DRAFT

PROGRAM AND

EXPENDITURE PLAN REQUIREMENTS

FOR MENTAL HEALTH SERVICES ACT--
COMMUNITY SERVICES AND SUPPORTS

CALIFORNIA DEPARTMENT OF
Mental Health
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MENTAL HEALTH SERVICES ACT (MHSA)
THREE-YEAR PROGRAM and EXPENDITURE PLAN
COMMUNITY SERVICES AND SUPPORTS

Plan Face Sheet

County: ___________________________ Date: ___________________________

County Mental Health Director:

________________________________________
Printed Name

________________________________________
Signature

Date: ___________________________

Mailing Address: __________________________________________________

________________________________________

Phone Number: ___________________________ Fax: ___________________________

E-mail: ____________________________________________

Contact Person: ____________________________________________

Phone: ____________________________________________

Fax: ____________________________________________

E-mail: ____________________________________________
The Mental Health Services Act (MHSA or the Act) represents a comprehensive approach to the development of community based mental health services and supports for the residents of California. The Act addresses a broad continuum of prevention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. To provide for an orderly implementation of MHSA, the California Department of Mental Health has planned for sequential phases of development for each of the components.

The first component to be implemented will be those elements of the Act that define the requirements of service delivery to children, youth, adults and older adults with serious emotional disturbances and/or severe mental illnesses. The pertinent sections of the Act are Sections 5, 7, 10 and 15 that add or amend significant portions of the Welfare and Institutions Codes defining program requirements.

County proposals will be evaluated for their contribution to meeting specific outcomes for the individuals served including:
- Meaningful use of time and capabilities
- Safe housing
- A network of supportive relationships
- Access to help in a crisis
- Reduction in incarceration
- Reduction in involuntary services.

(The department recognizes the unique needs and resource constraints of small counties. These requirements have not yet been adapted for small counties. The department invites stakeholder input on small county flexibility and has scheduled a workgroup meeting on March 16, 2005 specifically focused on that issue.)

PURPOSE

The MHSA requires that “each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health (DMH) after review and comment by the Oversight and Accountability Commission.” The MHSA further requires that “the department shall establish requirements for the content of the plans.” The purpose of this document is to set forth the requirements for the first three-year program and expenditure plans to be submitted by counties requesting funding for the Community Services and Supports component under this Act. Annual updates of this plan will be required pursuant to MHSA requirements.
SUBMISSION GUIDELINES

An original and 10 copies of the completed program and expenditure plan should be submitted to:

California Department of Mental Health
MHSA Three-Year Program and Expenditure Plan
County Operations
1600 9th Street, Room 100
Sacramento, CA 95814

1) Applications submitted must contain the face sheet form furnished by the Department of Mental Health. The Face Sheet must be printed in ink or typewritten.

2) While there is no limit to the length of the application narrative, applications must follow the order and format included in this document. Failure to do so could result in postponement of your application’s review and delays in approval of funding.

3) Program and expenditure plans must be unbound. Proposals will not be accepted via fax or e-mail. Proposals must be typed in size similar to 12-point Arial font with one-inch margins or larger.

PLAN REVIEW PROCESS

County mental health programs must submit a Three-Year Program and Expenditure Plan for MHSA Community Services and Supports to the Department of Mental Health (DMH) to receive MHSA funding to implement this component. (Requests for funding for city mental health programs need to be included in the overall county mental health request.) DMH expectations are that due to the comprehensive review and approval process for these applications by both the Oversight and Accountability Commission and DMH, the review process may take up to three months.

INTRODUCTION TO PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

These application requirements are intended to build upon and operationalize the concepts in the Statement of Guiding Principles issued by DMH. Additional documents that inform the application requirements are Welfare and Institutions (W&I) Code Sections 5801, 5802 and 5806, relating to AB34 and AB2034 programs, and W&I Code Section 5850 et seq. which define the core values and infrastructure requirements for Children’s System of Care.

In January 2005, counties received DMH Letter: 05-01 outlining requirements to request funding to support their local MHSA planning processes. As stated in that document the goals for local planning are to determine how best to utilize funds that will become available for the Community Services and Supports component of the MHSA. That document clearly outlined requirements for how to conduct a local planning process.
including that it must be comprehensive and representative and include meaningful involvement of consumers, family members and other stakeholders.

