

5/23/05

DRAFT

Mental Health Services Act—
Community Services and Supports

**TECHNICAL
ASSISTANCE
DOCUMENTS**

To Aid Counties in Preparing
The Three-Year Program and Expenditure Plan

Fiscal Years 2005-06, 2006-07, 2007-08



CALIFORNIA DEPARTMENT OF
Mental Health

Technical Assistance Documents

The following Technical Assistance Documents are provided to aid the Counties in their planning processes to develop Community Services and Supports Program and Expenditure Plans as required under the Mental Health Services Act (See 5/18/05 Program and Expenditure Plan Requirements):

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Technical Assistance Document 1

County Readiness Self-assessment for Implementation Of the MHS Community Services and Support Component

As part of the comprehensive planning process to develop the required three-year plan for the Community Services and Support component under the Mental Health Services Act (MHS), counties and their stakeholders may find it helpful to use this County Readiness Self-assessment. This information could provide a broad base of critical information for the further development of your Plan.

1. Organizational Vision, Mission and Values

- a. Does the county have:
 - i. Vision Statement
 - ii. Mission Statement
 - iii. Values Statement
- b. If no, you should develop these as part of your planning process. If yes:
 - i. Were these documents adopted or updated within the last two years?
 - ii. Do they reflect a recovery/resiliency orientation? For example, do they embody the concepts of empowerment, hope, respect, self-determination, self-responsibility, social connections and development of a sense of competence?
 - iii. Were they developed with client and family input?
 - iv. Were they developed with equal input from all levels of staff?
 - v. Do they address issues of cultural diversity?
 - vi. Are the vision, mission and values visible throughout the system?
 1. Brochures
 2. Staff training
 3. Posters
 4. MHB/C training
 5. Client materials
 6. Client records
 7. Staff language and interactions with clients

2. Planning

- a. If you have done strategic planning, developed a master plan or produced an annual report in the last two years, you may want to begin with such documents and update them. The County Cultural Competence Plan may also provide information, and some of this information is available on the DMH website.

b. Population information

- i. What is the population of the county? By age? By gender? By ethnicity?
- ii. What is the Medi-Cal population of the county?
- iii. How many people in the county are under 200% of poverty (including Medi-Cal)?
- iv. How many people in the county are homeless? How many of these have a serious mental illness? How many have a co-occurring substance abuse disorder?
- v. How many people in the county are incarcerated? What percentage of the local incarcerated population has a serious mental illness? How many have a co-occurring substance abuse disorder?
- vi. How many people in the county are in a juvenile justice facility? What percentage of youth in a juvenile facility has a serious emotional disorder? How many have a co-occurring substance abuse disorder?
- vii. How many children/youth in the county are in foster care placements both in county and out-of-county? What percentage of youth in foster care has a serious emotional disorder? How many have a co-occurring substance abuse disorder?
- viii. What is the graduation rate of children/youth with emotional and behavioral and mental health conditions?
- ix. How many children/youth with serious emotional disorders are in non-public school settings?
- x. How many children/youth are in residential treatment program placements under AB 3632, child welfare and juvenile justice?

c. Service utilization information

- i. How many clients did the county serve in Fiscal Year 2003/2004?
 1. By age
 2. By age, by gender
 3. By age, by gender, by ethnicity
 4. By payer category
 - a. Uninsured
 - b. Partially insured
 - c. Medi-Cal
 - d. Medi-Cal/Medicare
 - e. Medicare only
 - f. Others
- ii. How many clients are in nursing facilities and mental health rehabilitation centers (MHRCs) including those designated as Institutions for Mental Disease (IMDs)?
- iii. How many clients are housed in Board and Care facilities?

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3. Quality Improvement Assessment – Describe the current status and assess the adequacy of the organization in each of the following areas:
 - a. Performance outcomes, including client/child/youth and family satisfaction
 - b. Training
 - c. Practice guidelines
 - d. Level of care guidelines
 - e. Special studies

4. Budget Information – You should have the most recent county cost report and budget information in an easily understandable format that will enable stakeholders to comprehend current and proposed revenues, expenditures, operating and administrative costs and total costs per client (broken down at least by age). Budget documents should show what percentage of the budget is spent on direct services and what percentage is spent on administrative costs.

Technical Assistance Document 2

Performance Measurement

The DMH is currently engaged in a collaborative process to develop the specific tools and data elements to measure performance. The specific methodology is currently in a developmental stage and the Department is not expecting a county to definitively address performance measures in this application cycle. However, it is expected that counties begin the deliberative process to determine how data collection and outcome reporting will be facilitated. When the performance measures are established it is expected that a county be able to fully comply with the expected measures.

To assist counties in their planning process there are certain assumptions. It is expected that a portion of the data collection will be similar to what is required in AB 2034 and that direct service staff will play an increased role in the data collection. In addition, performance with respect to the MHSA will be measured on three levels: the individual client outcome level, the mental health program/system accountability level, and the public/community-impact level. Attention to cultural competency and elimination of disparities will be emphasized at each level.

With respect to the individual client level in the initial three-year community services and supports plan, counties will need to be able to track information with respect to those individuals identified for MHSA Full Service Partnership funding, including all services, supports and performance outcomes.

Consistent with the requirements regarding community issues, mental health needs and the initial focal populations, programs funded through the MHSA will need to comply with standard data capture and reporting procedures (to be determined) with respect to the following focal client-level outcome areas:

- Recovery and wellness
- Housing
- Criminal and/or juvenile justice system involvement
- Employment/education
- Hospitalization (acute/long term restrictive levels of care)
- Income/entitlements
- Family preservation
- Symptoms/suffering
- Suicide
- Functioning
- Substance use
- *Quality of life*
- Illness self-management
- Social/community connectedness
- Individualized service plan goals
- Physical health
- Out-of-home placement

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- Non-public school placement
- Graduation rates for children/youth diagnosed with serious emotional disorders
- Child welfare status

The data capture mechanism for client, services and outcome information will be new or existing local/county information systems along with data capture mechanisms developed by DMH. Data will need to be captured relevant to outcomes, access, appropriateness of service including culturally specific indicators, Full Service Partnership identification, new services/programs/supports pertinent to the MHSA, evidence-based practices, process between various levels of services/supports and reason for disengagement from services/support, if applicable. DMH will work with counties to address information technology issues related to these additional reporting needs.

DMH assessment of program and system performance will be facilitated through persistent, collaborative outreach and engagement with county mental health programs. This will be followed by focused technical assistance, ongoing monitoring, and oversight activities. Counties will be expected to monitor program/system accountability indicators such as cultural competency, recovery and wellness orientation/promotion, fidelity to evidence-based and value-driven practices, budget and reporting guidelines, and comprehensive, interdisciplinary, interagency service delivery models. Technical assistance, training, monitoring, quality improvement projects and oversight processes at the local/county and state level will ensure that mental health system activities are consistent with the MHSA goals and intent.

