiscal years would build on the work already underway in our Latino Access project. This involved a collaborative, community-based planning process with Latino stakeholders to identify problems in access and recommend models for improvement. Similarly, we would work with the Chinese, Filipino, Samoan and

Tongan and African American communities in a process of needs assessment, training, materials development, human resource development, specific service design and building of linkages into the mental health system. We would also entertain proposals that focus on Latino issues and build on the work already underway. We know from our outreach forums and focus groups that each ethnic and linguistic community has differing needs and differing ways of talking about mental health issues. We also know that members of each community have ideas about specific services and activities that would strengthen their capacity to serve their population. We need to work collaboratively with them to find the messages and partnerships that will support identification of SMI and SED populations and their inclusion in the mental health services system.

This program will also seek to identify and serve at-risk individuals that present for healthcare in primary care practices and assure that they receive appropriate mental health services, improving the disparity of mental health access for un-served populations. It will target children/youth and families served by the San Mateo County primary care clinics and a community-based federally qualified health center (FQHC). These clinics serve Medi-Cal or uninsured patients and have a high proportion of Asian, Pacific Islander, Latino and African American patients in their populations. In addition, we will focus on public and private primary care providers with a high proportion of dual eligible (Medicare/Medi-Cal) older adults in their patient populations, including Latino, Asian, Pacific Islander, and African American patients.

The current Mental Health Services Primary Care Interface program has 3.4 FTE mental health clinicians providing services in five county-operated clinic sites, principally serving adult patients. This program would add 2.0 FTE County mental health clinicians to the team to work in two primary care clinics (one in north county, one in south) not currently served, both of which have large pediatric practices—the focus of these new clinicians will be on children and youth identified in these primary care settings. We would also explore how to extend this resource to provide services for a portion of each week to the Coastside region. These clinicians will be bilingual/bicultural to mirror the populations served in the clinics. The role of these clinicians in to provide assessment, brief treatment and referral for more intensive services required by patients with SMI or SED, as well as consultation for primary care providers. The current program has no identified psychiatric capacity, so this program would also add 1.0 FTE psychiatrist (with child/adolescent knowledge) to provide training and consultation to primary care providers serving all ages as well as consultation to the mental health clinicians.

2.0 FTE bilingual/bicultural Mental Heath Clinicians (one Asian, one Latino)
1.0 FTE Child Psychiatrist
+admin support

Over time, we will work with the major primary care clinics, all of which (County and contracted) are FQHCs, and their leadership to develop a more expanded program that implements emerging best practice in this arena—universal screening of adolescents/adults/older adults for depression and clinician capacity to address the numbers of patients that would be identified through this process. We will look at how to use FQHC status of primary care clinics to expand the effort within the existing clinics as well as other appropriate sites.

For older adults found in primary care, our focus will be on primary care practices, whether private or public, serving a high proportion of Medi-Medi older adults, principally Latino, African American, Asian and Pacific Islander populations. Working with the Health Plan of San Mateo, we will identify these practices and collaborate with them. (The Health Plan is currently the County-operated health system (COHS) health plan for all Medi-Cal beneficiaries and has tentative approval to operate a specialty Medicare Advantage Plan for all Medicare/Medi-Cal beneficiaries.) Services will be provided by a County-operated field based team that will provide assessment, brief treatment and referral for more intensive services required by patients with SMI, as well as consultation for primary care providers. In addition to working with the targeted primary care practices, the team will link with senior peer counselors and other community resources for seniors.

Staff:
1.0 FTE bilingual/bicultural Asian/Latino/or African American Mental Health Clinician
0.5 FTE Psychiatrist
0.5 FTE Nurse
+admin support and vehicle

Another aspect of this program is to improve the multi-agency response to crisis situations with the goal of reducing hospitalizations, involuntary care, criminal justice involvement and increasing appropriate connection to mental health services, especially for diverse populations.

During our planning process, there was considerable support for a 24/7 mobile crisis team to provide on-site response to individuals of all ages in mental health crisis, as an alternative to the emergency room and/or inpatient services. Similarly, there was a desire for respite and crisis residential capacity as an alternative to inpatient services. Unfortunately, the resources currently available under the MHSA do not allow us to broadly pursue these options, which are costly. Individuals enrolled in Full Service Partnerships will have access to team services 24/7 and, for transition age youth and older adults, access to respite or emergency beds.

For other consumers of mental health services, as well as those that become known to us through their use of crisis services, we have designed modest investments for improving the system and better engaging people in ongoing mental health services. Already underway, and to be maintained in the future, is the Crisis Intervention Training (CIT) training for law enforcement personnel. This training, a joint project with the criminal justice system, is targeted at skill development for law enforcement interaction with individuals that may have a mental illness as well as building knowledge of the resources within the mental health system and how they can be accessed.

San Mateo County has also been planning a SMART response capability—specially trained medics in a mobile van that will respond to requests for ambulance transport to emergency departments for individuals that may be involuntarily detained. As a result of our MHSA planning process, a decision has been made to add a mental health clinician to provide clinical support and backup to the medics and assure follow-up linkage of clients to appropriate mental health and community resources. This position will not be funded with MHSA resources.

As a next step, we will convene all of the key agencies that provide crisis and after-hours response in San Mateo County, to fully identify all of the components that are available and improve the collaboration and effective use of all resources and timely connection to the mental health system for persons with SMI or SED. This group will include representation from diverse communities to assure that the planning is responsive to the ideas being developed in the community outreach mini-grants.

None of the crisis response improvement activities described above will utilize MHSA funds, but are responsive to issues identified during our MHSA planning process.

We will use MHSA funds for two improvements in the crisis system. Youth and Family Enrichment Services currently operates a 24/7 suicide prevention line targeted to children/youth. This service would benefit from the addition of a licensed mental health clinician to provide additional clinical expertise and to better follow-up and link referrals to the mental health system. The Mental Health Services Division currently has an identified Community Response Team that is available to respond to major community incidents, such as a suicide or other major student crisis at a school. The new mental health clinician, an employee of the community-based agency, will also link into the Response Team, a county agency activity, to better connect existing resources to community needs.

| Staff:<br>1.0 FTE licensed Mental Health Clinician<br>+admin support |
|---|

Finally, the Older Adult Work Group identified the need for Warm Line services for isolated, homebound seniors. We plan to use one-time funds to develop education and outreach materials to assure that San Mateo seniors are aware of the services that are available to them, including the Goldman Institute for the Aging 24-hour warm friendship phone line for Bay Area seniors.

*3) Description of housing or employment services to be provided*

No housing or employment services are a part of this program.

*4) Average cost for each Full Service Partnership participant*

We do not anticipate that FSP participants will utilize these Outreach and Engagement Services once they are enrolled in services. However, the Outreach and Engagement activity will be critical if we are to reach un-served diverse populations where they currently connect with the community and engage individuals with SMI or SED in appropriately intense, evidence based services. We anticipate, based on the Surgeon General's Report, that 10% of the population contacted through this program would enter into mental health services (either FSP, if slots are available, or other services for persons with SMI or SED). This equates to $563 per person whether FSP or mental health services.

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

This program seeks to identify diverse un-served populations where they are more likely to seek care—the healthcare system and other community-based agencies. By providing access to assessment, brief treatment and referral in primary care, we will reduce the stigma of receiving mental health services and appropriately connect those with SMI and SED to a level of service that will support recovery/resiliency and achievement of individual goals.

