

A SUMMARY OF FIRST YEAR COUNTY CSS IMPLEMENTATION PROGRESS REPORTS

**Discussion Document Presented to
California Department of Mental
Health**

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Background

- ♥ Department of Mental Health (DMH) Information Notice 07-02 provided a format for county reports on the progress of the initial implementation of the Community Services and Supports (CSS) component of the Mental Health Services Act (MHSA.)
- ♥ Counties which had received approval of their initial CSS Plans by September 1, 2006 were to submit an Early Implementation Progress Report.
 - 39 counties submitted Implementation Progress Reports in the summer of 2007
 - One county did not report in time to be included in the analysis
- ♥ The intent of the report was to obtain the counties' perspectives on implementation. This information was intended to be used to provide individual county supports. In addition, these individual county reports were to be analyzed for statewide trends to inform policy development and technical assistance.

- ♥ For each question included in DMH Information Notice 07-02
 - There is a table which places the responses of the 39 counties into summary categories - the numbers and/or percentages can total more than 39 since for some questions the county indicated multiple responses
 - Examples are included as illustration where it was felt useful
 - Major findings are presented
 - Implications and issues for discussion are presented as relevant

- ♥ The results are presented in the order of the questions in the report format provided in DMH Information Notice 07-02.

- ♥ There is some overlap among the questions - particularly regarding cultural competence and ethnic disparities - so questions on a particular topic should be viewed together to get a more comprehensive view.

♥ Cautions and caveats

- We attempted to limit the summary to what was the result of CSS funding and what occurred during 2006 but this was not always possible
 - It was not always possible to determine what activities were the result of CSS funding and what had been happening already, e.g. with hiring practices, consumer/family involvement, outreach, cultural competence
 - It was not always possible to determine when actual programs or activities were implemented because reports were completed subsequent to the December 31, 2006 date and seemed to include activities during 2007
 - It was not always possible to separate what had actually happened from what was planned to happen

- The results should not be interpreted as indicating what the counties are doing in their total program but refer specifically to CSS funded activities during a specified implementation period.

Describe the major implementation challenges the county has encountered.

	<i>CHALLENGE</i>	<i>N</i>	<i>%</i>
INFRASTRUCTURE:	Human Resources- Workforce General or specific to a profession (26) Bilingual, bicultural (14) Civil service, job classifications (9) Need for training (2)	32	82%
INFRASTRUCTURE	Space/siting of programs	18	46%
INFRASTRUCTURE	Contracting process, lack of appropriate bidders	14	36%
INFRASTRUCTURE	General infrastructure	14	36%
INFRASTRUCTURE	Information technology	6	15%
COUNTY ISSUES	Bureaucratic inflexibility (e.g. use of flex funds, after-hours coverage)	11	28%
COUNTY ISSUES	Budget issues	4	10%
COMMUNITY	Collaboration (partners nor doing what they said, need to establish referral relationships, need to build trust)	10	26%
COMMUNITY	Lack of community resources (housing, transportation, board and care)	9	23%
PROGRAM	Multiple and new roles for program staff , client engagement, high cost of services, too many referrals	15	38%
Other		3	8%

KEY FINDINGS:

- ♥ Infrastructure challenges are by far the most significant
 - These have significantly delayed implementation in some counties
 - These are far more common and pressing than programmatic challenges

- ♥ 82% of the counties reported some type of human resources issue
 - Workforce shortages
 - Civil service issues
 - Training needs

- ♥ Space and contracting issues are also common noted by about one-half and one-third of the counties respectively

DISCUSSION/IMPLICATIONS:

- ♥ Is there any way to get more realistic about the infrastructure enhancements needed to implement new programs? Particularly as new MHSA components are rolled out?
- ♥ Would county mental health departments benefit from a state guideline (developed in collaboration with counties based on experience to date) that a percentage of their CSS allocation be spent for infrastructure?
- ♥ How can the delays caused by infrastructure issues best be communicated with stakeholders?
- ♥ How can DMH be helpful on any of the infrastructure issues?