DMH will work with counties and other stakeholders in establishing appropriate program and system performance indicators, monitoring criteria, and evaluation designs. DMH will further provide guidance and technical assistance, and will develop templates, forms, and electronic interfaces for information capture and accountability reporting where feasible.

With regard to the third level of performance measurement, counties will also need to work with community partners and DMH to measure information applicable to the public or community impact level, which includes:

- Tracking of mental health promotion and awareness activities
- Measurement of mental health system structure/capacity in the community
- Assessment of community reaction, evaluation and satisfaction with regard to mental health services
- Measurement of large-scale community indicators, such as population prevalence of mental illness, mental health need, and other issues of community concern with respect to persons with mental illness, e.g., homelessness, justice system involvement, emergency room, psychiatric hospital and IMD utilization, out-of-home placement and school attendance for youth, etc.

DMH will determine the performance indicators and measurement methods relevant to examining the public/community impact of MHSA services, supports and system transformational processes. Performance indicators are likely to be specific to particular

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efforts, and special evaluation studies may be needed that are tailored to such strategies as they are developed and implemented. DMH will work with counties to develop tracking and data capture methods to measure performance at this broad impact level.

A more comprehensive document, Preliminary Discussion of the Performance Measurement Design for the Mental Health Services Act (MHSA) is available on the DMH website.

Technical Assistance Document 3

Wellness/Recovery/Resiliency Services and Support System Planning Checklist for Children, Youth, Transition Age Youth and Families' Service Planning

This document is designed to be used in your community planning process for the MHSA. In order to create a plan to transform your local mental health system into a comprehensive community system that is client and family directed, culturally competent and recovery/resiliency oriented, it is important to think about the current culture of your system and how it is perceived by a variety of stakeholders. This checklist is intended as a learning tool, to get stakeholders to begin thinking about the concepts and principles underlying a transformed system, and review where they believe their local service system currently functions in relation to these concepts.

It is important to understand that this checklist is designed to be an aid and provide focus in your planning process. An honest assessment of where you are will allow you to more effectively plan how to reach your goals. Areas of strength should be identified and used as models. Areas in which your system has challenges are productive areas for discussion of creative ideas about how to meet the challenges. Change is difficult and transformation is even more challenging, but committed communities can make it happen.

Communities may use this tool in a number of different ways. As part of the planning process, you may have a series of workgroups that use this document as a catalyst for discussion about what terms like wellness, recovery, resilience, cultural competence and client/family centered really mean in operational terms. You may want to have different stakeholders groups, such as clients, family members and staff discuss these checklists separately, coming together after having done so to discuss their perceptions and hear those of others. You may want to use separate checklists for different age groups. Large programs and communities with defined geographic areas may want to have each area or region use these tools in the planning process.

In the Community Plan requirements, there is a section in which you are asked to describe how you used these tools in your planning process.

- 1. To promote wellness and resiliency in children and families, our services and supports:**
 - Use a strength-based approach to assessment and services
 - Foster problem-solving skills, confidence, autonomy, cultural strength and a sense of purpose in the children and families served
 - Strive for stability in the child's living, community and educational environment
 - Promote school readiness and/or school success

2. As a child and family driven system:

- Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking and what services they think are required to meet these goals.
- Children, youth and their families/caregivers are responsible for making plan decisions based on partnership with their provider(s).
- Service plans are clearly related to the child, youth and family/caregiver beliefs, opinions and preferences.
- Children, youth and their families/caregivers are respected and valued.
- 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.
- Parents are given the information they need to make informed decisions about their child's mental health services and supports.
- 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.
- Communication with children, youth and their families/caregivers is clear and honest.

3. To ensure effective and appropriate services for children, youth and their families:

- Comprehensive assessments are provided to ensure that children/youth and their families receive the appropriate type and intensity of service.
- 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.
- Services are flexible and allow children and families to integrate them into their daily routines.

4. To ensure community-based services and supports:

- 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.
- Services are provided in the least restrictive setting possible and in as normal an environment as possible.
- Families' informal/natural sources of support are included in formal service planning and delivery.

5. (For counties that have a Wraparound program) We have a Wraparound program that incorporates the ten essential elements of Wraparound:

- Families have a high level of decision-making power at every level of the Wraparound process.
- Team members are persevering in their commitment to the child and family.
- Wraparound efforts are based in the community and encourage the family's use of their natural supports and resources.
- The Wraparound approach is a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
- 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 process is culturally competent, building on the unique values, preferences, and strengths of children, families, and their communities.
- The plan is developed and implemented based on an interagency, community/neighborhood collaborative process.
- Wraparound plans include a balance of formal services and informal community and family resources, with eventually greater reliance on informal services.
- 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.

Technical Assistance Document 4

Wellness/Recovery/Resiliency Services and Support System Planning Checklist For Older Adult, Adult and Transition Age Service Planning

This document is designed to be used in your community planning process under the MHSA. In order to create a plan to transform your local mental health system into a comprehensive community system that is client and family directed, culturally competent and recovery/resiliency oriented, it is important to think about the current culture of your system and how it is perceived by a variety of stakeholders. This checklist is intended as a learning tool, to get stakeholders to begin thinking about the concepts and principles underlying a transformed system, and review where they believe their local service system currently functions in relation to these concepts.

It is important to understand that this checklist is designed to be an aid and provide focus in your planning process. An honest assessment of where you are will allow you to more effectively plan how to reach your goals. Areas of strength should be identified and used as models. Areas in which your system has challenges are productive areas for discussion of creative ideas about how to meet the challenges. Change is difficult and transformation is even more challenging, but committed communities can make it happen.

Communities may use this tool in a number of different ways. As part of the planning process, you may have a series of workgroups that use this checklist as a catalyst for discussion about what terms like wellness, recovery, resilience, cultural competence and client/family centered really mean in operational terms. You may want to have different stakeholders groups, such as clients, family members and staff discuss this checklist separately, coming together after having done so to discuss their perceptions and hear those of others. You may want to use separate checklists for different age groups. Large programs and communities with defined geographic areas may want to have each area or region use these tools in the planning process.

In the Community Plan requirements, there is a section in which you are asked to describe how you used these tools in your planning process.