ESSENTIAL ELEMENTS FOR ALL THREE-YEAR PROGRAM AND EXPENDITURE PLANS

There are five elemental concepts inherent in the MHSA that must be embedded and continuously addressed throughout the applications submitted by counties. These include:

- Community collaboration: Community collaboration refers to the process by which various stakeholders including groups of individuals or families, citizens, agencies, organizations, and businesses work together to share information and resources in order to accomplish a shared vision. Collaboration allows for shared leadership, decisions, ownership, vision, and responsibility. The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically solve existing and emerging problems that could not easily be solved by one group alone.

- Cultural competence: Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, and among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations (Source: (Cross, Bazron, Dennis, and Isaac, Towards a Culturally Competent System of Care Volume I, 1998).

  Cultural competence includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities. There is a clear focus on improved quality and effectiveness of services. Culturally competent programs and services are viewed as a way to enhance the ability of the whole system to incorporate the languages and cultures of its clients into the service that provide the most effective outcomes and creates cost effective programs.

  Identification, development, promulgation, and adoption of culturally competent best practices for care must be an integral part of ongoing culturally competent planning and implementation of the MHSA.

- Client/family driven mental health system: In a consumer and family-driven system, consumers identify their needs and preferences which lead to the programs and providers that will help them most. Their needs and preferences drive the policy and financing decisions that affect them. Services are consumer-centered; with providers working in full partnership with the consumers they serve to develop individualized service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.
Currently, adults with serious mental illness and parents of children with serious emotional disturbances typically have limited influence over the services they or their children receive. Increasing opportunities for consumers to choose their providers and allowing consumers and families to have greater control over funds spent on their care and supports facilitate personal responsibility, create an economic interest in obtaining and sustaining recovery, and shift the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing choice protects individuals and encourages quality (Source: The President’s New Freedom Commission on Mental Health – Achieving the Promise Transforming Mental Health Care in America).

- Wellness focus, which includes the concepts of recovery and resilience: Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery truly is recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery.

  Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members (Source: The President’s New Freedom Commission on Mental Health – Achieving the Promise Transforming Mental Health Care in America).

- Integrated service experiences for clients and their families throughout their interactions with the mental health system: The integrated service experience is predicated on a range of community-based treatment, case management, and interagency system components required by children/transitional age youth/adults/older adults. Although seriously emotionally and behaviorally disturbed individuals may have multiple issues, the many different state, county agencies, and community agencies involved with the individual/family will develop and deliver integrated programs. With a full range of integrated services to treat the whole person, it is hoped that the goal of self-sufficiency will be reached for those who may have otherwise faced homelessness or dependence on the state for years to come. The integrated service experience centers on the individual/ family as part of a strength based approach of multiagency programs and joint case planning to best address the individuals/families needs.

TWO TYPES OF SYSTEM TRANSFORMATION FUNDING AVAILABLE

MHSA funds are to be used to fundamentally transform how mental health service is conceptualized and delivered in California. The transformation of public mental health
and the key goals have been articulated within the President's New Freedom Commission on Mental Health and the California Mental Health Planning Council's Master Plan, and will serve as guiding documents within the implementation of the MHSA in California. Initially, since everyone in need of mental health service cannot be enrolled as a member of this transformed system at once, DMH will make available two types of system transformation funding under the Community Services and Supports Component. The first will relate directly to individual consumers and will use the type of enrollment model established for persons served under AB 2034. The second will be more general system transformation funds, which will allow counties to begin to fundamentally change their service delivery systems and build transformational structures and services. For purposes of this document these two types of funding will be referred to as (1) enrolled member service funds, see Section IV, and (2) system capacity, see Section V. DMH expects that most of the money will be used for Enrolled Member Services.

**Conditions**

The MHSA specifically defines funding restrictions in Section 15, Welfare and Institutions Code, Section 5891. The funds "shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services." Additional information about the requirements for non-supplantation will be provided by the department in draft in mid-March, 2005.