Consumers of mental health services statewide and nationally have noted that poorly designed crisis systems and their interface with the criminal justice system have the effect of additionally traumatizing people who are in psychiatric crisis—certainly, the antithesis of supporting recovery/resiliency. This program uses modest resources to improve the current crisis system along with a commitment to collaborative planning which will result in future improvements that incorporate the needs of diverse populations.

The development of community connections aligns with concepts pioneered in children's system of care—be strengths-based and use natural supports. The development of relationships by outreach workers and community planning will not only bring people into the mental health program, it will build ongoing supports for them in the community. Our work with the community will give us the opportunity to address stigma and educate people on the role they can play in supporting recovery/resiliency for those receiving mental health services.

*6) If expanding an existing program, describe the program and how it will change*

The outreach workers and community planning components are new efforts for San Mateo County. The results of the collaborative crisis planning process will probably require changes, but they are yet to be identified beyond the improvements noted above. The Youth and Family Enrichment Services suicide prevention line is not a current program of the Mental Health Services Division.

The current Mental Health Services Primary Care Interface program has 3.4 FTE mental health clinicians providing services in five clinic sites, principally serving adult patients. This program would add 2.0 FTE mental health clinicians in two primary care clinics (one in north county, one in south) not currently served, both of which have large pediatric practices. The current program has no identified psychiatric capacity, so this program would add 1.0 FTE psychiatrist (with child/adolescent knowledge) to provide training and consultation to primary care providers in all primary care sites as well as consultation to the mental health clinicians.

*7) Describe which services and supports clients or family members will provide*

As noted above, the outreach worker positions might be filled by people with experience as consumers or family members of consumers. However, the principal requirement is that they be bilingual, bicultural and connected to the community, as the focus is on outreach to those not currently receiving mental health services. As summarized in Section 4, we have also devoted substantial resources to adding peers and parent partners for those engaged in the mental health system.

The primary care based program will not utilize peers or parent partners. Individuals with SMI or SED that are referred for more intensive services will have access to peer or parent partner supports through FSPs or other Mental Health Services Division programs.

Future improvements to the crisis system might include a role for peers and parent partners. The current improvements identified above are focused on bringing more clinical expertise to current and planned services.

*8) Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

The key to this program is collaboration—it is essential if we are to reach those that have not been served by the mental health system in the past. The community forums and focus groups that were conducted as a part of our MHSA planning started the collaboration process, as we worked with many diverse community groups and leaders to organize and conduct these community dialogues. Please see Appendix F for a listing of these contacts. Many of the participants challenged us to follow through on the ideas generated, and this program is our initial mechanism for doing so. The results of the outreach work and the community planning mini-grants should be even stronger collaborative relationships that improve overall system performance in addressing the needs of diverse populations.

The primary care component will work closely with other San Mateo County agencies, including the Health Plan of San Mateo, the Health Department, Aging and Adult Services, and the San Mateo Medical Center. It will also work with the Ravenswood Family Health Center, a federally qualified health center that serves East Palo Alto as well as private practitioners that have a high proportion of Medicare/Medi-Cal older adults in their patient populations. The intent of the collaboration is to identify patients presenting for healthcare services that have significant needs for mental health services. We know that many of the diverse populations that are now un-served will more likely appear in a general healthcare setting; we expect this program will substantially impact the ability of the mental health system to identify and serve them at an appropriate level either in the primary care setting or by referral to specialty mental health services for SMI and SED.

The collaborative crisis planning will involve all agencies that have a component of crisis or after-hour services for people in psychiatric or emotional distress. This will build on the current collaboration with the criminal justice system, adding both public and community-based agencies. An improved crisis system will reduce hospitalizations, involuntary care and criminal justice involvement and increase appropriate connection to mental health services. The collaborative planning process will include representation from diverse communities to assure that service improvements are culturally competent.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities*

Another key to this program is that the collaborative relationships be with culturally and linguistically diverse communities, bringing them into the process of changing the mental health system to make it more culturally competent.

For the outreach workers, the principal requirement is that they be bilingual, bicultural and connected to diverse communities. The mental health clinicians in the pediatric practices and the older adult field team will be bilingual/bicultural, mirroring the populations served by the primary care practices. By providing access to mental health services in primary care settings, we will be serving diverse populations where they are more likely to seek care.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

As a part of the System Transformation Program, there will be system wide training for staff in County and contract programs that will include sexual orientation and gender differences. Crisis intervention is a point where individuals often experience additional trauma or re-traumatization. This is often even more difficult for girls, women, and lesbian/gay/bisexual/transgender individuals. The issue of supports and services for lesbian/gay/bisexual/transgender/questioning youth were clearly identified by the transition age youth participating in our MHSA planning process. Among the services to be offered by the FSP transition age youth peer drop-in center would be lesbian/gay/bisexual/transgender/questioning groups.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

These services will be focused on individuals in San Mateo County that are un-served by the current system. To the extent that individuals residing out-of-county are members of diverse populations, the work on stigma and building of community supports will eventually support them upon return to the community.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above.

*13) Timeline for this work plan*

*Outreach Workers*

| | |
|---|---|
| December 1, 2005 | Publish Request for Proposals (contingent on state awarding funding) |
| December 13, 2005 | Bidder's Conference |
| January 6, 2006 | Responses Due |
| January 14, 2006 | Panel Review |
| January 20, 2006 | Tentative Awards (contingent on state awarding funding) |
| Pre-notice from State | Identify potential space, draft outreach materials |
| April 1, 2006 | Contract start date |
| April 15, 2006 | Fully hired |
| April 30, 2006 | Staff trained and oriented to mental health system resources and processes |
| May 1, 2006 | First outreach contacts occur |
| May 1-30, 2006 | Outreach events occur at community sites through out the county, link to FSP and other services |
| June 30, 2006 | First 200 outreach contacts have occurred |

| | |
|---|---|
| June 30, 2007 | FY 06-07 1300 outreach contacts |
| June 30, 2008 | FY 07-08 1300 outreach contacts |

*Cultural Disparity Grants*

| | |
|---|---|
| Fall 2005 | Planning process for RFPs |
| January 3, 2005 | Release RFPs |
| February 14, 2005 | Responses due |
| February 14-18 | Panel reviews |
| February 25 | Tentative Awards (contingent on state awarding funding) |
| March 15-30 | Contract start dates |
| FY 06-07 | New cycle |
| FY 07-08 | New cycle |

*Primary Care Interface*

| | |
|---|---|
| December 1, 2005 | Identify primary care sites/providers in coordination with Health Plan of San Mateo, San Mateo Medical Center, and Ravenswood Family Health Center |
| February 15, 2006 | Initiate hiring from pre-existing lists (recruitment/outreach prior fall) |
| February 15, 2006 | Initiate purchasing of start-up equipment and supplies |
| April 1, 2006 | Employee start dates |
| April 15, 2006 | Fully staffed and trained |
| April 17, 2006 | Commence service delivery |
| June 30, 2006 | First 150 clients served |
| June 30, 2007 | FY 06-07 900 clients served |
| June 30, 2008 | FY 07-08 900 clients served |

*Crisis Services*

| | |
|---|---|
| February 15, 2006 | Initiate amendment of Youth and Family Enrichment Services agreement |
| March 15, 2006 | Effective date of contract |
| April 15, 2006 | Hire new employee |
| May 1, 2006 | Complete training/orientation of new employee in Mental Health Services Division and resources |
| May 2, 2006 | Implement enhancement to hotline |

*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

### 5. School Based Services

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

This program will identify and serve SED youth that are not receiving 26.5 (Individualized Education Plan [IEP]) or other mental health services, may have co-occurring disorders, and are at risk of school drop-out, gang involvement/juvenile justice or child welfare involvement. Currently the services available to serve these youth are offered through clinics and their families must bring them to appointments. San Mateo County's outreach during the MHSA planning process revealed that parents, youth, and school personnel feel that stigma, transportation, and inconvenience are all significant barriers to mental health treatment. Schools offer a normative environment that is community-based, culturally diverse, involves families, and focuses on resilience in all areas of life. This program will offer mental health services on-site at the school, eliminating barriers to access. Youth and their families will be engaged in mental health services to enable them to stay at home, in school, and out of the juvenile justice or child welfare system. The program will initially focus on Asian, Pacific Islander, Latino, and African American SED/non 26.5 youth in several selected middle schools in under-served regions of the County. Note that Asian, Pacific Islander and Latino populations are under-represented in our current service population; African Americans are over-represented in child welfare and juvenile justice populations.