Highlight any transformational activity in community collaboration

<i>ACTIVITY</i>	<i>N</i>	<i>%</i>
New collaborative activities, e.g. co-location of services, MOUs, formal referral arrangements, housing agreements	22	56%
Joint planning around needs and services	22	56%
Involvement of other organizations in CSS implementation work groups	19	49%
Joint service teams with other organizations	8	21%
Creation of new collaboratives	7	18%
Joint training	6	15%
Involvement in countywide initiatives, e.g. housing	6	15%

Examples

New Collaborative Activities:

- ♥ Working with a senior center to provide periodic MH services on site and train staff to recognize MH needs
- ♥ Working with First Five on screening of 0-5 year olds and on development of an Evidence Based Practice
- ♥ MOU with Housing Authority to distribute one-time funds for housing support
- ♥ Providing mental health services on-site at a domestic violence center
- ♥ Collaboration with schools led to providing mental health service to a young woman at the school where she was receiving English as a Second Language (ESL) class

Joint Planning:

- ♥ Held a community event -"A Community Dialogue on the MH Needs of (*specified*) County"
- ♥ Working with Community Action Division, Adult Services and the Public Authority to provide a better system of care for the unserved and underserved

New Collaboratives: Participation in new countywide Transition Aged Youth Collaborative to bring awareness of resources, coordination of resources, development of new strategies and partnerships necessary to meet the needs of youth in transition. Initial members include such entities as parents, mental health staff, Office of Education, Social Services, probation, regional centers, local universities

KEY FINDINGS

- ♥ Collaborations resulted in the initiation of actual service-related activities in addition to joint planning and/or education and/or training
 - More than half the counties initiated a new collaborative *activity* with another entity or organization
 - Half undertook joint planning
 - Half involved other organizations in their CSS implementation efforts

- ♥ One-fifth of the counties undertook a joint service team with another organization

DISCUSSION/IMPLICATIONS

- ♥ This analysis refers only to objective events with other organizations:
 - Is there a better way to describe the distinction between community collaboration and the consumer/family “integrated service experience”
 - Or, alternatively, should both terms be renamed and/or redefined both terms to clarify their distinctive meanings

- ♥ Are there way(s) to better describe and categorize the types of collaborative activities being undertaken by the counties

- ♥ Is there a way to assess the effectiveness of the collaborative activities

Highlight any transformational activity in cultural competency

<i>ACTIVITY</i>	<i>N</i>	<i>%</i>
Internal: Hiring of additional bilingual-bicultural staff	18	46%
Internal: Enhanced training	15	38%
Internal: Translation of materials, addition of translators	9	23%
Internal: Enhanced recruitment efforts	7	18%
Internal: Strengthening of CC structure, management, and policies	7	18%
Internal: Adding outreach workers for specific communities	5	15%
External: Contracts with community organizations to provide more culturally competent services	8	21%
External: Establishing more and better relationships with community based organizations	8	21%

Examples of Strengthened CC Structures, Management, and Policies

Inclusion of ethnic representatives on review panels

Requiring contractors to have set numbers of bilingual-bicultural staff

Requirements for all MHSA programs for numbers of Latino staff

Hired a consultant to conduct an assessment of cultural competence of whole system and develop an improvement plan

Other Examples

NAMI (under a county contract) is providing outreach and training with a special focus on Latino and Asian/Pacific Islanders and a curriculum in English, Spanish, Vietnamese and Arabic.

