San Luis Obispo County Mental Health Services Act

Implementation Progress Report for Community Services and Supports for 2007

Posted for Public Notice May 27, 2008

BACKGROUND

This report represents the implementation of the MHSA Community Services and Support Plan for San Luis Obispo County from January 1, 2007 through December 31, 2007. The report follows the outline provided by the Department of Mental Health Information Notice No. 08-08 dated March 18, 2008.

The Mental Health Services Act (MHSA) was enacted into law January 1, 2005. This followed the passage of Proposition 63 in November 2004, which proposed a 1% tax on adjusted annual income over $1,000,000. This new stream of funding is dedicated to transforming the public mental health system and seeks to reduce the long-term adverse impact from untreated serious mental illness.

The 2005 through 2008 Community Services and Supports (CSS) Plan is a result of extensive and intensive stakeholder involvement. It represents new and expanded programming intended to improve the quality of life of persons most in need of care and facilitates the following outcomes:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities
- Safe and adequate housing and reduction in homelessness
- A network of supportive relationships
- Timely access to needed help, including times of crisis
- Reduction in incarceration
- Reduction in involuntary services, institutionalization and out-of-home placements

The Community Services and Supports plan also incorporates the fundamental concepts needed to ensure system transformation:

- Community collaboration
- Cultural competence
- Client and family driven systems and services
- Wellness focus, including recovery and resiliency programming that assists individuals in leading a fulfilling and productive life with optimism and hope
- Integrated services that are coordinated between agencies

MHSA funds are available for three types of system programming:

1) *Full Service Partnership Funds* provide for “whatever it takes” intensive services to a small focal population of persons with severe mental illness. (MHSA requires that at least 51% of the funds be used for FSP programming.)

2) *General System Development Funds* improve programs, services and supports for individuals in full service partnerships as well as the entire population of persons with severe and persistent mental illness.
3) *Outreach and Engagement Funds* provide for special activities needed to reach un-served populations.

MHSA funds are used to implement the following ten initiatives that make up the full CSS plan. The initiatives were selected based on the integration of MHSA required outcomes and approved strategies, funding criteria and our community's input and priorities. They include the following:

- Four *Full Service Partnership* programs provide a broad range of mental health services and intensive supports to targeted populations of children, transition age youth, adults and older adults.
- *Client and Family Wellness Supports* provide an array of recovery-centered services to help individuals improve their quality of life, feel better and be more satisfied with their lives. Support will include: vocational training and job placement; community and supportive housing; increase day to day assistance for individuals and families in accessing care and managing their lives; expand client and family-led education and support programs; outreach to un-served seniors; and expand services for persons with co-occurring substance abuse.
- *Enhanced Crisis Response and Aftercare* increases the number of mobile responders and add follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility.
- *Latino Outreach & Services* program provides outreach to un-served and underserved limited-English speakers and provides community-based, culturally-appropriate treatment and support.
- *Mentally Ill Probationers Services* program is doubled in capacity.
- Intense, daily school-based mental health services for students with serious emotional disturbances is provided at a North County community school.
- A county-wide outreach and education campaign will promote awareness of mental illness and stigma reduction and education about services available and how to access care.

San Luis Obispo County's Behavioral Health Services Department (BHS) Community Services and Support (CSS) Plan was approved by the Board of Supervisors on December 20, 2005. The CSS plan was submitted to the State Department of Mental Health on December 22, 2005. On April 28, 2006 BHS received formal notification that the CSS plan was approved for program start-up beginning April 1, 2006. A revision to the CSS plan was completed and the final plan was submitted to DMH on May 8, 2006.

Since the approval of the initial CSS plan, additional funding has been made available as announced in DMH Letter 06-09 dated November 29, 2006 (Growth

Funds) in the amount of $934,100. The DMH Information Notice 07-21 dated October 18, 2007 announced that San Luis Obispo would receive an additional One-Time Augmentation to the CCS Plan in the amount of $935,200. These funds were used to enhance current programming and resulted in two plan amendments. The currently operating CSS plan was approved by the State on April 7, 2008.