1. In our mental health program:

- Staff believe in recovery
- Clients believe that recovery is possible
- Expectations of recovery are maintained
- Recovery is in the mission statement, goals, and objectives of the service
- Administrators, staff and clients exchange information freely
- Clients are related to as individuals, not as illnesses
- Psychosocial rehabilitation is emphasized

- Resources to meet educational objectives are available
- Clients learn to manage their own resources

2. To actively encourage client empowerment and self-determination:

- Client goals are critical in planning
- Clients are treated involuntarily as little as possible and clients are encouraged to develop advance directives for involuntary treatment when it occurs
- Individual services and supports plans integrate the client's goals
- Clients' needs and preferences determine service structure and opportunity
- Clients participate in service planning, development and governance of the agencies and/or service systems
- All services are oriented to improving the lives of clients, their families and support systems
- Necessary financial supports are considered

3. In order to support clients in taking responsibility for their own behavior:

- Set-backs are incorporated as learning experiences
- Support for clients is consistent with that which is necessary and consistent with a recovery plan
- Clients and staff share responsibility for safety
- Staff and clients share the same spaces, e.g., offices, bathrooms, recreation areas

4. Client participation in regular community activities is expected and supported in the following ways:

- Community employment is supported
- Community activities are supported
- Community recreation is supported
- Community interaction with other than the mental health community is encouraged and supported
- Interpersonal and family relationships are supported and encouraged
- Family members are welcomed and appropriately involved – spouses, children, siblings and parents

5. In order to ensure that services are available and accessible:

- Services are culturally appropriate for the client, family and ethnic community
- Services are safe for the client socially, emotionally and physically
- Services a client needs are identified through a single plan and personal service coordinator
- Clients have access to staff and there is availability of staff who are aware of their needs 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

Technical Assistance Document 5

Considerations for Embedding Cultural Competency

Purpose:

Cultural Competency continues to be a critical component for all mental health programs and policies. Now, the Mental Health Services Act (MHSA) provides an opportunity to develop a transformed culturally competent mental health system. This concept is embodied in the Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act, “DMH will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system...” This document offers operational strategies for embedding Cultural Competency in the Community Services and Supports component of the MHSA. The operational strategies in this document, however, are not meant to be exhaustive. Rather, it is recommended that the counties and stakeholders use these strategies as a compliment to their own materials and the expertise gained through their on-going Cultural Competence activities, pursuant to the Medi-Cal Specialty Mental Health Services–Cultural Competence Plan Requirements (DMH Information Notice No. 02-03). The strategies to achieve a culturally competent mental health system and thereby eliminate the existing disparities in the current system have been discussed over the years in a variety of documents. Many of these documents are available on the DMH Website at: www.dmh.ca.gov.

Cultural Competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members, and professionals that enables that system, agency, or those professionals and consumers, and family member providers to work effectively in cross-cultural situations (adapted from Cross, et al., 1989; cited in DMH Information Notice No.: 02-03).

Background:

Rapidly changing demographics in the United States (U.S.) and California, and the increasing numbers of Californians without health care have accelerated the need to change the system. Presently, the non-Hispanic white population in California stands at 47%, making ethnic, racial, linguistic, and multiracial groups the majority of the State’s population.

Racial and ethnic populations are a growing segment of the U.S. population and are currently either underserved, and/or inappropriately served in the metal health system (Rice, 1996). In California, County Mental Health Plans have been required to submit Cultural Competency Plans since 1998. These plans include population and utilization

data. The data clearly document the disparities that exist among ethnic and racial groups.

Collectively, the ethnically, racially, and linguistically diverse populations experience greater disability from emotional and behavioral disorders than do white populations (Mental Health: Culture, Race and Ethnicity, A Supplement to the Surgeon General's Report, 2001). The higher burden is partially attributed to receiving less access to care, and poorer quality of care rather than from disorders being inherently more severe or increased prevalence in racially, ethnically, linguistically diverse populations. In general, mental health disparities among ethnically, racially, and linguistically diverse populations have been attributed to inadequate funding of the public mental health system and its inability to understand and value the need to adapt the service delivery process to the histories, traditions, beliefs, languages and values of diverse groups. This inability results in misdiagnoses, mistrust, and poor utilization of services by ethnically, racially, and linguistically diverse populations seeking services. These groups also experience more stressful environments due to poverty, violence, discrimination and racism.

Developing effective and efficient culturally competent organizations, access, and programs is fiscally prudent. The lack of these components in a mental health system results in inappropriate and inefficient services leading to higher levels of care for clients and higher costs. It is estimated that the general cost of untreated or poor treatment of mental illness costs the government, business, and families \$113 billion a year (Rice, 1996).

Additionally, the mental health system has to comply with federal and state legislation when delivering services to persons who are limited English-proficient. Title VI of the Civil Rights Act of 1964 (U.S. Congress, 1964) mandates meaningful and equal access to health and social services. California counties started to work towards this goal among a myriad of rules, regulations, and limitations. The MHSA allows California counties to advance the mental health system into a transformed culturally competent mental health system for those ethnically, racially, and linguistically diverse groups who are unserved and underserved

A culturally competent service delivery system accomplishes the following efficiency elements:

- ◆ Improved service access, including early intervention
- ◆ Accuracy of diagnosis
- ◆ Appropriate and individualized service planning and delivery
- ◆ Effective integration of the client's family (including extended family members) into services
- ◆ Use of relevant community supports
- ◆ External resources in client services
- ◆ Financial efficiencies – cost-avoidance and cost-effectiveness

Considerations for Embedding Cultural Competency in Organizations

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>1. Counties/organizations to identify values, principles, and commitment to Cultural Competency</p>	<p>It is recommended for counties/organizations to have:</p> <ul style="list-style-type: none"> • Written policies and procedures that clearly identify Cultural Competence principles and values • Written policies and procedures that acknowledge Cultural Competency as developmental and continuous 	<p>“Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health: A Report to the Community,” February 6-8, 2002</p>
<p>2. Counties/organizations include Cultural Competency in vision statements, speeches, and public communications</p>	<p>It is recommended that mental health directors and senior staff advocate for/institutionalize Cultural Competence in the broader mental health community and in the stakeholder process</p>	<ul style="list-style-type: none"> • Ethnic Services Managers (ESM) • “Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health: A Report to the Community,” February 6-8, 2002 • “Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General,” 2001
<p>3. County mental health directors establish expectations and objectives for senior management staff to promote Cultural Competency</p>	<p>It is recommended that directors:</p> <ul style="list-style-type: none"> • Develop performance objectives • Communicate expectations/objectives through all the mental health system/organization/structure 	