Developed relationships with cultural and ethnic community brokers and their constituencies

Highlight any transformational activity in client/family driven mental health system

<i>ACTIVITY</i>	<i>N</i>	<i>%</i>
Involvement of consumers/family members in program design	17	44%
Hiring of consumers and family members	17	44%
Consumer-driven centers	11	29%
Creation of collaborative committees or committees with major consumer input	10	26%
New or expanded training program or activity for consumers or family members	11	29%
Hiring of consumers or family members in management positions	3	8%
Training for staff on welcoming and working with consumer and family member staff	3	8%
Consumers and family members on review panels	3	8%
Redesigned services to provide more client direction	2	5%

Examples

Creation of a consumer housing group to provide input on housing issues

Monthly open meeting for consumers and family members

Consumers served as "change agents" directing transformation of current clubhouse programs to reflect their needs.

Consumers and family members serving on many internal standing committees such as Program Improvement Project (PIP) and Quality Management

Consumers are participating on subcommittees charged with developing a Consumer Navigation Tool and consumers and family members attend the monthly Admin/Supervisor meeting which is a staff leadership committee.

The Consumer Relations Manager is recruiting 150 consumers into a "pool of champions" that will support emerging consumer leadership and fill advisory positions throughout the County

KEY FINDINGS

- ♥ The counties indicate significant involvement of consumers and family members in their CSS implementation activity
 - Nearly half have hired consumers or family members to work as staff in the public mental health system
 - Nearly half are including consumers or family members in the design of their CSS services

- ♥ 29% indicate some type of consumer-driven service or program

- ♥ Only 8% indicate the hiring of a consumer or family member into a management position in county mental health or contract agency.

DISCUSSION/IMPLICATIONS

- ♥ How can the state DMH encourage more hiring of consumers/family members into management positions?

- ♥ Given its importance and growth should consumer-driven services be a high priority topic for one of DMH's special studies to determine the variation in the nature of the services and the issues involved in their implementation?

Highlight any transformational activity in wellness orientation

<i>ACTIVITY</i>	<i>N</i>	<i>%</i>
Training on concepts, practices, programs	20	51%
Wellness centers	11	36%
Putting recovery language into contracts and MOUs	7	18%
Creation of special committees or management position to promote concepts and practices	6	15%
Development of concepts to fit other populations or services, e.g. older adults, crisis centers	5	13%
Other, e.g. celebrations, recovery action plans	3	8%

Examples

Designed a Department of Behavioral Health Transformation Plan that strongly incorporates the philosophy of wellness and recovery throughout the entire system of care.

Hold a monthly “Celebrating Recovery” event which celebrates accomplishments with consumers and family members

Newly formed Wellness and Recovery Advisory Boards for Adults and TAY ensure active participation and decision-making in planning and implementation of MHSA programs

KEY FINDINGS:

- ♥ Change is occurring more at the learning, training, conceptual level rather than actual changes in practices
 - Most frequent activity is training
 - Change in policy involves inserting language into contracts but no indication of how this is to be implemented or monitored
 - Work being done on how to apply the concepts to other populations and service settings

- ♥ The most common service innovation is the creation of Wellness Centers

- There is a wide range of interpretation about what constitutes a “wellness” center

DISCUSSION/IMPLICATIONS

- ♥ How can we move past the conceptual and training levels?
 - How can the recovery/resilience concepts be put more into action?
 - How can we assess the extent to which this is actually happening?
- ♥ Should DMH attempt to find out more about the Wellness Centers and what is encompassed under this terminology?

Progress on Implementing an SB 163 Wraparound Program (Welfare and Institutions Code, Section 18250)

17 counties (44%) said they already have an SB 163 wraparound program

9 counties without SB 163 programs are in some stage of considering or planning for such a program

- ♥ Received training
- ♥ Talking to other counties about special issues, e.g. public-private collaborations, small county issues
- ♥ Meeting with social services and other agencies
- ♥ Writing a plan
- ♥ Submitted a plan

Only 2 counties seemed to suggest that their current FSP approach incorporates the principles of SB 163 and so a formal program may not be necessary

Describe how the Systems Development programs have strengthened the county's overall public mental health system?