We know that schools are one of the places we can find and serve un-served populations, but we need better information about where to make those investments over time. San Mateo County has 144 schools. We will conduct a collaborative resource mapping process with the County Office of Education, School Districts, and the Human Services Agency school-based Family Resource Centers, school collaboratives including Redwood City 2020, Daly City Peninsula Partnership, community-based organizations with school-based services, philanthropic organizations such as Peninsula Community Foundation and the Center for Venture Philanthropy and other stakeholders to identify existing mental health resources, prioritize needs and facilitate increased school based services in future years, all in coordination with the possible changes in the 26.5 process and other schools initiatives. The Mental Health Services Division provides mental health services related to schools as described in 6) below. The Human Services Agency has funded Family Resource Centers in 15 schools. These are "one-stop" centers to provide health, education, and social services to families in one convenient location. Most are located within schools. Community-based agencies are active in some schools. Schools are variable in the amount of resources dedicated to school based counselors and psychologists. The purpose of this process would be to assure coordination of existing resources and inform long term planning regarding the school population as a foundation for future investment. No MHSA funding will be spent on this activity, but it is critical in guiding future MHSA funding requests. The mapping process will begin later this year and the report generated from the process will be provided to the Mental Health Board, County Office of Education, Human Services Agency and Mental Health Services Division.

Given preliminary data on resources, middle school students are probably least served currently, compared to elementary and high schools, and youth in this age range are at-risk for juvenile justice involvement. There are 28 middle schools in San Mateo County. Our intent is to initially assign 4.0 FTE mental health clinicians to cover middle schools that have few, if any resources, to address mental health issues in the student population. The clinicians will be employed through community-based organization(s) that are experienced in school collaboration and will mirror the populations of the selected schools. The program will pilot identification and referral mechanisms in these schools, delivering mental health services on site to SED children and their families, referring children eligible for 26.5 services to appropriate school staff to

initiate that process. Services will be individualized, based on the youth's mental health assessment, but it is expected that structured individual, group and family therapy will be provided to approximately 200 youth annually. This population of SED youth is often identified as a result of their acting-out behaviors in school, so Aggression Replacement Training will be explored as an evidence based approach to working with this population.

| Staff:<br>4.0 FTE bilingual/bicultural Mental Health Clinicians<br>+admin support |
|---|

*3) Description of housing or employment services to be provided*

No housing or employment services are a part of this program.

*4) Average cost for each Full Service Partnership participant*

Consumers being served in Full Service Partnerships will be able to use services funded under System Development. However, we do not envision that they would receive services under this specific program. Consumers appropriate for enrollment in Full Service Partnerships might be identified as potential enrollees through this program and referred to the FSP.

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

This program seeks to serve diverse un-served SED students and their families where they can be identified and engaged—the school system. By providing access to assessment and treatment on-site in schools, we will reduce the stigma of receiving mental health services and appropriately connect those with SED and their families to a level of service that will support recovery/resiliency and achievement of individual goals.

*6) If expanding an existing program, describe the program and how it will change*

Currently, Mental Health Division school-based programs target youth involved in the special education 26.5 program:

- Therapeutic Day Schools (adolescents), serving 72 students at multiple high school sites
- Milieu Enhanced Classes, serving 6-8 children in each class in two elementary and two middle schools (provides social skills, art therapy and psychotherapy) (24-32 total children)
- Services for children/youth subject to 26.5/individual educational plan (IEP) are provided on site at schools throughout the County—in FY 03/04, 525 of the total 3,122 children/youth served were served pursuant to an IEP; this group received, on average excluding the Therapeutic Day Schools, 40 hours of service per person, compared to 13 hours for non-IEP children
- Some groups are provided on-site at schools

The addition of the middle school pilots will augment but not change the current programming. The service mapping and overall planning process may result in changes to current programming.

*7) Describe which services and supports clients or family members will provide*

This program will not initially utilize peers or parent partners though parents will be integral to treatment planning and parents may be referred to parent activities developed through the parent partner initiative described later in this proposal. Currently there is a part-time parent partner assigned to our 26.5 school based program. Children with SED that are referred for Full Service Partnerships will also have access to parent partner supports. Future plans, based on the resource mapping process, may include parent partners as a part of school based services.

*8) Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

As described above, long term planning for school based services rests on the need to bring together the schools and other key agencies in a resource mapping process that will result in more effective coordination of current programs and an understanding of the gaps that need to be filled in future years. The intent is to improve the overall system of care for children/youth and its effectiveness in identification and engagement of children/youth and their families.

An increased mental health presence on school sites will strengthen collaborative relationships with school staff. This collaboration and communication will serve to increase awareness of mental health issues, combat stigma, and increase early identification of SED and appropriate referrals of unserved youth for treatment.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities*

San Mateo's outreach process for MHSA planning confirmed that schools are familiar and accessible to culturally and linguistically diverse families. They suggested that offering mental health services in schools would be a more accessible, culturally competent approach. The mental health clinicians will be bilingual/bicultural, mirroring the populations served by the schools. By providing access to mental health services in schools, we will be serving diverse populations where they are likely to be identified and engaged.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

As a part of the System Transformation Program, there will be system wide training for staff in county and contract programs that will include sexual orientation and gender differences. This will include staff providing School Based Services.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

These services will be provided on-site in schools within San Mateo County.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above.

*13) Timeline for this work plan*

| | |
|---|---|
| Sept 15-December 1, 2005 | Resource mapping process with County Office of Education and other stakeholders |
| December 1, 2005 | Publish Request for Proposals (contingent on state awarding funding) |
| December 15, 2005 | Bidder's Conference |
| January 6, 2006 | Responses Due |
| January 16, 2006 | Panel Review |
| January 24, 2006 | Tentative Awards (contingent on state awarding funding) |
| Pre-notice from State | Identify potential space, draft outreach materials |
| April 1, 2006 | Contract start date |
| April 15, 2006 | Fully hired |
| April 30, 2006 | Staff trained and oriented to mental health system resources and processes |
| May 1, 2006 | First services provided |
| May 1-30, 2006 | Staff provide orientation to school personnel about services |
| June 30, 2006 | 15-25 clients served |
| June 30, 2007 | FY 06-07 200 clients served |
| June 30, 2008 | FY 07-08 200 clients served |

*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

### 6. Pathways—Court Mental Health Program

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

The Pathways-Court Mental Health Program will be a partnership of San Mateo County Courts, the Probation Department, the District Attorney, the Private (Public) Defender, the Sheriff's Department (local Police Chiefs as appropriate), Correctional Health and the Mental Health Services Division. Services under the umbrella of this initiative integrate judicial and criminal justice sanctions/approaches while addressing individuals' underlying mental health and behavioral health problems that may have led or contributed to involvement in the criminal justice system. The goal of the program is to divert or provide post-incarceration

supervision and behavioral services and supports to seriously mentally ill and dually diagnosed non-violent misdemeanants so they can succeed in the community.