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>4. Counties/organizations dedicate a position responsible for providing leadership in multicultural/ethnic services which has the responsibility to review the major policies and agency products to ensure that Cultural Competence is included or addressed</p>	<p>It is recommended that counties/organizations establish policies and procedures that ensure the review of policies by the person who has been entrusted with leadership responsibilities for ethnic services</p>	
<p>5. Counties/organizations conduct a system-wide self-assessment related to Cultural Competence annually</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Conduct self-assessments as part of the counties'/organizations' Quality Improvement Plan • Conduct self assessment at multiple levels of administration, middle management, direct service providers, contract agencies, and clients/family members • Use a strength-based model • Develop dissemination formats that reflect the needs of stakeholder groups, i.e., translation of information, regional meetings, etc • Disseminate results of self-assessment to all internal and external stakeholders 	<ul style="list-style-type: none"> • Cultural Competence Plans • Georgetown Cultural Competence Organizational Assessment Tools • Cultural Competency Methodological and Data Strategies to Assess the Quality of Service in Mental Health Systems of Care," Carol Siegel, G. Haugland, E. Davis, Center for the Study of Issues in Public Mental Health

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>6. Counties/oranizations conduct a baseline needs assessment that includes a profile of racially, ethnically, and linguistically diverse groups currently being served</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Review the 2003-04 cultural competence population, utilization, organizational, and provider data and update data • Review data per MHSA plan requirements • Analyze current levels of disparities to county population • Set strategies and objectives to eliminate identified disparities in county, regional, or service areas 	<ul style="list-style-type: none"> • DMH Information Notice No.: 02-03, Medi-Cal Specialty Mental Health Services– Cultural Competence Plan Requirements • Georgetown Cultural Competency Organizational Assessment tools • Carol Siegel Organizational Assessment
<p>7. Counties/organizations have developed a strategic plan for Cultural Competency, pursuant to DMH Information Notice No.: 02-03, Medi-Cal Specialty Mental Health Services– Cultural Competence Plan Requirements</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Utilize self-assessment tools and the Cultural Competency Plans as a starting point to begin a strategic planning process for the MHSA • Ensure stakeholder process includes multicultural community groups and client/ family members 	<p>Each county’s Cultural Competence Plan, pursuant to DMH Information Notice No.: 02-03, Medi-Cal Specialty Mental Health Services–Cultural Competence Plan Requirements</p>
<p>8. Counties/organizations have a process to assess language, access, capacities, and needs in the county</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Monitor county language access needs, and set objectives to meet need • Develop strategies to hire bilingual staff and trained interpreters 	<p>National Standards for Cultural and Linguistically Appropriate Service (CLAS) in Health Care, U.S. HHS, OMS, Final Report, 2001</p>

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>9. County mental health programs have an accountability system that monitors and assesses the following on an ongoing basis, and it is inclusive of the components of the MHSA: 1) increasing its culturally competent programs and 2) elimination of disparities</p>	<p>It is recommended that the:</p> <ul style="list-style-type: none"> • Data collected to assess programs' outcomes is by race and ethnicity • Data be reviewed annually and that it reflects the Cultural Competence Plan objectives and outcomes • Review evidence of embedding cultural and linguistic competency factors in new and existing programs 	<ul style="list-style-type: none"> • Cultural Competence Standards in Managed Mental Health Care Services, U.S. HHS, 2000 • "Cultural Competency Methodological and Data Strategies to Assess the Quality of Service in Mental Health Systems of Care," Carol Siegel, G. Haugland, E. Davis, Center for the Study of Issues in Public Mental Health
<p>10. Counties/organizations ensure that Cultural Competence and strategies to eliminate and prevent disparities in the planning and implementation of the MHSA are embedded in all MHSA efforts</p>	<p>It is recommended that the county mental health planning and implementation of the MHSA utilizes leaders in ethnic services to assist in efforts to identify and include the perspective of multicultural client/family member community and ensures that cultural competence factors are embedded in each of the six components of the MHSA as they are being developed</p>	

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>11. County's/ organization's dedicated budget is established for activities to address unserved and underserved racial/ethnic groups</p>	<p>It is recommended that counties/organizations develop budgets that include the following:</p> <ul style="list-style-type: none"> • Outreach activities to multicultural groups • Translation of materials • Purchase of interpreter devices • Hiring of multicultural and bilingual clients and family members • Training and certification of interpreters • Hiring of cultural brokers • Hiring of Culturally Competent consultants 	<ul style="list-style-type: none"> • National Technical Assistance Center (NTAC) for State Mental Health Planning www.nasmhpd.org/ntac • Cultural Competence Standards In Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups • National Standards for Cultural and Linguistically Appropriate Service (CLAS) in Health Care, U.S. HHS, OMS, Final Report, 2001
<p>12. Counties/organizations execute contracts/agreements with agencies that support the counties'/ organizations' commitment to Cultural Competency</p>	<p>It is recommended that in the contracts/agreements the counties/organizations include language requiring agencies/contractors:</p> <ul style="list-style-type: none"> • To report activities that promote and sustain Cultural Competency • To include quality improvement activities and projects 	<ul style="list-style-type: none"> • National Technical Assistance Center (NTAC) for State Mental Health Planning www.nasmhpd.org/ntac • Cultural Competence Standards In Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups • National Standards for Cultural and Linguistically Appropriate Service (CLAS) in Health Care, U.S. HHS, OMS, Final Report, 2001

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Recommendation for Counties/Organizations	Recommended Action	Resources
13. Counties/organizations administratively monitor accessibility for all regions and areas	It is recommended that counties/organizations establish location of services and hours of operation to ensure maximum accessibility	
14. Counties/organizations develop recruitment, hiring, and retention plans that are reflective of the counties'/ organizations' ethnic, racial, and linguistic populations	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Dedicate a staff to be responsible for overseeing the plan • Link the plan to Cultural Competence Plan, pursuant to the Medi-Cal Specialty Mental Health Services–Cultural Competency Plan Requirements and Program Improvement Projects (PIPs), pursuant to federal Medicaid Managed Care regulations • Expand access studies to include other underserved populations as the required Latino access studies • Disseminate plan to all internal and external stakeholders 	<ul style="list-style-type: none"> • “Promoting Cultural Competence in Children’s Mental Health Services.” M. Hernandez, M. Isaacs, J. Romero, p. 81, Ch. 5 • Recruitment, Retention, Training, and Supervision of Mental Health Staff • California Mental Health Planning Council–Human Resources Project • Summit Workshop Report “Multilingual & Multicultural Pipeline,” 2000
15. Counties/organizations have members from ethnically/racially/ linguistically diverse communities participating on advisory boards/committees	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Develop policies and procedures which outline counties’ plans for ongoing recruitment, mentoring of community participants • Support the principle of communities defining their challenges and solutions 	