<i>PROGRAM</i>	<i>N</i>	<i>%</i>
Developing or strengthening of infrastructure , e.g. developing system of care for OA or TAY	9	23%
Collaborations with forensics	9	23%
Changes or enhancements to crisis and emergency system	9	23%
Consumer driven initiatives	8	21%
Training initiatives	8	21%
More evidence-based practices	6	15%
Collaborations with physical health	6	15%
Moving from clinics to community	6	15%
Other	3	8%
Too soon to say/implementation delayed	12	31%

KEY FINDINGS

- ♥ Nearly one-quarter (23%) are undertaking infrastructure changes to strengthen their service systems
- ♥ The most frequently cited general program element affected with system development funds was the emergency/crisis system reflecting stakeholder concern about this system element
- ♥ Some of the cited changes may reflect a broader shift in overall orientation and philosophy, even though they are being initially implemented within specific CSS funded programs
 - Moving from clinics to community
 - Consumer-driven initiatives
 - Collaborations with physical health and forensic systems
 - Instituting evidence-based practices

- ♥ Some counties used the System Development funds for training of not just new but all the county mental health staff

DISCUSSION/IMPLICATIONS

- ♥ Should there be differentiation between System Development funds used to fund new or enhanced services versus System Development funds used to transform the system, such as funds used for training, collaborative planning, infrastructure, etc.?
- ♥ How can the impacts of the System Development funds on the county's whole mental health system be measured?
 - Can the state DMH highlight examples of counties which have used the funds in this way?
 - How should the number of clients impacted by System Development funds be counted?
 - Should the success of System Development funds be measured solely in terms of numbers served?

Describe efforts to address disparities in access and quality of care among underserved populations

EFFORT	N	%
Addition of outreach workers for the purpose of case finding, linking clients to services, and/or making contacts with community groups	17	44%
Addition of bilingual-bicultural staff	16	41%
Greater presence in community, e.g. attendance at fairs, presentations to community groups, educating others about mental health system	14	36%
Enhanced training of staff on ethnic-cultural issues	13	33%
Contracts with community groups for the provision of direct services within their communities	11	29%
Addition of direct service staff/programs for specific ethnic populations	10	26%
Development with community representatives of a specific plan for addressing a the community's needs	9	23%
Special meetings or committees established with ethnic communities to explore needs and issues	6	15%
Strengthening county's cultural competence structure or management	5	13%
Opening of access to system, e.g. same day services, providing something to whoever enters system	4	10%
Targeting of FSP slots or other services for specific ethnic populations	4	10%
Emphasizing a more "welcoming" environment	3	8%

EXAMPLES OF SUCCESSES

Examples of outreach, education, and linkages with community leaders and organizations

Meetings with Lesbian, Gay, Bisexual and Transgender (LGBT) community and hiring of an advocate

Joint sponsorship with African American community organization for concert with artist who spoke about major depression - attended by 1000+

Through a contract with Filipino agency did a day-long training for 80 providers

Dr.conducted presentation in Spanish designed to educate the public about MH issues through the use of music and videos. The public responded enthusiastically to his presentation

Greatest success is the development of relationships with cultural and ethnic community brokers and their constituencies

Examples of altered service structure to be more welcoming

Wellness Center open to anyone - makes it easier for other cultures because don't have to buy into MH system – the blending numerous cultures into one facility with an open acceptance of their differing customs has been a clear success

Welcoming plans for whole department and for each clinic to engage consumers from first contact

Examples of changes in structures

Inclusion of one consumer and one family member of ethnic diversity on each RFP review committee

Examples of new staff and programs

Has been successful in hiring bilingual, bicultural staff - Latino, Hmong, Indian/Punjabi and have established a Hmong socialization/rehabilitation group

Latino Outreach and Services program has been well received - there has been an increase in demand to the point that there is now a waiting list which will be addressed by additional MHSA growth funds

Training in CC of all their managers and supervisors and evaluating its impact and seeing a significant difference.