A. PROGRAM/SERVICES IMPLEMENTATION

1) The County is to briefly report by Work Plan on how the approved programs/services is proceeding.

a. Report on whether the implementation activities are generally proceeding as described in the County's approved plan and subsequently adopted in the MHSA Performance Contract/MHSA agreement. If not, please identify the key differences.

b. Describe for each FSP Work Plan what percent of anticipated clients have been enrolled.

c. Describe for each System Development Work Plan what percent of anticipated clients have received the indicated program/service.

d. Describe the major implementation challenges that the County has encountered.

San Luis Obispo County has submitted their current Exhibit 6, Three Year Plan – Quarterly Progress Goals and Report. The following is a brief description of the implementation progress of each of these plans.

Full Service Partnership Programs (FSP)

a. The CSS Plan developed a FSP program for children, transitional age youth, adult and older adult. Implementation has proceeded as described in the plan for the children, transitional age youth and adult teams. The Older Adult FSP Team is the last team to be implemented and will be begin in 2008. The Full Service Partnership Teams were designed as a dyad with County Mental Health staff as the therapist and a Community Based Organization staff as the resource specialist. The hiring priority was for the FSP Program Supervisor first and then the Child and TAY FSP Teams. The Child and TAY FSP Teams were hired and fully implemented in 2007. The first of two Adult Teams began in February, 2007. Due to the 2007 expansions (through Growth Funds and one-time funding allotment) in the number of full service partnership teams and the complexity of the cases, more supervision and guidance of the staff was needed. In 2007, utilizing unspent funds, an interim full time Program Supervisor was added to the Adult FSP and Older Adult FSP Teams for the purpose of overall system support.

   While the majority of the services provided are delivered in the community, larger office space was obtained to co-locate staff. This enabled the teams to increase collaboration for treatment services. This increased communication between the county and the community based providers resulted in better

access to services and comprehensive treatment planning. These teams have focused on providing the "whatever it takes" model for service delivery in order to move clients towards wellness and recovery.

b. The following describes the percent of anticipated clients that have been enrolled in the full service partnerships.

FSP Program	Served	Target	Percent Served
Children	14	20	70%
Youth	20	20	100%
Adult	14	20	39%

c. Not applicable

d. The major implementation challenge for this county has been that the hiring process has taken longer than expected and there has been difficulty in recruiting bilingual and bicultural staff. One key position that has been difficult to recruit for is the psychiatrist. Competitive employment from nearby Atascadero State Hospital and a local prison, both offering higher wages than County jobs, has created difficulty in hiring staff for the Adult FSP positions.

An unanticipated delay occurred in hiring for the Older Adult FSP team. This delay was due to the complexity of starting up a new treatment modality and the need to develop infrastructure for the FSP teams. To complicate this delay, the County implemented a hiring freeze in 2007 due to a budget shortfall which caused a substantial delay in hiring.

General System Development

General System Development consists of the following programs:

- Client and Family Wellness and Recovery
- Enhanced Crisis Response and Aftercare
- Latino Outreach and Treatment Services
- Mentally Ill Probation Program
- School-based Services.

Each of these programs has a number of components with an update on the progress for each component.

1. **Client and Family Wellness and Recovery (Workplan #05**) consists of the following components:

i. Vocational training and supportive employment services were provided by a local community-based organization. Vocational services had exceeded the number of anticipated clients by 200%. Additionally, a new opportunity arose in 2007. A cooperative agreement was developed with the Department of Rehabilitation. MHSA funds were leveraged with the Department of Rehabilitation in order to provide more intensive and expanded services to the clients we both serve. This cooperative agreement became effective in January, 2007 and 25 clients received services that year.

ii. Expanded housing for TAY and Adults was implemented with 20 beds for FSP participants. A total of 420 bed days were provided for three adult clients and a total of 761 bed days for four TAY clients.

iii. Co-occurring substance abuse care provided mental health services in collaboration with Drug and Alcohol Services. A staff was hired but because the FSP program was not implemented as yet, this staff had not begun delivering services. This staff person resigned and another Drug and Alcohol Specialist was hired in May, 2007. In the interim the program was re-evaluated to include staff training and community awareness of an integrated model of service delivery. The specialist has been providing consultation services to the FSP team, developing treatment groups and a caseload based on FSP and community referrals.

iv. Expanded *Peer-to-Peer* client-led mentoring and support program provided through NAMI. With the Growth Funds, this program was expanded to provide 4 classes for a total of 80 participants. By the end of December 2007, 72% of anticipated clients received services.