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>16. The county's Cultural Competence Committee (CCC) meets regularly and is representative of the county's multicultural/race/ethnicity/linguistic populations</p>	<p>It is recommended that CCC:</p> <ul style="list-style-type: none"> • Establish written procedures which ensure a process for membership that reflects the multicultural/race/ethnicity/linguistic populations of the county • Provides for interpreters, interpreter aids, translated materials to allow for full participation of multicultural members, especially those members who are limited English-proficient • Conducts pre-meetings with clients and family members to provide an opportunity for questions and answers and an education process • Conducts meetings with community leaders within multicultural groups 	
<p>17. The county's CCC is a part of, or has a communication/reporting link to the county's Quality Improvement Committee</p>	<p>It is recommended that the:</p> <ul style="list-style-type: none"> • CCC's policies and procedures outline the communication process to and from the Quality Improvement Committee • Quality Improvement Committee has members of the CCC as part of their membership 	

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>18. Activities and recommendations of the CCC are distributed system-wide</p>	<p>It is recommended that managers and supervisors:</p> <ul style="list-style-type: none"> • Communicate information from the CCC to direct services staff and establish communication link back to the CCC with staff input • Train staff on policies, procedures, and new recommendations 	<p>“Towards a Culturally Competent Systems of Care,” Georgetown, Vols. I and II</p>
<p>19. The CCC is responsible for reviewing policies and making recommendations related to Cultural Competence</p>	<p>It is recommended that:</p> <ul style="list-style-type: none"> • Policies and procedures related to the CCC be developed and clearly delineate the CCC’s purpose and responsibilities • County administration reports back to the CCC the status of its recommendations 	
<p>20. The Quality Improvement Committee meets regularly and is representative of the county’s multicultural/linguistic populations</p>	<p>It is recommended that the Quality Improvement Committee:</p> <ul style="list-style-type: none"> • Establishes written procedures that ensure a process for membership that reflects the multicultural/linguistic populations in the county • Provides for interpreters, interpreter aids, translated materials to allow for full participation of multicultural and limited English-proficient members • Conducts pre-meetings with clients and family members to provide an opportunity for questions and answers and an education process 	

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Recommendation for Counties/Organizations	Recommended Action	Resources
21. Outcome measures and quality indicators are based on culturally competent criteria	It is recommended that the county develop an accountability system to assess progress in eliminating disparities	

Considerations for Culturally Competent Client, Family Member, and Community Engagement

California's mental health system will be well on its way to transformation when it successfully engages clients, family members, and extended families of the ethnically, racially, and linguistically diverse groups that comprise 53% of California's population. Engaging these groups is vital to developing a responsive mental health system that will meet their needs and lessen their marginal status. The planning process for engaging ethnically, racially, and linguistically diverse communities will call upon counties to have informed discussions with those cultural brokers, consultants, and community stakeholders who have expertise in working with multicultural populations. Also, county leadership will be called upon to develop different avenues and methods to reach these historically underserved and unserved populations. The successful engagement might result in new and different community partners with whom county mental health systems collaborate.

California's mental health system has a responsibility to respond to community needs regarding access to services, delivery systems, and culturally and linguistically proficient services. Culturally competent systems include the community as well as families and extended families in determining how these responsibilities will be met. It includes the community in setting system goals and outcomes. It is a system that recognizes the different help-seeking behaviors, communication styles, parenting styles, culturally based treatments and cultural healers of its populations. A culturally competent system adapts its operating procedures to meet community needs as opposed to expecting that the various ethnically, racially, and linguistically diverse communities adapt to the system.

Soliciting the participation of ethnically, racially, and linguistically diverse groups is challenging (especially in rural areas) but achievable. It is achievable by adopting various existing models such as the "*Promotora*" program models. The *Promotora* program is a program that uses culturally and linguistically proficient health educators/advocates who go into communities to deliver services using the community's structures rather than an agency structure. The *Promotora* programs have long been used in Latino communities in the physical health care system with much success.

Another model is the increasing use of telehealth, which provides an opportunity to engage rural communities in a much expanded dialogue in addition to providing services for populations who lack access to care.

It is imperative that the planners of the service delivery system understand the complexities of the mental health needs of the various ethnically, racially, and linguistically diverse groups as well as acknowledge the value of their strengths and expertise through their participation.

Client/Family Member/Community Engagement

Recommendation for Counties/Organizations	Recommended Action
<p>1. Counties/organizations adopt an organizational commitment to eliminate disparities to racial and ethnically underserved and unserved populations and assign leadership for operationalizing the commitment</p>	<p>It is recommended that the leadership:</p> <ul style="list-style-type: none"> • Be knowledgeable and familiar with concepts of Cultural Competency • Have working knowledge of mental health system’s values, philosophy, and guiding principles • Have experience working with multicultural communities • Be familiar with disparities in access to and the effectiveness of mental health services among multicultural communities • Work with client and families of multicultural communities
<p>2. Counties/organizations identify a team of multicultural and bilingual staff, clients, and family members who are hired to assist in addressing elimination of disparities to underserved and unserved racial/ethnic clients and family members</p>	<p>It is recommended that members of the team:</p> <p>Be knowledgeable of the barriers specific to targeted racial ethnic groups for whom county is trying to increase access and appropriateness of care</p> <ul style="list-style-type: none"> • Have knowledge of how to engage the gatekeepers of multicultural groups/communities • Encourage the leadership of clients and family members of these diverse groups. Leadership among racial/ethnic clients and family members is needed to give voices to these relatively unheard stakeholders • Include those who are bilingual to help address monolingual and bilingual clients who experience barriers to access to care • Help to create and imbed cultural and linguistically appropriate services in collaboration with other county client-run programs, such as peer support programs, etc.

<p>Recommendation for Counties/Organizations</p>	<p>Recommended Action</p>
<p>3. Counties/organizations develop an outreach plan that maximizes input and involvement of multicultural communities in the planning process</p>	<p>The outreach plan must include all regions of the county—rural and urban</p> <p>Outreach activities should occur where the population lives and or gathers. For example outreach efforts should:</p> <ul style="list-style-type: none"> • Take place in juvenile halls. Two thirds of incarcerated youth are persons of color. A focus group could be held in juvenile hall to get input from youth. • Occur when people are available: Community meetings could be held on Sundays, after church, or temples, or places of worship. • Include the expertise and involvement of clients and family members from the groups that are targeted by county to increase/improve access to care. <p>In addition, outreach efforts should also:</p> <ul style="list-style-type: none"> • Include ethnic-specific activities. Examples of ethnically appropriate activities include Discussion and Dinner (Platicas y Comida) at neighborhood community centers, Healthy Start Centers, ethnic fairs, etc. • Include stipends for clients and family members providing expertise and input • Provide transportation and child care • Emphasize and encourage immediate and or extended family members to attend outreach activities • Include interpreter services with staff that are trained in the skills and ethics of interpreting • Use of culturally competent telehealth programs to reach rural communities and use of telehealth consultants to assist in the planning