San Mateo County Superior Court and other County agencies have a long history of partnering to develop programs that reduce crime and recidivism cost-effectively. Among the collaborative efforts are Juvenile and Adult Drug Court, Domestic Violence Court, the GIRLS (Gaining Independence and Reclaiming Lives Successfully) program in Juvenile Court, the Options Program, and the nationally acclaimed Bridges Program, an alternative to incarceration for addicts and dually diagnosed offenders. The Pathways-Court Mental Health Program will build on these successful programs.

This program is also grounded in research and evaluation findings of California's Mentally Ill Criminally Ill Crime Reduction (MIOCR) program, including San Mateo's Options Program that was one of the States successful MIOCR projects, and national effectiveness research through the national GAINS Center for People with Co-occurring Disorders in the Justice System.

The goal of Pathways is to meet the unique needs of SMI and dually diagnosed offenders (non-violent misdemeanants) by offering three different paths to treatment and supports:

a) Path #1: a diversion component for SMI and dually diagnosed individuals who have committed certain non-violent misdemeanor offenses. One option for eligible individuals will be the new proposed Full Service Partnership (FSP) for Adults. Eligible offenders would plead guilty to charges and waive time for pronouncement of judgment. Upon successful completion of the program, the criminal charges against the person would be dismissed.
b) Path #2: a post-adjudication component for individuals with SMI or dual diagnoses who are facing a few months to a year in the County Jail for non-violent misdemeanor offenses. Eligible offenders would be convicted and sentenced but offered alternatives to incarceration in exchange for participation in the program. These might include the dual component of the Bridges program or the new FSP for Adults.
c) Path #3: a post-adjudication component for individuals with SMI or dual diagnoses who have committed a wide range of offenses, from minor misdemeanor property crimes to non-violent felony violations. Eligible offenders would participate in an intensive supervised probation program.

The vision for this collaboration will require resources beyond this MHSA Community Services and Supports proposal. The Court is willing to assign a judicial officer to coordinate and oversee the program, if adequate supports are in place. These supports will include additional 3 Probation Officers to dedicate to the program that will not be funded through MHSA funds. This aspect of the program is under consideration by the Board of Supervisors' Bench Committee, which is comprised of representatives from the Board of Supervisors and the Court. Participants would receive specialized court services, access to therapeutic treatment, cognitive skills training, and intensive supervision as appropriate from a dedicated Pathways probation officer. Linkages to community services would be available to address homelessness, medical and health issues, and vocational/educational needs.

Diversion and post incarceration services have been demonstrated to reduce incarceration, jail time and re-offense rates of offenders for whom their untreated mental illness has been a factor in their criminal behaviors. This program will be designed to be appropriate to the issues and needs of Latino, African Americans and Pacific Islander populations that are over-represented in the criminal justice

system. The Pathways-Court Mental Health Program will provide pre-trial and post-adjudication alternatives to criminal justice sanctions in which the consumer retains the choice to "voluntarily" participate in the program or to revert to standard Court and legal procedures. To the extent feasible, staff will reflect the cultural and linguistic background of the population targeted by the initiative.

Staff:
1.0 FTE Mental Health Clinician
0.5 FTE Family Liaison (Community Worker)
0.5 FTE Consumer Liaison (Community Worker)
+admin support
Probation Officers (the Court has requested 3)

Upon arrest, clients will be screened by the Correctional Health/Jail Mental Health Services and the Sheriff and Probation Departments in coordination with the District Attorney to assess the current booking status, involvement with other courts, warrants, holds, and prior criminal history to determine if the offender qualifies for mental health diversion [Seattle/King County and Santa Clara County have developed criteria that will provide guidance to local program design.] For those determined to be eligible, the mental health clinician will conduct a mental health screening assessment that will be used to determine if consumers are SMI or dually diagnosed and appropriate for the Pathways Program.

For those who are determined eligible by both the Mental Health Services Division and Justice System partners, a meeting will be held with the consumer, the consumer liaison and the Private Defender to outline the conditions of participation in the program. If the consumer elects to participate in the program, an agreement will be reached with the District Attorney to defer criminal proceedings for a specified period of time with the understanding that charges may be dropped if compliance with treatment is sustained and reinstated if a commitment to treatment is not maintained. The consumer liaison will work with the consumer to explore housing, employment, and educational options and peer support needs including support groups related to co-occurring drug/alcohol and mental illness. The consumer liaison will coordinate service plan development with the program clinician to insure a comprehensive treatment plan that reflects the consumer's goals as well as his/her commitments to the Court. The consumer will meet on a regular basis with the Pathways-Court Mental Health clinical liaison who will act as his/her coordinator throughout their involvement in the diversion program. If approved by the consumer and if a family member(s) is interested in being involved, the family liaison will also become involved in treatment planning, facilitating the integration of family support with other community resources. Individuals who participate in this program will receive a high priority for consideration for membership (enrollment) in the new FSP for Adults or the County's existing AB 2034 program—Telecare Transitions Program.

As noted above, one source of referrals to the program will be primarily through a pre-trial diversion of SMI consumers. Another source of referrals will be the Sheriff's Department and in-custody Correctional Health staff and or Probation Department staff that determine that Court monitoring of probation status/conditions of probation is needed.

3. *Description of housing or employment services to be provided*

No specialty dedicated housing or employment services are a part of this program unless the client is enrolled as a member of the Adult Full Service Partnership, however, the consumer liaison and personal services coordinator will work with providers of existing housing and employment services to facilitate the consumer accessing these resources. The Mental Health Services Division's Outreach and Support Team will facilitate access to existing shelter and temporary housing resources pending the development of a plan for stable, more permanent housing.

*4) Average cost for each Full Service Partnership participant*

Pathways-Court Mental Health program clients being served in Full Service Partnerships will have an average annual cost of $4,002 directly related to this program (in addition to other Full Service Partnership linked services and supports. In addition, consumers who are not Full Service Partnership members will have access to MHSA services funded under System Development or Outreach and Engagement Funding and current system resources.

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

This program will promote recovery and resiliency as values in the criminal justice system, increasing the extent to which a case, the evidence, and the offense are weighed and adjudicated in the context of the consumer's capacity and willingness to engage with community treatment and support options including wellness and recovery focused services. Consumer and system values and goals regarding recovery and resilience will be translated into concrete service strategies and action plans for individuals who have come into contact (and often repeated contact) with the criminal justice system. Individual treatment plans will incorporate specific action steps related to sustaining recovery, including co-occurring substance abuse/mental health conditions—treatment, recovery and relapse prevention. The consumer liaison and, as appropriate, the family liaison will work with the consumer to develop a network of resources, services and supports that strengthen resiliency. The treatment plan will be strengths-based, with the consumer identifying the domains that will be emphasized in the plan. The plan will specify a medication regimen and medication management schedule that will be approved by the consumer, as well as specifying any planned involvement in evidence based treatment, as appropriate. Currently all adult system of care staff are being trained in "Motivational Interviewing" and this skill development will support dual diagnosis interventions with Pathways-Court Mental Health clients. A process will be specified to review treatment refusals so that any decision to reinstate charges is made in an informed manner after all reasonable alternatives are exhausted. In this manner, the consumer will retain the right of refusal. In this framework, the consumer will remain in control of his/her treatment plan and the extent to which the plan and follow through on planned activities complies with Court requirements and conditions.