v. Expanded *Family- to- Family* mentoring and support program provided through NAMI. With the Growth Funds, this program was expanded to provide four classes for a total of 80 participants. By the end of December 2007, 78% of anticipated families attended this program.

vi. Client & Family Partners provide system navigation to assist in linking to resources and to provide support. Staffing was increased through Growth Funds for a total of three positions employed through a community-based organization, which resulted in 175% over the anticipated participation of clients by the end of December 2007.

vii. Added one new SAFE case manager in SLO. However, there were changes in the overall SAFE program (which is administered by the school district) that shifted goals away from CSS's target populations. By the end of 2007, the SAFE case manager left the position and MHSA participation has been reassessed with adjustments expected in 2008. Prior to the position vacancy, a total

of 586 contacts with families were provided during the year which far exceeded the anticipated number of families served.

viii. Adult case manager was added which reduced caseloads in the South County outpatient clinic. An additional adult case manger was added to the SLO outpatient clinic through Growth Funds.

ix. Through Growth Funds, a wellness center was developed in the north part of the county. The Peers Empowering Peers (PEP) Center is operated by a community based organization.

x. Outreach and care to un-served seniors has not been implemented because we have not hired the geriatric specialist yet.

xi. *Network of Care* web based information and referral service was implemented.

a. Overall, implementation of the above programs is proceeding as outlined in the CSS plan.

b. Not applicable

c. Indicated above

d. One major challenge with implementation has been with housing and the co-occurring program needing a design change. Since the Adult FSP Teams were delayed in being fully staffed, there has not been the number of adult clients housed as expected. It is anticipated that once all of the Adult FSP teams are operating at full capacity, the need for housing will increase.

2. **Latino Outreach and Treatment Services (Workplan #06)** consists of the following programs:

i. Focused outreach efforts to un-served Latino populations. By the end of December 2007, over 200% of anticipated number of people received outreach and education services. Outreach included presentations at local middle schools, high schools, health fairs, local providers and other community-based stakeholder committees.

ii. Culturally-appropriate mental health services and coordination with Latino community. Two bilingual full-time staff were hired in 2007 to expand services to this community. Demand for services and the wait list for bilingual/bicultural services continued to increase. In 2007-08, unspent funds allowed the one half-time Mental Health Therapist to be increased to a full time position.

iii. Bilingual/bicultural psychiatrist and medication manager. Recruitment is on-going for these positions. It has been difficult to recruit bilingual/bicultural staff for these two positions.

iv. Expanded bilingual community-based therapy. By the end of December, 2007 over 200% of the estimated number of clients were served.
v. Create bilingual support groups, which were accomplished through the outreach efforts as described in section (i) above.
vi. Intensive marketing campaign to the Latino community. This has not been implemented yet as the capacity to treat those that are identified is still being built. This campaign will be combined with the Outreach and Education Campaign outlined in Work Plan 10 in the CSS plan.

a. The outreach effort was led by a contracted bilingual/bicultural clinician and coordinated with existing Latino interest groups. There has been an increase in demand for these services. The services have been primarily focused in the southern and northern part of the county. There is currently a wait list for services. The clients on the wait list are contacted weekly and offered additional resources. The clients have stated that they wish to wait for these services. The major challenge for implementation has been recruitment of bilingual and bicultural staff. Flyers were developed and distributed in the Latino community and position announcements were placed in the Latino newspaper with no results to date. Recruitment will continue until the position is filled.

b. Not applicable

c. Indicated above

d. The major implementation challenge was that the hiring of the bilingual and/or bicultural staff. We are experiencing difficulty in recruiting a bilingual/bicultural psychiatrist and medication manager. Recruitment efforts will continue. It also took longer to recruit the bilingual therapists than expected.