Consistent with MHSA statutory requirements (Welfare and Institutions Code Sections 5848(a) and (b)), each county’s three-year program and expenditure plan shall be developed with local stakeholders and made available in draft and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the plan. At the close of the 30-day comment period the local mental health board shall conduct a public hearing on the draft plan or annual updates. Each adopted plan and update shall include any substantive written recommendations for revisions and a summary of the analyzed recommendations. The mental health board shall review the adopted plan and make recommendations to the county mental health department for revisions.
OVERVIEW OF PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Three-Year applications submitted by counties must follow the format of this application including structuring the application response by the section headings identified below.

Section I: Description of County/Community Public Planning Process
Section II: Identifying Community Issues Resulting from Untreated Mental Illness
Section III: Analyzing Mental Health Needs in the Community
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Section VIII: Developing Budget Requests
Section IX: Local Review and Public Hearing
PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

SECTION I: Results of County/Community Public Planning Process

Direction:

Pursuant to DMH Letter: 05-01, counties submitted requests to DMH for funding to support the local community planning processes. Included in those requests counties provided information about how their planning process would include consumers and families, how it would be comprehensive and representative, how the planning process would be staffed, and how staff and stakeholders would be trained in advance to participate in the planning process. This section asks counties to explain what happened in that process and how the identified goals were met.

Appendix A provides a County Readiness Self-Assessment for the Implementation of the MHSA Community Services and Support Component that clients, families, counties and stakeholders may find helpful.

Response:

1) How did your local public planning process include meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities? Please include detailed information about:

a) The outreach and other activities used by the county to insure comprehensive participation from diverse consumers and families. (Include information about how consumers and family members were informed about methods of giving input in the public planning process. Describe how this was accomplished for every age group, if different what strategies were used.)

b) How your organization reached out to consumers and families who do not belong to organized advocacy groups. (Identify existing organized advocacy groups in your county and explain methods used to involve consumers and families outside these organizations.)

c) How your organization reached out to consumers and families who have been traditionally un-served or underserved whether by reason of race/ethnicity, language, cultural competence, geographic location or other factors. (How did you identify consumers and family members that have been traditionally unserved or underserved and what methods were used to bring them into the public planning process.)

d) Provide a comprehensive list of activities designed to encourage consumers and family members to participate in the public planning process. (These could include but are not limited to: surveys, focus groups, interviews, conference calls, client advisory committees, consumer/family meetings, public meeting, public hearings, town hall meetings, video conferences, and media announcements.)
e) For those counties who previously did not have established consumer and family
groups participating in county mental health program policy and planning, explain
how you have initiated this type of resource and how you plan to sustain it.

f) Describe in detail any financial or additional supports (such as stipends,
childcare, supplemental meals, housing, transportation assistance, etc.) the
county provided to encourage and assure consumer and family involvement in
the public planning process. (Include the actual costs of providing all of the
above.)

2) In addition to consumers and family members, how comprehensive and
representative was your public planning process? Please provide detailed
information about:

a) The numbers and types of individuals who participated in your public planning
process in addition to consumers and family members. (Identify in total the
number of persons who participated and categorize them by organization
represented. If some did not represent an organization – categorize as county
constituent.)

b) What methods were used to insure that the stakeholder participation reflected the
demographics of the county including geographic location, age, gender and
race/ethnicity. (Include information about how the process included stakeholders
throughout the various regions of the county, representatives of all ages, and
race/ethnicities residing in the county.)

c) How were meetings organized for public planning and who facilitated those
meetings. How were county mental health staff involved in these processes?
(Include information about the types and number of meetings held associated
with public planning for MHSA implementation, identify the number of persons
who attended and identify who they represented, provide meeting minutes.)

3) Who in your county had overall responsibility for the planning process? Please
provide information about:

a) Provide the name of the person with overall responsibility for the public planning
process in your county and the percentage of their time devoted to the effort.

b) Provide the names and titles of other persons who supported the public planning
process, identify their function and how much time they each devoted to the
effort. Provide a summary of all staff functions performed and the amount of time
devoted to the public planning process to date. (Include information about who
handled the organizational work of the planning process, who was responsible
for ensuring the participation of stakeholders from un-served and underserved
populations, who was responsible for ensuring the participation of ethnically
diverse populations, and whether or not consultants performed any of the
functions identified. If other county staff were involved in public planning
activities, please identify by function.)
4) Provide a description of the types and amount of training you have provided to date, using MHSA community planning funds. For each of the following groups identify the number of trainings provided, the content of the training, the name of the trainer, the length of the training; the number of persons attending each training and who they represented.