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Recommendation for Counties/Organizations	Recommended Action
4. Client-run programs must be culturally and linguistically competent	DMH recognizes that the client and family member movements have made progress to be more inclusive of multicultural and bilingual clients and family members. It is important to include the voice of multicultural client and family members, including monolingual and bilingual clients and family members in the expansion of client-run programs. MHSA client-run expansion programs should include the voices of new refugees and immigrant communities.
5. Counties/organizations develop language access plans to include interpreter services in stakeholder planning process	<ul style="list-style-type: none"> • It is critical that the voices of monolingual or limited English-speaking clients and family members be included in the early and ongoing planning process. Consider working with county leadership staff, client and family members for ideas on creative strategies for inclusion of limited English-speaking clients and family members in the planning. • Consider hiring interpreters for clients at planning meetings. “Nothing about us without us” should also include the many voices of limited English-speaking clients and their families.
6. Counties/organizations identify ethnic-based community groups outside of the mental health system to involve in stakeholder process	<ul style="list-style-type: none"> • Examples include faith based organizations, churches, temples • Ethnic-specific civic groups, e.g., ethnic-specific Chambers of Commerce • Ethnic-specific social clubs
7. Counties/organizations collaborate with primary health provider partners including rural health clinics, urban health clinics, private health care providers, etc.	Establish and formalize collaborative relationships with health care providers – approximately 50% of ethnic groups access mental health services through primary care

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Recommendation for Counties/Organizations	Recommended Action
8. Counties/organizations collaborate with current client groups in county to include a more multicultural client voice	Work with client and family member groups to address expansion of services/inclusion to underserved racial ethnic groups. Help resolve barriers to their participation including, but not limited to language, and other program and participation barriers.
9. Counties/organizations collaborate with non-mental health community groups/agencies which serve multicultural groups	<ul style="list-style-type: none"> • Identify non-mental health community groups/agencies e.g., schools, YMCA, YWCA, and conduct focus groups with staff • Involve appropriate staff as cultural brokers in communicating with the multicultural groups they serve
10. Value and respect the role of natural healers in multicultural client communities	<ul style="list-style-type: none"> • Acknowledge the client choice of a culturally based healer (“alternative” describes the opinion of the mental health system) • Actively seek cultural healers in the design of services
11. Counties/organizations apply Cultural Competence values, philosophy, and guiding principles to high-risk youth populations—homeless, foster care and incarcerated	Develop training module for staff working with high-risk youth on Cultural Competency, the impact of culture, family and extended family systems
12. Counties/organizations develop outreach/access plan for ethnic and racial groups living in rural geographic areas	<ul style="list-style-type: none"> • Use of telecommunications to facilitate participation in system program design, goal setting • Encourage the use of <i>Promotora</i>-type models • Train outreach staff in use of telecommunications

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Recommendation for Counties/Organizations	Recommended Action
13. Counties/organizations reduce disparity in multicultural client participation by developing client leadership training with added emphases on racial ethnic clients and family members	Racial ethnic and monolingual and bilingual clients and family member voices need to be supported to include their input and serve as new leaders in client focus involvement. Consider replicating the San Francisco “Asian Client Leadership Team” training programs to expand involvement of diverse clients and family members.

Considerations for Culturally Competent System Transformation

The MHSA addresses the need that exists to evaluate, develop, and implement a mental health system for all the communities of California. Leaders of California's mental health system are acutely aware of the critical needs that exist in ethnically, racially, and linguistically diverse communities. A myriad of documents give evidence to these needs and reinforce the call for action. Studies that clearly define data regarding mental health treatment in these communities are much less available. The perspective of these communities is often not represented in treatment studies, position papers regarding changes in practice, and quality improvement standards. A special analysis performed for the Surgeon General's Office, entitled, "Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General" reveals that controlled clinical trials used to generate professional treatment guidelines do not conduct specific analysis for any racial/ethnic groups. This exclusion hampers the efforts to develop values-based and evidence-based treatments, and therefore guidelines and treatment protocols for practitioners working with these populations. Culturally and linguistically proficient mental health providers (both individual and agency level) struggle to provide appropriate treatment within frameworks that may not "fit" the majority of the population to be served. The concept of "family" as perceived by the system is an example that illustrates this point. Currently, services are organized in youth, adult, and older adult segments throughout the system, frequently having different providers and provider locations by age group. Ethnic/racial/linguistic populations operate as an integrated system. More often than not, these populations live in multi-generation households. In a transformed system, services would be delivered to families within a community setting, not individuals by age group.

There is an increased focus on providing culturally responsive mental health services to vulnerable populations in which ethnic and racial groups are over-represented—homeless, foster care, incarcerated youth, refugees, etc. Counties can use these models and the data generated from them and add the participation of multicultural stakeholders to develop their service delivery systems.

Considerations for Culturally Competent System Transformation

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>1. Counties/organizations conduct training on the use of DSM IV R-cultural formulation in assessment of racial ethnic populations</p>	<ul style="list-style-type: none"> • Develop process for continuous training of staff to maintain standards as work force changes occur • Monitor staff use in individualized treatment planning documents 	<ul style="list-style-type: none"> • DSM IV R • Culture of Emotions Video: A Cultural Competence and Diversity Training Program (Harriet Koskoff, 2002)
<p>2. Counties/organizations conduct Cultural Competence training needs assessed for county and contract providers</p>	<ul style="list-style-type: none"> • Use well-established tools to assess training needs for Cultural Competency for providers • Practitioners and other service providers need tools that are appropriate for or can be modified to address needs of increasingly diverse populations 	<ul style="list-style-type: none"> • CA Brief Multicultural Competence Scale and Training Program • California Mental Health Planning Council's Mental Health Master Plan • Cultural Competence Training Plans
<p>3. Counties/organizations collaborate and consult with other programs/agencies engaged in ethnic/racial-specific services</p>	<ul style="list-style-type: none"> • Modify and adapt existing evidence-based practices to meet needs • Collect best and promising practices, demographic, and outcome data on all programs 	<p>"Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General," 2001</p>

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>4. Counties/organizations provide training in understanding the dynamics of race, culture, and ethnicity in mental health treatment for practitioners</p>	<ul style="list-style-type: none"> • Maximize use of county staff who have expertise in areas as trainers • Actively seek partnerships with educational institutions who may provide classes/expertise • Use available training resources • Provide training in the use of cultural brokers 	<ul style="list-style-type: none"> • “Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General,” 2001 • Cultural Competence Standards in Managed Mental Health Care Services, U.S. HHS, 2000 • National Standards for Cultural and Linguistically Appropriate Services in Health Care, US HHS, OMS, 2001 • California Mental Health Planning Council’s Mental Health Master Plan