Latino outreach -- a bilingual psychiatrist works with organizations that serve Latinos, is on radio and provides services in homes and community sites

KEY FINDINGS

- ♥ Counties are embarked on a wide range of initiatives including many efforts which are new to the county systems
- ♥ Some initiatives rely on enhancing the county's capacity to serve the targeted populations
 - Hiring of more bilingual-bicultural staff
 - Addition of specialized outreach functions
 - Strengthening cultural competence of system through enhancements to structure, management, training
- ♥ Some initiatives rely on strengthening relationships with community organizations to overcome barriers to access to the county's system of services
 - Enhanced presence in the community with education and relationship building
 - Special targeted outreach to community groups
 - Joint planning for how to better serve the community
- ♥ Some initiatives rely on community organizations providing direct services themselves as the best way of overcoming barriers to service

CHALLENGES

- ♥ Difficulty in hiring bilingual-bicultural staff
- ♥ No community organizations with capacity and/or interest to provide or develop mental health services to a specific ethnic group
- ♥ Ongoing distrust of any governmental organization including county mental health
- ♥ Stigma about mental health problems and services

DISCUSSION/IMPLICATIONS

♥ How can the variation in approaches including those that are more innovative and potentially successful be highlighted?

What Native American organizations or tribal communities have been funded to provide services under MHSA?

<i>ACTIVITY</i>	<i>N</i>	<i>%</i>
They were either not interested or failed to submit response to RFP	10	26%
Having discussions but nothing funded yet	9	23%
Something funded through MHSA	6	15%
Something funded through other sources	3	8%
No tribes or organizations or effort	11	29%

WHAT FUNDED THROUGH MHSA

- ♥ Mini-grant programs funded thru competition for planning and outreach - included a Tribal Health Project and Indian Health Center - will fund actual services later
- ♥ Contract signed with Consolidated Tribal Health Project (9 tribes) for 1/2 time psychologist for children
- ♥ Native Americans (among other groups) a priority population for enrollment in an FSP
- ♥ Funding a Native American organization to provide services with MHSA funding.
- ♥ No tribal organizations funded, but have hired a Native American program manager
- ♥ Funded the Inter-Tribal Council of California (ITCC) to provide a cultural competency workshop for staff, providers and the Native population

EXAMPLES OF EFFORTS WHICH DID NOT RESULT IN FUNDING

- ♥ They attended trainings and we had two meetings with Indian Health agency during planning. No response to follow-up letters.
- ♥ Two tribal communities in county which participated in planning but no responses to RFPs and so no contracts

- ♥ An Indian Center is represented on the steering committee but they did not submit a proposal for funding, nor did any other Native American organization.
- ♥ A tribe runs casino and is self-sufficient; declined to be involved in MHSA planning and programs
- ♥ No proposals targeting this population were submitted in response to RFPs

EXAMPLES OF ONGOING EFFORTS

- ♥ We attended conference with a person from local inter-tribal council and began discussions on things to do maybe in next funding cycle
- ♥ We did presentations to tribal groups and met with the Tribal Council during planning but they didn't bid on a One Stop or a Mobile program. There have been additional meetings with councils and Indian TANF programs
- ♥ None now but plan to contract for a Native American case manager through a Native American community agency
- ♥ Has recently renewed discussions with the Native American Health Center in order to better identify and involve Native Americans in MHSA planning and services.
- ♥ None funded, but extensive outreach and engagement activities have taken place with key cultural brokers in the Native-American community

KEY FINDINGS

- ♥ Successful involvement of Native American tribes or organizations has been limited, but ongoing efforts are being made by many counties
- ♥ Outreach efforts were undertaken but often did not result in the development of funded proposals either because of lack of interest or potentially because of lack of resources or capacity

IMPLICATIONS/DISCUSSION

- ♥ Developing relationships which result in meaningful collaborations with Native American tribes or organizations requires more than a “one time” effort

- Counties need to better understand why Native American tribes or organizations did not follow-through on initial overtures
 - Counties need to commit themselves to building long-term relationships
 - Counties may need to either adapt their regular RFP requirements or provide special assistance in order for successful collaborations to occur
- ♥ How can the state DMH assist counties in their efforts at engagement of the Native American communities?