a) Consumer and family training
b) Mental health management and supervisor training
c) Mental health line staff training
d) Mental health contractor training
e) Training for other agency personnel who have direct contact with mental health clients, such as teachers, child welfare workers or probation officers. This should include training for line staff as well as managers and supervisors in these other agencies.
f) Mental Health Boards and Commissions member training
g) Other stakeholder training

SECTION II: Identifying Community Issues Resulting from Untreated Mental Illness

Direction:

Counties should identify which of the community issues and concerns that result from untreated mental illness, as specified in the MHSA, will be focused on in counties’ initial three-year program and expenditure plan. For adults and older adults, and some transition age youth, the issues identified in the MHSA include homelessness, inability to work, isolation, involuntary care, institutionalization and jail. For children, youth and some transition age youth issues include inability to be in a normal school environment, hospitalization, out-of-home placement and juvenile justice system involvement. Counties should select one or more of these issues for each age group based on community input.

If, through the planning process, a county decides to focus on an issue or issues not specifically described in the MHSA, the application must describe why these issues are more significant for their community and how the issues are consistent with the purpose and intent of the MHSA.

Response:

Please answer each of the following questions pertaining to how community issues resulting from untreated mental illness were identified in the public planning process.

1) Which county/community issues were identified to be the focus of MHSA services over the next three years? (Please provide information by age group, identify all
issues for every age group even if some issues are common to more than one group.)

County/Community Issues Identified in the Public Planning Process:

<table>
<thead>
<tr>
<th>Children/Youth</th>
<th>TAY</th>
<th>Adults</th>
<th>Older Adults</th>
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<tbody>
<tr>
<td>1.</td>
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2) Please describe what factors or criteria led to the selection of each distinct issue identified above. How were issues prioritized for selection? (If one issue was selected for more than one age group – describe the factors that led to including it in each.)

3) If the community issues are not consistent with those included in the MHSA (See ‘Direction’ provided above), please describe why these issues are more significant for your county/community and how the issues are consistent with the purpose and intent of the MHSA.

SECTION III: Analyzing Mental Health Needs in the Community

Direction:

The MHSA states “untreated mental illness is the leading cause of disability and suicide…” This three-year program and expenditure plan must include an assessment of the mental health treatment needs of county residents including adults, older adults and transition age youth with severe mental illness, and children, youth and transition age youth with serious emotional disorders. The intent is to identify all those that would qualify for MHSA services. This assessment must identify the numbers of clients and family members estimated to be un-served, underserved and inappropriately served. The assessment should also address the mental health treatment needs of individuals with special needs, such as those with hearing and visual impairments and other physical disabilities. Particular attention must be paid to the issue of ethnic disparities. Counties should use their updated cultural competence plans and DMH prevalence data (http://www.dmhc.ca.gov/SADA/default.asp#Reports1) to assist with this analysis. It is expected that the number of persons un-served can be roughly estimated by subtracting the number of persons currently served from those identified in the prevalence data as needing services. If prevalence rates based on households are used, then some adjustments may be necessary since persons who are homeless or living in other residential settings are not included in households.
The number of persons underserved and/or inappropriately served will be harder to determine. As noted in Section IV, the underserved are defined as those that are so underserved that they are “at risk of”: out-of-home placement, homelessness, criminal justice involvement, institutionalization, hospitalization and/or emergency room services. The Department’s expectation is that counties will identify the number of persons, by age group, that may be underserved, including individuals that some might define as inappropriately served such as someone living in an institution for mental disease (IMD) because of the lack of supported housing services. (DMH intends to review the methodologies used by counties to determine for future applications methods to be used statewide to calculate number of persons unserved and underserved.)

The MHSA acknowledges disparities in access for racial ethnic populations. Counties shall complete a comprehensive assessment of those disproportionately underserved racial ethnic populations. Counties are encouraged to use and benefit from the previous cultural competence assessment which will allow them to expand upon the population assessment completed in their Fiscal Year 2003/04 Medi-Cal Cultural Competence Plans. This assessment requires an updated and an expanded collection of data to all individuals/populations served because prior information was required only for Medi-Cal populations.