*6) If expanding an existing program, describe the program and how it will change*

This program is new; however, it builds on and leverages existing partnerships and resources. See # 8.

*7) Describe which services and supports clients or family members will provide*

Priority will be given in hiring the consumer liaison and the family liaison to individuals who represent the ethnic diversity of populations who are disproportionately represented in the criminal justice system—and who have had direct experience with criminal justice. The consumer liaison will be responsible for establishing and supporting positive social/recreational activities of participants and will encourage connections with regionally based and culturally appropriate client run services (both existing self-help centers and a new culturally focused center to be established through MHSA funding.) The consumer liaison will facilitate and/or co-lead weekly groups and will encourage client participation in skills development programs such as the evidence-based Substance Abuse and Mental Health Services "Wellness (Illness) Management and Recovery" toolkit and "Wellness Action Recovery Plans." Participation in peer and self-help strategies may be incorporated in the individual client's treatment plan, where appropriate.

The family liaison will work with consumers to facilitate the involvement of their family to identify opportunities for family members to support the consumer's recovery plan. Among the possible roles for family members: housing support, social/recreational activities, advocacy, and support in relation to specific elements in the treatment plan. The family liaison will also facilitate linkage of the consumer's family members to ongoing family support and education, including NAMI's "Family to Family Education Program" family education workshops that are held in various locations throughout the County and family self-help support groups. The family liaison will also explore the feasibility of establishing a special focus family support group for family members of individuals who have had criminal justice system involvement.

8) *Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

The Mental Health Services Division has partnered with criminal justice system agencies for the past six years in the development of initiatives and services to address the criminalization of persons with mental illness and co-occurring SMI and substance abuse disorders. Initiatives have included:

- Pathways-Court Mental Health Program—The design of this program is currently being addressed not only through MHSA implementation planning processes but also at the "Bench Committee"—a standing committee of the Board of Supervisors and the Court .
- Options Program—an assertive community treatment program to provide engagement, linkage, service coordination and treatment to incarcerated SMI adults. Options operated from 1999/2000 until May of 2004 when MIOCR grant funding terminated. Options was a collaborative design and initiative that included the Mental Health Services Division, the Sheriff's Department, the Probation Department and other criminal justice agencies. The proposed new FSP for Adults will incorporate many of the successful features of the Options Program.
- Criminal Justice/Mental Health (CJ/MH) Steering Committee—This committee serves as a needs assessment, planning and program design forum and is co-chaired by the Mental Health Director and the City of Belmont Police Chief (as a representative of the Police Chiefs and Sheriff's Association.) Members include: consumer/Mental Health Board representative, family/NAMI representatives, representatives of 4-6 local police departments and the Sheriff's Department, Adult Protective Services, Alcohol and Other Drug Services. The CJ/MH Steering Committee sponsored a full-day MHSA forum on evidence-based practices and the criminal justice system

including mental health courts, in March of 2005. The Steering Committee has also promoted and supported other program initiatives including: a monthly mental health/law enforcement case consultation and problem solving committee (Field Crisis Consultation Committee); Crisis Intervention Training (CIT) for law enforcement—the second class was held in September 2005.)

- The Probation Department and the Sheriff's Department as well as a Police Chief have participated in MHSA Work Groups as well as the MHSA Steering Committee. In addition, the Mental Health Board has included a local Police Chief as a member since 2000.

Implementing an effective Pathways-Court Mental Health Program requires that all participants fully understand their roles and responsibilities, the eligibility criteria being utilized and how relapse and failure to adhere to treatment plans will be addressed by the project. A collaborative planning process is, and will continue to address, mutual education among Court and criminal justice partners and mental health providers and stakeholders to address the impact of criminalization of people with mental illness and development of effective intervention/treatment alternatives. An effective program must also address/understand the forces that have lead to an overrepresentation of some ethnic populations in the criminal justice system—the impacts of discrimination/social and economic factors, health/mental health disparities in access and retention in services and the impact of stigma related to serious mental illness. The continuous and core involvement of advocates—both consumer and family members, is essential to insure adherence and support for the wellness, recovery and resilience values that are core foundations of the MHSA. The outcomes of the Pathways-Court Mental Health Program will include an increase in post-arrest diversion, reduction of jail time and jail recidivism, increased treatment retention and improved quality of life of program participants.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities.*

The staff hired as part of the initiative will reflect the cultural and linguistic diversity of the targeted populations. Staff will receive training in culturally competent treatment strategies and how to effectively engage and build on individual, family cultural strengths and cultural organizations to build consumer resiliency. The consumer and family liaisons will further strengthen the cultural competence of the program through involvement of the consumer in the context of his/her family and community. This is particularly critical given clear research evidence regarding the importance of family and community acceptance in treatment access and retention among ethnic/linguistic populations.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

System wide training initiatives have and will address gender/sexual orientation issues, gender/sexual orientation needs and effective gender-specific/sexual orientation-specific community resources, services and supports. Pathways-Court Mental Health Program staff will participate in all of these trainings. Part of this training will focus upon how to incorporate issues related to gender differences and sexual orientation in the treatment plan with assurances that these differences are incorporated as strengths, not viewed as deficits.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

The initial focus of this program will be to work with residents who are at risk or are incarcerated in the local jail system. There are also individuals who were stepped down/discharged from jail to out-of-county locked psychiatric programs. These individuals will be a focus of Full Service Partnership enrollment and will be supported through the Pathways-Court Mental Health Program as appropriate.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above. The introduction of wellness, recovery and resiliency as guiding values will support effective criminal justice system initiatives including de-stigmatizing and de-criminalizing mental health behaviors. With community treatment options being preferred to criminal justice sanctions and relapse being viewed as part of recovery and warranting changes in treatment plans, not criminal justice sanctions, the Pathways-Court Mental Health program will strongly promote the goals of the MHSA.

*13) Timeline for this work plan*

| | |
|---|---|
| September-February | Work with Courts and criminal justice partners to develop plan and infrastructure |
| February 15, 2006 | Initiate hiring from pre-existing lists (recruitment/outreach prior fall) |
| February 15, 2006 | Initiate purchasing of start-up equipment and supplies |
| April 1, 2006 | Employee start dates |
| April 15, 2006 | Fully staffed and fully trained |
| April 15 -May, 2006 | First hearings of participants |
| June 30, 2006 | First 40-56 clients served |
| June 30, 2007 | FY 06-07 225 clients served |
| June 30, 2008 | FY 07-08 225 clients served |

*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

### 7. Older Adult System of Care Development

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

This program will focus 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 with SMI in their homes and community and in optimal health—the intent is to assist seniors to lead dignified and fulfilling lives; sustaining and maintaining independence and family/community connections to the greatest extent possible. The program will focus on older adults with SMI, including those served by County clinics,

community-based mental health providers, mental health managed care network (private practitioners and agency) providers, primary care providers, Aging and Adult Services, and community agencies targeted at senior services. To increase access by culturally and linguistically diverse populations, there will be an increased emphasis on specific ethnic/linguistic populations for different regions of the County. For example, in the coast region the focus will be on Latino populations, in north county the focus will be on Asian populations, in south and central county the focus will be on African American, Latino, and Asian and Pacific Islander populations.