3. **Enhanced Crisis Response and Aftercare (Workplan #07)** consists of the following programs:

i. Expanded staffing for mobile crisis unit so that there are two regionalized responders on call 24/7. Over 100% of the anticipated clients have received services through this program.
ii. Provide next day follow up to individuals that were not hospitalized at the Psychiatric Hospital Facility (PHF) and assist in linking to resources.

iii. Aftercare Specialist to assist individuals and their families when released from the Psychiatric Health Facility to provide support and linkage to the outpatient clinic and other resources. This program was implemented.

iv. Sponsor Crisis Intervention Training (CIT) for law enforcement and other field responders and sponsor the planning coordination to create a multidisciplinary team response. This was completed in 2006.

a. The mobile crisis unit was expanded so that there are two regional responders on call 24/7. This has dramatically impacted the mental health system. During the input process for the CSS plan, there were a high number of complaints regarding the mobile crisis unit. Expanding the service to two responders has provided a more efficient level of service and decreased response time. The mobile crisis unit is able to stay with a family or client for a longer period of time. They also conduct follow up telephone contact with the client or family the next day if the client was not hospitalized. This contact enables additional support and assistance in following through with appointments or referrals.

The Multidisciplinary Team was developed and launched in 2007. It was renamed to Forensic Coordination Team (FCT) mid year. A coordinator was hired through Growth Funds. This half-time Mental Health Therapist was expanded to a permanent full time position in late 2007 due to success of the program and demand for services. This additional staff time increased the ability to meet the demand to assist law enforcement with more cases. Improving crisis response and assistance to adults involved in the criminal justice system is a community priority.

b. Not applicable

c. Indicated above

d. This program has been successfully implemented as outlined in the CSS plan.

4. **Mentally Ill Probationers Program (MIPS**) **(Workplan #08)** was expanded to an additional Mental Health Therapist.

a. The therapist was hired in January, 2007 and a 200% of the anticipated clients were served by the end of December, 2007.

b. Not applicable

c. Indicated above

d. This program has been successfully implemented as outlined in the CSS plan.

5. **School-based Services (Workplan #09)** consisted of the following programs:

   i. Full-time on-campus mental health services for teens at Chalk Mountain Community School. One full-time mental health therapist was hired in November, 2006. The school has been very appreciative of having a therapist in the classroom. Due to the success of this program, it was been expanded to another school in 2007 through Growth Funds. A therapist was been hired at the Mesa View Middle School to provide mental health services. Probation and law enforcement have also been appreciative of these services and has seen a positive impact to the youth served. Over 200% of the number of anticipated youths were served by the end of December 2007.

   ii. Depression screening for all eighth grade students at three middle schools was scheduled for implementation in fiscal year 2007 through 2008. However, in December 2007, the MHSA Community Planning Team recommended that this component be eliminated due to the statewide initiatives administered through Prevention and Early Intervention component of MHSA.

b. Not applicable

c. Indicated above

d. There have been no major challenges with implementation of the therapist in the school. The second component of this work plan may be transferred to P/EI and eliminated from this Workplan.

<u>Outreach and Engagement (Workplan #10)</u>

Outreach and Engagement has three components in the CSS plan. The first is to conduct a promotional campaign to un-served populations and underserved communities in coordination with the Latino Outreach campaign (Workplan #06). Another is to outreach to the community at large to educate about mental illness and reduce stigma (Workplan #10). Since the new and expanded FSP and general system development programs have taken longer than anticipated to be fully operating, we have postponed outreach campaigns. It is anticipated that these campaigns will occur in late 2008 and could be even enhanced with new Prevention and Early Intervention activities.

The third component is *In Our Own Voice* which is a client-led educational presentation on living with and the realities of mental illness. This program was

expanded in 2007 to an ongoing, rather than one-time funded effort. By December 2007, 79% of the total number of anticipated participants attend these client-led presentations.

b. Not applicable

c. Indicated above

d. There have been no major challenges with implementation of *In Our Own Voice.* The two outreach campaign efforts will occur in late 2008.

2) For each of the six general standards in California Code of regulations, Title 9, Section 3320, very briefly describe one example of a successful activity, strategy or program implementation through CSS funding and why you think it is an example of success e.g. what was the result of your activity. Please be specific.

- **Community collaboration between the mental health system and other community agencies, services, ethnic communities**
- **Cultural Competence**
- **Client/family driven mental health system**
- **Wellness/recovery/resiliency focus**
- **Integrated services for clients and families: changes in services that result in services being seamless or coordinated so that all necessary services are easily accessible to clients and families.**

<u>Community Collaboration</u>

Community collaboration occurred through our MHSA stakeholder planning team as outlined in the original CSS Plan. This planning team continued to meet in 2007 regarding the Growth Funds and the One-Time Augmentation Funds and to monitor overall plan progress.