Response:

Please address each of the following questions pertaining to the mental health needs assessment completed as part of the MHSA public planning process.

1) Provide data and an analysis of the most current available information for county population and utilization data.
   a) Provide data on the county demographics by ethnicity, age, gender and primary language spoken for
      i) The general population of the county, by region if available and appropriate
      ii) Population under 200% of federal poverty level in the county
      iii) Uninsured population in the county
      iv) Seasonal migrants
   b) Provide data on the utilization of mental health services by all clients
      i) by ethnicity, age, gender, diagnosis, and primary language spoken
      ii) by service category groupings
         (1) inpatient
         (2) crisis
         (3) outpatient
         (4) day treatment/residential
   c) Analyze the population assessment and utilization data. Provide conclusions drawn in terms of designing and planning for the provision of appropriate and effective MHSA Community Services and Supports.
(DMH will provide some data for counties based on the 2000 U.S. Census, updated Department of Finance population data, and utilization data as reported to the Client and Service Information (CSI) system. Counties may be able to use the data as provided in some cases but will also need to supplement it with information from their own information systems as well as information from other county offices, such as, Social Services, and other data sources such as recent county homeless surveys to estimate some of the populations.)

2) Based on completion of the county mental health needs assessment described above, indicate the total number of persons estimated to need MHSA-level mental health services in your county including those currently served and those un-served by age group.

<table>
<thead>
<tr>
<th>Total Persons Needing MHSA-Level Mental Health Services</th>
<th>Total Persons Currently Served</th>
<th>Total Persons Un-Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
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<tr>
<td>TAY</td>
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<tr>
<td>Adults</td>
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<td>Older Adults</td>
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<tr>
<td>TOTAL</td>
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3) Describe the methodology and any calculations used to determine the numbers identified in No. 2 above? (Indicate whether DMH prevalence data is the basis for the number of persons needing MHSA-level service, and whether that is true for all populations. If additional information was used please explain.)

4) Describe the situational characteristics of the un-served population identified in No. 3 above for each age group. (Examples: child or adolescents with serious emotional disturbance in foster care or juvenile hall, homeless adults with serious mental illness and criminal justice issues, isolated older adults not seeking treatment.)
5) Of the persons currently receiving mental health services what number do you estimate are “so underserved” that they meet the “at risk of” criteria for MHSA services? (See ‘Direction’ above.)

<table>
<thead>
<tr>
<th></th>
<th>Total Persons Currently Served</th>
<th>Total Persons Underserved Meeting “At Risk of” Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
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<td>TAY</td>
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<td>Adults</td>
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<td>Older Adults</td>
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<tr>
<td>TOTAL</td>
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</table>

6) For each age group describe the methodology and any calculations used to identify the ‘numbers’ of individuals who are “so underserved” that they meet the “at risk of” criteria for MHSA services. For each age group please describe their situational characteristics that demonstrate consistency with the definitions of underserved included in this section.

7) Did the methodology described in No. 5 also include analysis of persons who may be inappropriately served? (Example: an individual living in an IMD because supported housing services are not available.) If so, please explain by age group.

8) Did the county mental health needs assessment also identify other underserved individuals who do not meet the “at risk of” criteria for MHSA services? If so, please provide the numbers below and explain how they were derived.

<table>
<thead>
<tr>
<th></th>
<th>Persons Underserved Who Do Not Meet “At Risk of” Criteria for MHSA Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
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<tr>
<td>TAY</td>
<td></td>
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<tr>
<td>Adults</td>
<td></td>
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<tr>
<td>Older Adults</td>
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<tr>
<td>TOTAL</td>
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</tbody>
</table>
9) Does this application propose to serve any of the underserved individuals (those not meeting “at risk of” criteria for MHSA services) identified in No. 8 above? If so please describe their situational characteristics by age group and indicate how serving these individuals is more appropriate for this initial plan and how it is consistent with the purpose and intent of the MHSA.