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Recommendation for Counties/Organizations	Recommended Action	Resources
<p>5. Counties/organizations develop programs to address the needs of youth in the juvenile justice system by gender, and race/ethnicity. Counties/organizations acknowledge and address disproportionate confinement to these groups and address mental health treatment needs</p>	<ul style="list-style-type: none"> • Specialized family group input for this population • Establish/strengthen school linkages with program for transition planning • Establish mentoring programs in partnership with ethnic-specific community groups • Develop specific strategies for ethnic/cultural youth in the juvenile justice system program 	<p>Recommendations for Juvenile Justice Reform, American Academy of Child and Adolescent Psychiatry Task Force on Juvenile Justice Reform, October, 1999-2001</p>
<p>6. Counties/organizations develop and support evidence-based practices that are congruent with ethnic/racial/linguistic group belief systems, cultural values, help-seeking behaviors</p>	<ul style="list-style-type: none"> • Collect sufficient data to begin establishing evidence-based treatments • Links to Quality Improvement Committee 	<p>Review research documentation and other evidence of treatment interventions beneficial for racial ethnic groups</p>
<p>7. Counties/organizations allow for the inclusion of natural healers in the community</p>	<ul style="list-style-type: none"> • System can consult with natural healers to add to knowledge base • Included on treatment team at request of client/family members 	

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Recommendation for Counties/Organizations	Recommended Action	Resources
8. Counties/organizations train providers on cultural values and world views and beliefs as they relate to the role of an older adult, their place in the family and care-giving expectations	County and contract providers adopt/develop practice standards for older adult populations within ethnic/racial/linguistic groups	Older Adult System of Care Framework, California Mental Health Directors Association, 2001
9. Counties/organizations train providers on cultural values, beliefs, parenting styles, regarding children	County and contract providers adopt/develop practice standards for children and youth, including transition age within ethnic, racial, and linguistic groups	
10. Counties/organizations provide training in ethno-psycho-pharmacological concepts and management for medical staff	<ul style="list-style-type: none"> • Hire specialists/consultants to conduct training • Collaborate with other counties to establish peer-to-peer physician training to provide for exposure to treatment with different ethnic, racial, linguistic groups 	
11. Counties/organizations explore the use of telehealth to create access to services in rural/small counties	Identify regions within counties impacted by underserved/unserved	

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Recommendation for Counties/Organizations	Recommended Action	Resources
12. Counties/organizations develop transformative mental health service interventions. Expand the growth of new treatment/service interventions for unserved or underserved racial/ethnic groups and document evidence of successful specific alternative treatment interventions	Work with racial ethnic clients and family members and other multicultural experts to develop and or try new mental health services interventions for unserved and underserved groups, for children, youth, adults and older adults. Include Quality Improvement Committee or research assistance to document new intervention and outcomes	

Technical Assistance Document 6

Program and Expenditure Plan Examples

The following examples are general and greatly simplified. In developing plans, counties must provide all of the required responses under each section. These examples are intended to illustrate what DMH is looking for in each of the plan requirements sections. As illustrated by the example, counties may request any of the three types of funding for programs/strategies listed under the System Development section.

In reviewing these examples, keep in mind that it is expected that counties will be asking for funding to expand and transform their existing programs as well as implementing new programs. Although these examples only address the new funding requests, counties will be building upon existing resources and will be describing these in their plans and expenditure requests. In addition to existing mental health funding, many counties have also developed blended funding arrangements and shared costs for interagency programs. It is expected that these will continue and be expanded as well.

MHSA Program and Expenditure Plan Example

Children, Youth and Families - County A

Section I: Community Issue

Many of our youth who have serious mental health issues are ending up in juvenile hall. Although some of these youth have been diagnosed with serious emotional disorders, they and their families are not getting the services they need to be successful at home, in school and in the community.

Section II: Unmet Mental Health Needs

Among the unmet needs identified by County A, 60% of youth in juvenile hall are estimated to have serious emotional disorders. In any given year, only about 20% of youth in juvenile hall have received any mental health services, and of those 20%, an estimated 40% are underserved. For example, they may have been screened for mental health problems but had only two follow-up visits and no family contacts or interventions. Estimated ethnicity percentages of these youth and their families are as follows: -----

Section III: Full Service Partnerships

The initial full service population selected for children, youth and families by County A is youth diagnosed with serious emotional disorders who end up in juvenile hall, and their families. County A will prioritize those youth who are entering the hall for the first time. County A expects to enter into Full Service Partnerships with ----- of these families in year one and an additional ----- in years two and three. Of these families, it is estimated that ---% have been unserved (meaning that they did not get any service other than the mandated health screening) and --% have been underserved (meaning that they had some mental health services but not a comprehensive service plan to address their needs and support their strengths). When all of the youth/families with first-time incarcerations have been fully served, County A will start providing Full Service Partnerships with youth with repeated juvenile hall incarcerations. Estimated ethnicity percentages of participating youth and their families will be as follows: -----

Section IV: Strategies

Every participating youth/family will have a mental health case manager with a caseload of no more than 10 families. In addition to existing services, County A will offer these youth and their families the following new or expanded services*:

- Wraparound

* Not every youth/family will get every service, but these services will be available as needed.

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- Multisystemic Family Therapy
- Mentoring
- Family run parent/caregiver self-help groups
- Integrated juvenile hall/probation/mental health/family service planning and monitoring

County A will use Full Service Partnership funding to fund case managers and the services listed above. System Development funds will be requested to train and contract with mentors, to establish a parent/caregiver education program training staff with capacity in three languages and to start up a Wraparound program which will be funded by a combination of interagency funding including CDSS placement funds. County A will use Outreach and Engagement funds to provide outreach workers in ---- middle schools throughout the county, and to provide staff with expertise in culture-specific barriers to work in juvenile justice settings.

MHSA Program and Expenditure Plan Example

Transition Age Youth – County A

Section I: Community Issue

Youth who have been diagnosed with serious emotional disorders who “age-out” of the child serving systems (primarily child welfare and the juvenile justice system) are in double jeopardy. In addition to having been housed within a variety of group living situations that limit development of independent living skills, disrupted educational opportunities and their own emotional issues, they lose their “peer group,” housing and their existing agency and community supports.