List changes in policies or system improvements specific to reducing disparities

<i>POLICY OR SYSTEM IMPROVEMENT</i>	<i>N</i>	<i>%</i>
Requiring contractors to have a cultural competence plan and/or specific hiring practices or specific types of staff	18	46%
Increased commitment to outreach	7	18%
Enhanced translation or interpreter capacity	6	15%
Training or conferences	5	13%
Inclusion of representatives on hiring or review panels	4	10%
Specific needs assessments	3	8%

FINDINGS

- ♥ The most common system change was the inclusion of requirements regarding cultural competence within contracts with providers
- ♥ This area overlapped with the cultural competence key element and question and some of the findings, challenges and discussion items are reported there

Summarize involvement of stakeholders in ongoing planning and implementation

<i>Involvement</i>	<i>N</i>	<i>%</i>
Involvement in implementation workgroups	22	56%
Continuation or all or most of the original stakeholder process	17	44%
Creation of new permanent advisory groups	11	29%
Use of the Mental Health Board as the primary ongoing stakeholder entity	10	26%
Creation of special structures or sessions for updates on implementation	9	23%
Inclusion of stakeholders on RFP response review panels	8	21%
Publication of written updates and reports	7	18%
Involvement of stakeholders in special ad hoc workgroups to address specific issues	7	18%
Training of stakeholders	4	10%
Major modifications in stakeholder process in response to changed needs of monitoring implementation	3	8%

FINDINGS

- ♥ Counties indicate that stakeholders continue to play a role during the early stages of implementation with 56% having them participate in implementation workgroups
 - Most counties have continued to use the basic stakeholder structures and processes as used in the initial planning with modifications as needed
 - Many counties are using advisory boards –either the Mental Health Board or new committees to address specific issues or needs
 - Some counties have added stakeholders to their RFP response review panels
 - A few counties have needed a more significant restructuring of the stakeholder process to accommodate the different needs of implementation

- ♥ Many counties have found the need to supplement usual processes to ensure that stakeholders are informed about the implementation progress – this is done through written reports and/or special meetings

IMPLICATIONS /DISCUSSION

- ♥ How do we reconcile these reports of continued participation with some of the interview data from the County Implementation Study suggesting that there had been a drop-off in stakeholder involvement?
- ♥ Should we be asking more about the specific “monitoring” function, i.e. how the stakeholder process is being set up to do that? And about holding the county “accountable” for what it is doing?
- ♥ How do we assess the quality and meaningfulness of on-going stakeholder involvement?

Substantive issues raised during review process

<i>ISSUE</i>	<i>N</i>	<i>%</i>
Specific service-system issues, e.g. lack of specific services, access and linkage issues, lack of services in rural areas	10	26%
Lack of or inadequate information about implementation including need for clarifications on programs goals, FSP definitions	9	23%
Planning issues, e.g. ongoing role of Steering Committee, consumer-family involvement	5	13%
Consumer hiring and support including need to prepare professional staff	3	8%
Hiring and training of staff	3	8%
Delays in implementation	2	5%
None noted	16	41%

KEY FINDINGS

- ♥ Almost half the counties indicated no issues were raised during the Implementation Report review process
- ♥ Stakeholders are most concerned about ongoing problems with the existing service system including access, available services, linkages
- ♥ Stakeholders in some counties feel they are not getting enough or the right kind of information about implementation
- ♥ The county reports included actions they intended to take in response to the issues raised in the public review

IMPLICATIONS/DISCUSSION

- ♥ Some of the reports did not include results from the 30-day comment period and public hearings. Should DMH be concerned that there were no issues raised in so many counties?
- ♥ Are there ways to make this formal review process more meaningful at the county level?