Currently the Mental Health Services Division does not have a separately managed system of care for seriously mentally ill older adults. We will add a clinical services manager for older adult services to develop a system of care for the senior population. The responsibilities of this person will include:

- Oversee the development of MHSA older adult service capacity including the older adult FSP, home care assistance for older adults, and the expansion of older adult peer supports
- Oversee and increase capacity of Mental Health Services Division Senior Peer Counseling program that served 141 people in FY 03/04; and, develop older adult focused services in our current clinics, which served 372 older adults, as well as with our contracted and network providers, which together served 261 older adults—see System Transformation for overall information about changing the current system
- Coordinate with the development of the MHSA Primary Care Integration Services component that is targeted to older adults
- Participate in Crisis Services program improvement planning, to assure that the needs of older adults are addressed (170 older adults utilized the psychiatric emergency room in FY 03/04)
- Work with Aging and Adult Services, the Ron Robinson Senior Center (FQHC focused on older adults, with some current mental health services capacity), senior centers and other community-based providers to develop an organized system of care for seniors with SMI

The 3.0 FTE Peer Partners will be contracted through a community-based agency to 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 will also recruit and participate in training volunteers for an expansion of 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 15 years that recruits, 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 will 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 will facilitate consumers to attend client run self-help centers described under System Transformation. Staff will be bilingual/bicultural.

The home care assistance component will expand current in-home mental health services to homebound seniors with SMI. It will be staffed by a 0.5 FTE nurse case manager employed by the Mental Health Services Division, with linkage to Aging and Adult Services. The nurse will provide education and monitoring of medications, increasing compliance and enabling the consumer to maintain their community

placement. Aging and Adult Services administers Multipurpose Senior Services Programs, Linkages and In-Home Supportive Services.

Staff:
1.0 FTE Older Adult Clinical Services Manager
3.0 FTE contracted Peer/Family Partners (Community Workers)
0.5 FTE Nurse Case Manager with linkage to Aging and Adult Services to provide home care assistance to home bound older adults.
+admin support and vehicle

*3) Description of housing or employment services to be provided*

No housing or employment services are a part of this program.

*4) Average cost for each Full Service Partnership participant*

Consumers being served in Full Service Partnerships will be able to use services funded under System Development. However, we do not envision that they would receive services under this specific program.

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

In serving older adults, the goals of recovery/resiliency will focus on maintaining the older adult population with SMI in their homes and community and in optimal health—the intent is to assist seniors in sustaining and managing independence to the greatest extent possible.

These values are the basis for the development of an older adult system of care, which may add more supports over time in addition to those identified for this initial round of MHSA funding. The planning process to date has demonstrated that this set of values is shared among those serving the older adult population in San Mateo County.

*6) If expanding an existing program, describe the program and how it will change*

Currently, the Mental Health Services Division funds a volunteer Senior Peer Counseling Program and La Esperanza Vive, a volunteer Spanish peer counseling program. These programs serve about 100 seniors a year. This new MHSA program would add full-time capacity to train an expanded volunteer corps with additional bilingual/bicultural capacity and peers that have the skills to work with over 300 older adults with SMI.

*7) Describe which services and supports clients or family members will provide*

The peer counseling component will be delivered by peers, and in this program, may also include caregivers providing support to other caregivers.

*8) Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

The development of the older adult system of care will bring together the Mental Health Services Division, Aging and Adult Services, San Mateo Medical Center, Ron Robinson Senior Center, primary care clinics, senior centers and other senior focused community-based providers to look at all of the components that are needed, identify gaps and develop methods for ongoing collaboration at both the system and the individual level. The Mental Health Services Division Older Adult Services Manager will be a key player in an existing and ongoing process collaborative process of needs assessment, collaborative planning for integrated/seamless services approaches and continuous outcomes evaluation that involves key county departments as well as community agency stakeholders. For example, expansion of culturally-focused peer support services and home care assistance have and will require continued collaboration.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities.*

The peer counselors will be bilingual/bicultural, reflecting key un-served/underserved populations to be targeted. The recruitment, training and ongoing supervision of additional senior peer counselor volunteers will be focused on the development of bilingual/bicultural capacity.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

As a part of the System Transformation Program, there will be system wide training for staff in County and contract programs that will include sexual orientation and gender differences. This will include staff providing older adult services.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

The development of an older adult system of care will include consideration of the needs of older adults now out-of-county in SNF/locked facilities, and what additional services, beyond those already identified among these proposed programs, might be needed to further support community-based care.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above.

*13) Timeline for this work plan*

| | |
|---|---|
| February 15, 2006 | Initiate hiring (recruitment/outreach prior fall) |
| February 15, 2006 | Initiate purchasing of start-up equipment and supplies |
| March 30, 2006 | Clinical Services Manager and Nurse start dates |
| April 3, 2006 | Contract start date for peer program |
| April 15, 2006 | Initial training completed |

| | |
|---|---|
| April 16, 2006 | Commence service delivery |
| June 30, 2006 | First 10 clients served by RN<br>First 70-90 served through peer counselors |
| June 30, 2007 | FY 06-07 50 clients served by RN<br>FY 06-07 396 clients served by peer counselors |
| June 30, 2008 | FY 07-08 50 clients served by RN<br>FY 07-08 396 clients served by peer counselors |

*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

### 8. System Transformation

*1) Please see Exhibit 4.*

*2) Detailed description of program and how the program advances the goals of the MHSA*

- Training
- Peer and Parent Partners and Self-help
- Evidence based Practice Capacity
- Expanded cultural/linguistic internships
- Expand supported employment

Throughout the MHSA outreach and planning process, participants spoke about the need to fundamentally transform many aspects of the system to truly enact wellness and recovery philosophy and practice and engage un-served ethnic and linguistic populations more successfully in treatment. This System Transformation program contains the elements identified as critical to the transformation in the planning: focus on recovery/resilience and transformation and increased capacity and effectiveness of current county and contractor services through an infusion of training, bilingual/bicultural clinicians, peers/peer-run services and parent partners as well as implementation of evidence based and culturally competent practices. All populations served by the Mental Health Services Division will 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. We will partner with community-based contract agencies in this effort, to assure that the transformation is system-wide. It has been noted throughout the planning process that everyone (County clinics, contract agencies and other systems [e.g., education, criminal justice, etc.]) will need to change in order to align everyone's assumptions and expectations toward the recovery and resilience vision.

As noted in our discussion of un-served and under/inappropriately served populations (Section 2.2), and confirmed in our focus groups, we must improve the process design for access and entering mental health services. There clearly are barriers to initiating and engaging in services, and while some of these will be identified and addressed as part of our community outreach and engagement initiatives, there are also internal issues that need to be identified and addressed. This is a conversation and change process we have already initiated and will continue to move forward as a part of System Transformation.

Training initiatives are critical components of System Transformation and will be available throughout the system to existing and new county and contract staff as well as consumers and family members. The major elements in this training component are:

- Multi-year integrated services program development and training for co-occurring alcohol, other drug, and psychiatric disorders for all providers (Mental Health Services Division, AOD staff and contracted providers) serving all ages. System design process will be co-chaired by the County's Mental Health Director and AOD Administrator and will include County and contracted service providers from the Mental Health Services Division and AOD.
- Cultural competence training for all providers serving all ages
- Sexual orientation and gender differences training for all providers serving all ages
- Family support and education training for all providers serving all ages (consider SAMHSA toolkit)
- Cognitive behavioral approaches for all clinicians serving all ages, including Trauma focused Cognitive Behavioral Therapy for those serving populations affected by trauma (children/youth in the child welfare system, girls and young women, etc.)
- Wellness and recovery training including the SAMHSA wellness management and recovery toolkit and Wellness Recovery Action Plans (WRAP) for providers serving transition age youth, adults and older adults. Wellness and recovery training would include modules led by consumers and family members.
- Other Evidence Based Practices and emerging practices as resources permit, which might include expansion of Functional Family Therapy (FFT) and Dialectical Behavioral Therapy, now available to a small proportion of clients, mostly in specialty programs.