Most of the CSS programs involve community collaboration. Examples of some of these collaborations are as follows:

a. The Full Service Partnership teams are comprised of dyads with one county mental health staff paired with a Community Based provider staff.
b. The SAFE Case Manager was out-stationed at the school district and the overall SAFE program is a multi-agency integrated services program.
c. The Growth Funds allowed one of the Community Based Organizations to develop a wellness center, Peers Empowering Peers (PEP), located in the north part of the county. This is a consumer run drop-in center that is open six days a week. Some of the services

offered at the center are family support, community support and vocational support groups.

d. The Latino Outreach and Treatment Services programs offer services including outreach and engagement in the Latino community.
e. The Forensic Coordination Team is in collaboration with more than ten law enforcement and criminal justice agencies, and over twenty community-based human services provider organizations.
f. The school-based services programs have therapists located in a number of schools.

Cultural Competence

Cultural competency training for all staff occurs on an annual basis. The most recent training occurred on March 19, 2007. While it has been difficult to hire bilingual and bicultural staff, there was an increase in hiring Spanish speaking staff in 2007. The department has a cultural competency committee that meets on a regular basis, with the following representation: Latinos, Lesbian, Gay, Bi-Sexual, Trans-Sexual and Questioning (LGBTQ), women and older adults. Staff also attend the annual Cultural Competency Summit.

Consumer and Family Member Driven Services

This method of service delivery is a key component in transforming the mental health system. Consumer and family members were included in the stakeholder process and continue to participate in the MHSA stakeholder planning team. Consumer and family members are now participating in a number of other mental health committees such as the Performance Improvement Project (PIP) and the Quality Management Committee.

Transitions-Mental Health Association (T-MHA) is a community-based organization that has hired consumers for many of their programs. T-MHA has a nursery and a store in downtown San Luis Obispo that sells plants from the nursery. Consumers are employed at both of these locations. T-MHA also opened the PEP center with MHSA funds which was previously described in this report.

Wellness/recovery/resiliency focus

Wellness, recovery and resiliency are concepts that are discussed in team meetings, staff meetings and supervision. These concepts are promoted throughout treatment objectives and through client participation. A wellness center was developed in the north part of the county. The Peers Empowering Peers (PEP) Center is operated by a community based organization. This is a consumer run drop-in center that is open six days a week. Some of the services offered at the center are family support, community support and vocational support groups.

Integrated services for clients and families

The services currently provided for children and youth already function in a SAFE System of Care (SOC) program. SAFE SOC is a multi-agency, co-located program in the north and south regions of the county. The Full Service Partnerships will build on the success of this program. Another aspect of this service delivery is with the co-occurring disorders population. Clients with issues of mental illness and substance abuse will have a focus of integrated services. The main clinic in San Luis Obispo is piloting the SAMHSA's Integrated Dual Disorders Treatment (IDDT) program.

3) For the Full Service Partnership category only:

a. If the county has not implemented the SB 163 Wraparound (Welfare and Institutions Code, Section 18250) and has agreed to work with the County Department of Social Services and the California Department of Social Services toward the implementation of the SB 163 Wraparound, please describe the progress that has been made, identify any barriers encountered, and outline the next steps anticipated.

San Luis Obispo is a county that has implemented SB 163 Wraparound.

b. Please provide the total number of MHSA funding approved as Full Service Partnership funds that was used for short-term acute inpatient services.

None

4) For the General System Development category only: Briefly, describe how the implementation of the General System Development programs has strengthened or changed the County's overall public mental health service system.

The General System Development category is comprised of the following programs in the County of San Luis Obispo:

1. Client and Family Wellness
2. Latino Outreach
3. Enhanced Crisis Response
4. Mentally Ill Probationers Program (MIPS)
5. School-based Services

Each of the above programs are implemented and operated successfully in 2007. There have been a number of significant changes in the mental health system since implementation. The first major change is in the Latino Outreach and Treatment Services program. This program was developed

due to the stakeholder surveys and other data that indicated that this was an un-served and underserved population. Since initial implementation of program, there has been a wait list for services. MHSA Growth Funds were used to address this wait list by expanding the one half-time therapist into a full-time position.