Identify technical assistance needs in County for supporting continued implementation of CSS

<i>TA NEED</i>	<i>N</i>	<i>%</i>
Developing housing resources	6	15%
Training in recovery orientation	6	15%
Information technology including electronic medical records and clarification on IT projects	6	15%
FSP definition, scope of commitment, time lines, how to get 24-hour coverage	6	15%
Data collection and reporting	5	13%
Promoting organization culture change	5	13%
Consumers in the workplace – hiring , training, preparation of workforce	5	13%
Outreach to and building relationships with special underserved populations including marginalized, ethnic, and Native American groups	5	13%
Training in evidence-based practices or specific models	5	13%
State outcome expectations for System Development and Outreach-engagement	4	10%
Administrative issues, e.g. recruitment of gerontology specialists, limitations and uses of flexible funds, project management, documentation	4	10%
Cultural competence	3	8%
Medi-Cal issues including contracting and how to get wellness services reimbursed	3	8%
How to implement SB 163 or Wraparound models	3	8%
Assistance to small counties that they can easily access	2	5%
CIMH leadership on older adult computerized diagnostic	2	5%
Physical health issues – how to access these services, how to build relationships with primary care	2	5%
Other (1 each) – how to develop/foster “natural” supports, community development, anti-discrimination social marketing, long-range service delivery strategy for clinics, consumer-family leadership development, clarification of Katie and Fed Acts related to CM for juvenile dependents	6	
None noted or did not address	7	18%

KEY FINDINGS

- ♥ The range of indicated technical assistance needs is very disparate
- ♥ Some of the more common needs are applicable to the whole system, not just CSS, and should not necessarily need to rely on specific DMH MHPHS resources
 - Development of housing resources
 - Training in recovery orientation
 - Cultural competence
 - Outreach to selected underserved populations
 - Evidence-based practices
 - Medi-Cal issues
- ♥ Some of the technical assistance needs are related specifically to MHPHS
 - FSP issues
 - Information technology issues
 - Data collection and reporting
 - Outcome expectations
- ♥ Some of the technical assistance needs are general but have arisen specifically in response to the CSS experience
 - Organizational change
 - Consumers in the workplace
 - Outreach to underserved populations

IMPLICATIONS/DISCUSSION

- ♥ Is there a more effective and timely way to gather this information on technical assistance needs other than this once a year mechanism? This is particularly relevant on the issues that are specifically related to MHPHS.
- ♥ What mechanisms exist to address these disparate needs?
 - Does anyone track these needs?
 - Is there co-ordination of technical assistance efforts?
 - Given the disparity of needs, is there the capacity to provide special consultation to individual counties?

Identify specific issues that need further policy development or program clarification

<i>ISSUE</i>	<i>N</i>	<i>%</i>
Reporting issues: streamlining (2), expectations about outcomes for SD and O-E, revisions to Exhibit 6, general outcomes	5	13%
Special provisions for small counties	3	8%
How to do "whatever it takes" in FSP within budget	3	8%
Housing issues, flexibility in types of funding, chart of streams of funding	3	8%
Clarification on funding issues: growth funds and unexpended funds, utilization of capital facilities and IT funds	2	5%
Expanded implementation timelines	2	5%
Integrated plan	2	5%

FINDINGS

- ♥ There were not a lot of issues cited requiring additional policy clarification
- ♥ Reporting issues were the most frequently cited issue needing additional policy action
- ♥ The need for special provisions for small counties was also cited

IMPLICATIONS/DISCUSSION

- ♥ The relatively small number of counties cited issues suggests that there are existing mechanisms for raising critical issues
- ♥ Reporting requirements need to be continually monitored and reviewed for utility