We will coordinate with various family and consumer groups, including NAMI, on provider and family training initiatives already developed, such as:

- Parents And Teachers As Allies
- Provider Education
- Family To Family Groups

Our Academy for peers and parent partners is intended to address the major expansion in these positions and the need to provide training for these individuals that will be a key element of a transformed system. The design of the Academy curriculum will begin this fall, involving peers and parent partners as well as service providers. This training program will build on a long-term collaborative program with the San Mateo Community College District (College of San Mateo) including a peer counseling program and a human services certificate program, private non-profit organizations and the Human Services Agency's Vocational Rehabilitation Services (VRS) supported employment services.

In order to meet our projected need for bilingual/bicultural clinical staff, we will expand our current cultural/linguistic stipended internships, adding 10 new positions to the current capacity of 12 stipended positions. Our stipend program offers $5,000 stipends to students working in the mental health system in hopes they will pursue careers in public mental health. A coordinator conducts outreach to graduate schools to identify a diverse pool of trainees and works with mental health programs to develop placements and provide ongoing training.

There will be a transformation of County clinics in the North, Coast, Central, South, and East Palo Alto regions of the County through the evidence-based practice and other system-wide trainings described above, the infusion of peer and family partners described below, and a significant increase in bilingual/bicultural clinical staff capacity. We will add 9.0 FTE mental health clinicians that are bilingual/bicultural to improve the cultural and linguistic capacity for evidence based practice in the regional clinics. Each regional clinic will have one additional clinician available for the child/youth/transition age youth population and one additional clinician available for the adult/older adult population. These bilingual/bicultural clinicians will enhance the ability of the mental health system to serve the County's diverse population. Please see the discussion in Section 5 regarding capacity for meeting the needs of our diverse populations. Augmented staffing will create capacity to provide dramatically expanded evidence-based practices including integrated AOD/Mental Health (engagement, treatment/commitment, relapse-prevention) cognitive-behavioral grounded individual and group services including the SAMHSA "Wellness" Management and Recovery Toolkit (locally renamed); dialectical behavioral therapy; Functional Family Therapy (FFT); and Aggression Replacement Therapy for youth and their families. 1.0 FTE mental health clinician will be contracted to develop and sustain the contract providers capacity to deliver integrated AOD/Mental Health evidence-based practices after participation in the trainings.

Additional Clinical Staff:
5.0 FTE bilingual/bicultural Mental Health Clinicians serving adults and older adults
4.0 FTE bilingual/bicultural Mental Health Clinicians serving children and youth
1.0 FTE to develop and sustain integrated treatment of co-occurring disorders.
+admin support

A high priority is to expand family support/education services for children/youth/transition age youth and peer supports for adults and older adults and make these available for consumers that are not served in Full Service Partnerships. Bringing peers and family members in as full partners in our delivery systems will not only change the experience of our clients, but will support the shift and transformation of the entire system of care towards recovery, wellness, and resilience (see discussion in Section 4). There are three major elements to this part of our transformation vision:

- Expanding parent partner service to team with clinic and contractor service providers in offering education, support, consultation, self help groups, peer counseling, and social activities, adding 5.0 FTE positions as County employees that are filled by individuals that are bilingual/bicultural.
- Expanding County operated program capacity with 6.0 FTE bilingual/bicultural peer positions and a 0.2 FTE benefits specialist to provide support, consultation on benefits, assistance navigating the system, and peers as group co-leaders for Wellness Management and Recovery groups and Co-occurring Disorder groups.

Staff:
6.0 FTE County-employed Peer Partners (Community Workers)
5.0 FTE contracted Parent Partners (Community Workers)
0.2 FTE Benefits Specialist
+admin support

- Expand a consumer self-help organization to establish a neighborhood based, contracted consumer-run self-help and support center in South County to complement existing and planned efforts that are focused on north and central county.

Contracted expansion of existing service with 2.0 FTE bilingual/bicultural Peer Self-help Partners
+admin support

The neighborhood-based, consumer-run self-help center will focus on Latino, African American and Asian/Pacific Islander communities. The Latino and Asian/Pacific Islander communities are historically under-represented among consumers served by the mental health system while the African American community has expressed concerns that services for their community are not culturally appropriate and responsive. Consumer-run services will be designed to overcome these cultural barriers to appropriate service delivery with a goal of increasing engagement and the proportion of under-served and un-served populations who are served by the mental health system.

The program will be located in the southern region of the county in either East Palo Alto or South Redwood City. The South County consumer-run self help center will be an expansion of an existing self-help center that is administered with the support of Caminar Inc. as fiscal intermediary. It would be operated with 2.0 FTE peer community workers as the core staffing; however, since the program is designed as a self-help program these peer community workers would engage and coordinate the delivery of a comprehensive range of peer-delivered and self-help services and opportunities. Staff will be recruited to reflect the cultural, ethnic and linguistic diversity needed to serve the un-served populations targeted by this program. Services offered at the center will include:

- Social model 'living room' drop-in center designed to provide an informal setting where consumers can be supported by peers without a formal assessment or efforts to engage in services
- Recreation and socializing opportunities organized by the community workers and peer volunteers
- On site benefits counseling will be delivered by an existing peer community worker benefits counseling program
- Peer support and self-help groups, both formal and structured and informal and drop-in, covering a range of topics responsive to needs identified by consumers such as dual support and wellness recovery action plan development
- Other services that are identified as needed by consumers

Finally, we would augment the existing State Department of Rehabilitation/Department of Mental Health Cooperative Agreement, leveraging the match program to increase access to job developer and job coach services, so more adults and transition age youth have access to employment supports and services.

*3) Description of housing or employment services to be provided*

No housing services are a part of this program. The State Department of Rehabilitation/Department of Mental Health Cooperative program would increase access to employment services, so more adults and transition age youth have access to employment supports and services.

*4) Average cost for each Full Service Partnership participant*

Consumers being served in Full Service Partnerships will be able to use services funded under System Development. We anticipate that FSP participants will use the peer-run self-help center and the expanded employment services in this program. The amount per FSP enrollee would be $1,810 for the employment services and $1,289 for the peer-run self help center.

*5) Description of how the proposed program will advance the goals of recovery/resiliency and how these values are promoted and continually reinforced*

Peer and self-help initiatives are the most powerful expression of recovery and resiliency as they build the capacity for consumers to generate their own sources of strength. The peer staff will engage other consumers and afford them with a range of meaningful opportunities to support themselves and each other. When staff is hired for the peer-run center, and prior to opening, the staff and a core group of peer volunteers will be trained by staff from the existing self-help centers. They will be introduced to a range of outreach, engagement and peer/self-help strategies that are being implemented in the other centers.

The training component of this program is also designed to bring all providers in the system to a common level of understanding about evidence based practices that support recovery/resiliency.

*6) If expanding an existing program, describe the program and how it will change*

The existing peer-run center program will not change as a result of the addition of this additional self-help center. The new center will simply extend the network of peer, self-help services available in the County by serving a community (south county) that is not extensively served by the current program.