Another major change is in the Enhanced Crisis Response. Adding an additional responder to the county has been well received. The department has received positive feedback from other community partners and law enforcement on the success of this expansion. The response time has decreased and the crisis staff is able to spend more time with the client in order to resolve the crisis and offer additional support. In addition, the Aftercare Specialist has had an impact with providing support and linkages to the clients discharged from the Psychiatric Health Facility. This has created a greater continuity of care for the clients and has provided better linkage to the outpatient clinics.

The success of the school-based program has resulted in the MHSA Stakeholder Planning Team wanting to expand that program to another school. The services offered by the therapists in the school programs have been proven successful and are seen as vital by school personnel, Probation, other stakeholders and the community.

Another significant change since the implementation of the CSS Plan was the cooperative agreement made with the Department of Rehabilitation. Using MHSA funds allowed us to leverage those dollars with the Department of Rehabilitation in order to provide more intensive and expanded services to the clients we both serve. This program was implemented in 2007 with twenty-five clients being referred for vocational services and six clients have successfully completed the program.

B. EFFORTS TO ADDRESS DISPARITIES

1) Briefly describe one or two successful current efforts/strategies to address disparities in access and quality of care among underserved populations targeted in the CSS component of your Plan. If possible, include results of the effort/strategy.

The current CSS plan identified the Latino community as a population that was un-served and underserved and services to the Latino community were ranked as a high priority by our stakeholders. The strategy for addressing this need was to have the therapist provide outreach and engagement services and treatment services in the

community. This has been very successful and the demand for these services and the wait list for bilingual/bicultural services continues to increase.

2) Briefly describe one challenge you faced in implementing efforts/strategies to overcome disparities, including where appropriate what you have outreach efforts and the progress made to date to involve the underserved populations that are specifically targeted in the CSS plan. Identify strategies and approaches employed.

   The major barrier continues to be in recruiting bilingual and bicultural staff. While the number of bilingual and bicultural staff increased in 2007, there are still two vacant positions that have been difficult to fill. Recruitment announcements were expanded to include the Latino community. In discussions with other community-based organizations, the same difficulty exists. One possible solution will be to examine the Workforce, Education and Training component for MHSA in order to "grow our own" staff.

3) Indicate the number of Native American organizations or tribal communities that have been funded to provide services under MHSA.

   The County's Native American population is less than 1%. There have been no requests for funding received from Native American organizations or tribal communities within our county. However, in 2007, a Northern Chumash Tribal Council was organized. Their input will be sought in future CSS planning activities in subsequent years.

4) List any policy or system improvements specific to reducing disparities, such as the inclusion of language/cultural competency criteria to procurement documents and/or contracts.

   All of the contracts with community providers require that provider meet the requirements of the County's Cultural Competency Plan. All new contracts with Behavioral Health include the five fundamental concepts of MHSA.

C. STAKEHOLDER INVOLVEMENT

Provide a summary description of any changes you have made during the time period covered by this report in your Community Program Planning Process.

There have not been any changes to the Community Program Planning Process.

D. PUBLIC REVIEW AND HEARING

Provide a brief description of how the County circulated this Implementation Progress Report for a 30-day public comment and review period including the public hearing.

1) The dates of the 30-day stakeholder review and comment period, including the date of the public hearing conducted by the local mental health board or commission.

The Progress Report was released for public review and comment from May 27, 2008 through June 26, 2008. The public hearing was conducted by the Mental Health Board on June 19, 2008 at the Health Campus located at 2180 Johnson Avenue, San Luis Obispo, California.

2) The methods used to circulate this progress report and the notification of the public comment period and the public hearing to stakeholder representatives and any other interested party.

The CSS Implementation Progress Report was circulated using the following methods:

a. Notice was published in the countywide Tribune, a daily public newspaper
b. Sent electronically to the MHSA Planning Team and stakeholder mailing list
c. Sent to the Mental Health Board members
d. Posted on the County Mental Health Services website
e. Posted at the County Mental Health clinics with the website location
f. Posted at the library.

3) A summary and analysis of any substantive recommendation or revisions.

Feedback received from the public during the 30 day review period or at the public hearing will be included here.