Section II: Unmet Mental Health Needs

Among the unmet needs identified by sample county, --% of transition age youth diagnosed with serious emotional disorders are either at the age or approaching the age where they will no longer be eligible for services from the child welfare system and/or will age-out of the juvenile justice system. It is estimated that --% of these youth have not received mental health services. Additionally, while --% of these youth may have received mental health services in the child and youth system, they may no longer be eligible for those services (for example, they may lose their Medi-Cal eligibility) and the services currently offered by the adult mental health system will not necessarily remain appropriate for them. The estimated ethnic breakdown of youth diagnosed with serious emotional disorders aging out of the welfare and juvenile justice systems each year is as follows: -----

Section III: Full Service Partnerships

The population selected for transition age youth are those youth diagnosed with serious emotional disorders and their families or designated caregivers, as appropriate, who are within one year of aging out of the child welfare or juvenile justice system. County A expects to reach out to this population and enter into Full Service Partnerships with ----- of these youth in year one and an additional ----- in years two and three. Of these youth, it is estimated that ---% have been “unserved” and --% have been “underserved,” “inappropriately served” or they are “at risk” of losing their current services or stable community living situation due to their age. Estimated percentages of participating youth by ethnicity will be as follows:

Section IV: Strategies

Every transition age youth and their family or designated caregiver, as appropriate, who choose to participate will have a transition age case manager with a caseload of no more than 10 youth/families who will remain with them until they are successfully transitioned into age and- developmentally-appropriate independence. This will include intensive services as needed and the necessary connections to the appropriate mental

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health or behavioral health care provider. Participating youth may also elect to not enroll or participate in the adult mental health system or the mental health system altogether. The case managers will be trained in the developmental, housing, education, employment, self-sufficiency aides (e.g., driver's licenses, taxes, checking, etc.) and clinical needs of these youth and will be able to respond to their needs 24/7. In addition to existing services, County A will offer participating youth and their families or designated caregivers the following new or expanded services:

- Integrated assessment and asset development teams that provide comprehensive mental health, social, physical health and substance abuse assessments which are strength-based and focused on engagement of the transition age youth and which can provide cultural specific assessments
- The integrated service and support planning which identifies needs in the areas of mental health service, education, job training, employment, housing, socialization and independent living skills will be tailored by the youth. It will include the options of youth-run services including peer support and self-help groups and family-to-family support and consultation focused on helping families or designated care givers support their youth through this transition-age period.

County A will use Full Service Partnership Funds to support the case managers and integrated assessment and asset development teams. Both Full Service Partnership and System Development funds will be requested for funding to develop and staff youth- and family-run services and to work with other agencies to develop housing options for youth leaving foster care, juvenile justice and group homes. System Development Funds will also be requested to work with the community college to develop and implement an associate degree program for peer counselors and case managers. Outreach and Engagement Funds will be used to hire and train transition age peers to work in school student health centers and reach out to youth who may have serious emotional disorders.

MHSA Program and Expenditure Plan Example

Adults – County A

Section I: Community Issue

Many adults in our community are without a place to live due to the fact that they have a serious mental illness for which they have not received adequate treatment, services and supports. In addition, other adults diagnosed with serious mental illness are at imminent risk of losing their housing and ending up on the streets because of similar concerns.

Section II: Unmet Mental Health Needs

Among the unmet needs identified by sample county, --% of adults with serious mental illness are without a place to live. It is further estimated that at any one time, --% of adults with serious mental illness are at risk of losing their housing. In any given year, only about --% of these adults have received any mental health services, and of those, an estimated --% are underserved, for example, they may have received only an assessment or may be receiving medications only. The estimated ethnic breakdown of the population of adults with SMI who are homeless is as follows:

Section III: Full Service Partnerships

The initial population selected for adults are those adults and their families, as appropriate, who are currently homeless or at risk of losing their housing. County A will prioritize those adults who are currently without a place to live. County A expects to reach out to this population and make a full service and support commitment to ----- of these adults in year one and an additional ----- in years two and three. Of these adults, it is estimated that ---% have been unserved and --% have been underserved. Estimated percentages of participating adults by ethnicity will be as follows:

Section IV: Strategies

Every adult who chooses to participate in a Full Service Partnership will be part of an integrated service agency and have a mental health personal service coordinator with a caseload of no more than 10 adults and will be able to respond to their needs 24/7. In addition to existing services, County A will offer participating adults and their families the following new or expanded service:

- Integrated assessment teams
- Self-directed care planning, such as Wellness Recovery Action Planning
- Supportive housing
- Integrated SA/MH

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- Integrated outreach and/or advocacy services with criminal justice system as appropriate
- Peer supportive services and client and family run services
- Supportive education and employment services

County A will use Full Service Partnership funds to support the Personal Service Coordinators and the costs of the services described above. County A will use System Development funds to establish a housing program to support the ongoing housing needs of all individuals served in the system, including using MHSA funds to leverage other funds to increase low-income housing for persons with serious mental illness, and for funding to work with the community college to develop and implement an associate degree program for peer counselors and case managers.

County A will use Outreach and Engagement Funds to train and fund peer-to-peer staff to reach out to adults with serious mental illness who are homeless and to hire and train culturally competent community health workers to reach out to the ethnic communities in which specific disparities have been identified.

MHSA Program and Expenditure Plan Example

Older Adults - County A

Section I: Community Issue

Older adults diagnosed with serious mental illnesses end up in hospitals and emergency rooms because they have not had comprehensive assessments and service planning in order to determine what supports they need to live independently in the community.

Section II: Unmet Mental Health Needs

Among the unmet needs identified by County A, 80% of older adults diagnosed with mental illnesses who end up in hospitals or emergency rooms have not had comprehensive assessments and integrated service plans. 70% of the 80% are underserved in that they have had some assessment but the assessment lacked social factors, thorough understanding of medical conditions and an assessment of their living situation. Estimated ethnicity percentages of these older adults and their families are as follows: -----

Section III: Full Service Partnerships

The initial populations selected for Full Service Partnership funding are older adults who are inappropriately served in emergency rooms or hospitals due to a lack of comprehensive assessments and supportive community living plans. County A will prioritize those older adults who are entering hospitals and emergency rooms. County A expects to enter into Full Service Partnerships with ----- of these older adults and their families in year one and an additional ----- in years two and three. Of these older adults, it is estimated that ---% have been unserved and --% have been underserved. Estimated ethnicity percentages of participating older adults and their families will be as follows: -----

Section IV: Strategies

In addition to existing services, County A will offer Full Service Partnership older adults and their families the following services:

- A comprehensive assessment with an integrated service team which will include mental health, social, physical, health and substance abuse assessments which are strength-based and focused on the client/member's engagement and which is specific to their culture
- A mental health case manager with a caseload of no more than 10 older adults and their families
- A comprehensive plan of community services and supports

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County A will use Full Service Partnership funds to support the case management costs and the services described above. County A will use System Development Funds to hire and train older adults to provide peer supportive services and client-run services including peer counseling programs for all clients as appropriate. County A will use Outreach and Engagement funds to provide outreach to older adults in their homes, through community service providers and through other community sites that are the natural gathering places for older adults.