The addition of new clinicians, peers and parent partners will change the capacity and mix of staff at five regional clinics, providing new resources responsive to the populations served. Adding in the impact of the trainings that are outlined, we anticipate that each regional clinic will need to evaluate and transform current access and engagement processes (no wrong door), services, and the configuration of the staff that support these services. At this point, it is difficult to project how that will unfold, but we do believe that this will be the core of system transformation in our system.

*7) Describe which services and supports clients or family members will provide*

As described above, peers and parent partners will provide a range of services in the clinics, and consumers will operate the peer-run center.

*8) Describe collaboration strategies with other stakeholders and how they will help improve the system and outcomes*

The training initiative will require collaboration among all of the contract providers, County staff, the community college system, and other county departments as well as consumer and family organizations (including NAMI) to assure that we reach all provider staff throughout the system—a significant logistical challenge! The Consumer and Family Academy may be developed in collaboration with other Bay Area counties that will share curriculum development and training resources.

The peer-run center will be a laboratory for developing and testing new peer and self-help strategies that can be implemented in Full Service Partnerships, in the County clinics, and in other community settings. Lessons learned will inform the use of peers throughout the system and will generate evidence of the positive impact of self-help strategies. As such, the peer-run center will become a point of learning where community-based agencies and county staff can find out how to better integrate peer and self-help strategies in other parts of the system--lessons learned at the peer-run center will be incorporated into service delivery throughout the system.

*9) Describe how program will be culturally competent and meet the needs of culturally and linguistically diverse communities.*

Self-help strategies are effective to a significant degree because they are culturally competent and responsive to consumer needs as framed by consumers. By hiring bilingual/bicultural staff, the clinics and the peer-run center will have the capacity to more effectively engage and involve a culturally diverse population.

Consumers of the peer-run center will develop surveys and facilitate a monthly consumer forum expressly focused upon generating consumer input into the design and delivery of services offered through the center. In this way, the services and supports delivered at the center will be directly responsive to the consumers it serves.

*10) Describe how services will be sensitive to sexual orientation and gender differences*

While this program will not target issues related to sexual orientation and gender differences, it will be important that the atmosphere is both inviting to and respectful of all consumers regardless of sexual orientation or gender. As such, all staff will participate in training which will include components focusing on gender issues and sexual orientation. Peer and parent partner staff will be responsible for ensuring that all peer services are respectful of gender differences and the sexual orientation of consumers. Educational forums on both gender differences and sexual orientation will be offered at the peer-run center to build a culture and climate that is respectful of all differences.

*11) Describe how services will be used to meet the needs of those residing out-of-county*

The development of these system changes will create services and supports that are not now available to those residing out-of-county, and should support their ability to transition into community-based services.

*12) Describe how strategies not listed in Section IV are transformational and promote the goals of the MHSA*

All of the strategies proposed in this program are listed in Section IV and promote the goals of the MHSA as described in 2) above.

*13) Timeline for this work plan*

*Evidence Based Practice*
*Capacity*

| | |
|---|---|
| February 15, 2006 | Initiate hiring from pre-existing lists (recruitment/outreach prior fall) |
| February 15, 2006 | Initiate purchasing of start-up equipment and supplies |
| March 30, 2006 | Employee start dates |
| April 15, 2006 | Fully staffed and oriented |
| April 30, 2006 | Initial EBP training completed, system wide |
| May 1, 2006 | Commence service delivery |
| June 30, 2006 | First 70 clients served through expanded capacity |
| June 30, 2007 | FY 06-07 374 clients served through expanded capacity |
| June 30, 2008 | FY 07-08 374 clients served through expanded capacity |

*Parent Partners*

| | |
|---|---|
| October-November | Process with parents to develop RFP |
| December 1, 2005 | Publish Request for Proposals (contingent on state awarding funding) |
| December 13, 2005 | Bidder's Conference |
| January 6, 2006 | Responses Due |
| January 14, 2006 | Panel Review |
| January 20, 2006 | Tentative Awards (contingent on state awarding funding) |
| Pre-notice from State | Identify potential space, draft outreach materials |
| April 1, 2006 | Contract start date |
| April 15, 2006 | Fully hired |
| April 30, 2006 | Staff trained and oriented to mental health system resources and processes |
| May 1, 2006 | First outreach contacts occur |
| May 1-30, 2006 | Outreach events occur at community sites through out the county, link to FSP and other services |

*Peer Partners*

| | |
|---|---|
| Fall-February | Develop Academy initiative |
| February 15, 2006 | Initiate hiring from pre-existing lists (recruitment/outreach prior fall) |
| February 15, 2006 | Initiate purchasing of start-up equipment and supplies |
| April 1, 2006 | Employee start dates |
| April 15, 2006 | Fully staffed and oriented |
| April 15, 2006 | Initial training completed |
| April 16, 2006 | Commence service delivery |

| | |
|---|---|
| June 30, 2006 | First 70 clients served<br>System wide Wellness and Recovery training<br>Peer Academy |

*Peer Run Self-help Drop-in Center*

| | |
|---|---|
| October-December | Process with existing provider to identify elements of expanded program |
| January , 2006 | Develop draft contract modification |
| January 20, 2006 | Identify potential space, draft outreach materials |
| February 15, 2005 | Upon hearing from the State, initiate recruitment for hiring for program |
| April 1, 2006 | Contract amendment start date |
| April 15, 2006 | Fully hired |
| April 30, 2006 | Staff trained and oriented to mental health system resources and processes |
| May 1, 2006 | Drop-in center opens, initiate peer-run planning process about what center should be |
| May 1-30, 2006 | Outreach events occur at community sites through out the county, link to FSP and other services |

*14) Please see Exhibit 5, Budget and Staffing Detail Worksheets and Budget Narrative*

*15) Please see Exhibit 6, Quarterly Progress Report*

*16) Please see Exhibit 7, Cash Balance Quarterly Report*

## Summary

The following table summarizes the eight Program Strategies in relationship to whether services are to be provided by county employees or by contracted agencies, and if contracted, whether as expansion of a current program or a new Request for Proposal (RFP) process.

| Proposed Programs | County Employees | Contracted Services (RFP or expansion) |
|---|---|---|
| Full Service Partnerships | | |
| 1. Full Service Partnership, Child/Youth/Transition Age Youth | | |
| *FSP Team | | RFP |
| *Drop-in Center | | RFP |
| *Supported Education | | Expansion |
| *Housing | | Expansion |
| 2. Full Service Partnership, Adults | | |
| *FSP Team | | RFP |
| *Housing | | Expansion |
| 3. Full Service Partnership, Older Adults | | |
| *FSP Team | | RFP |
| *Housing | | Expansion |
| Outreach and Engagement | | |
| 4. Community Outreach and Engagement | | |
| *Outreach Workers | | RFP |
| *Cultural Disparity Grants | | RFP |
| *Primary Care Interface/Pediatrics | X | |
| *Primary Care Team/OA | X | |
| *Mental Health Clinician/ Suicide Prevention | | Expansion |
| System Development: Transformation | | |
| 5. School Based Services | | |
| *Mental Health Clinicians/ Middle Schools | | RFP |
| 6. Criminal Justice Initiative | | |
| *CJ Team | X | |
| 7. Older Adult System of Care Development | | |
| *OA SOC Manager | X | |
| *Peer Counselors | | RFP |
| *Home Care Assistance | X | |
| 8. System Transformation | | |
| *Internships | X | |
| *Mental Health Clinicians/County Clinics | X<br>X | |
| *Peer Partners/County Clinics | X | |
| *Parent Partners/County Clinics | | Expansion |
| *Self-Help Center | | Expansion |
| *Employment Services | | |