SECTION IV: Identifying Focal Populations for Enrolled Member Services

**Direction:**

In the previous section of this application you were asked to identify in total the number of persons un-served and underserved that meet the criteria for MHSA services in your county. In this section you are asked to identify the numbers of persons by age, in each of those same categories that you intend to enroll in the first three years. As noted previously, it is the intent of DMH that counties will move toward identifying and serving all persons covered in the MHSA. This will need to be accomplished in phases, as not everyone who will eventually be included under the MHSA can be enrolled in the first three years. As part of the community collaborative process, counties are encouraged to start “small and smart” when identifying initial focal populations.

**General requirements for all populations:**

- Each county must specifically identify the focal populations including the number of persons to be served in the first three-year application.
- Each county must include all age groups in their populations to be served.
- Each county must review its cultural competence plan, expand its analyses to include non-Medi-Cal populations, specifically identify disparities in access for ethnic populations, and describe what strategies it will use to reduce those disparities in each focal population.
- Each county must review its data by gender and by ethnicity. For large and/or populous counties, regional and geographic sub-areas of the county must also review data.

Counties should initially determine through their planning process which populations are the most appropriate to focus on during the first three years. These decisions should be made in the context of the community issues and mental health needs identified in the two previous sections. What follows are recommended focal populations within each age group that are consistent with issues of public concern and the MHSA. Counties who choose not to select from the focal populations in each age group as described below must specify their reasons for not doing so. They will need to provide clear information as to why the focal populations they identify are more appropriate for this initial application and how they are consistent with the purpose and intent of the MHSA.
Specific Populations by Age Consistent with MHSA and DMH Priorities:

- Children and youth with serious emotional disorders and their families who are not currently being served. This will generally be youth and their families who are uninsured and/or youth who are not eligible for Medi-Cal because they are in the juvenile justice system. It could also include youth in foster care placed out-of-county. Children and youth who are so underserved that they are at risk of out-of-home placement are also included. Healthy Families enrollees with SED, while insured for other problems, are a responsibility of the counties for SED services and should be included in planning for focal populations.

- Transition age youth who are currently unserved or underserved who have serious emotional disorders and who are homeless or at imminent risk of being homeless, and youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems. Transition age youth who have experienced a first episode of major mental illness are also included.

- Adults with serious mental illness -- including adults with a co-occurring substance abuse disorder and/or health conditions-- who are not currently being served and are homeless and/or involved in the criminal justice system (including adults involved due to child protection issues). Individuals who are so underserved that they are at imminent risk of homelessness, criminal justice involvement or institutionalization are also included.

- Older adults 60 years and older with serious mental illness—including older adults with co-occurring disorders and a primary diagnosis of mental illness—who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of institutionalization, nursing home care, hospitalization and emergency room services. Older adults who are so underserved that they are at risk of any of the above are also included.

Each enrolled member will partner with the county mental health program to develop an individualized service and support plan. The county commits to do “whatever it takes” to assist the enrolled member to achieve that plan. All enrolled members must have a single point of responsibility - Personal Service Coordinators (PSCs) for adults — case managers for children and youth— with a caseload that is low enough so that their availability to the client and family is appropriate to their service needs. Services should include the ability of PSCs or children’s case managers to respond to clients, families, and collaborative partners, including landlords and law enforcement, 24 hours a day, 7 days a week. Services should also include linkage to, or provision of, all needed services or benefits as defined by the client and or family in consultation with the PSC for adults or case manager for children/youth. This includes the capability of increasing or decreasing service intensity as needed. Counties will be required to submit service, assessment and indicator/outcome information for each enrollee. (A brief description of performance measurement strategies is included as Appendix B.)

This application must identify the number of individuals within the focal populations for each age group that counties expect to enroll in the initial three-year period. Target dates for these enrollments must be reflected in the workplan required in Section VII.
Response:

Please address each of the following questions pertaining to the identification of focal populations to be enrolled during the first three years.

1) From your analysis of community issues and mental health needs in the community, identify which focal populations, by category, will be served in the first three years. (Fill in below the numbers of persons in each age group you expect to enroll during the first three years.)

**Year One: (FY 05/06)**

<table>
<thead>
<tr>
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<tr>
<td>Underserved (meet “at risk of” criteria for MHSA service)</td>
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**Year Two: (FY 06/07)**

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**Year Three: (FY 07/08)**

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</table>

2) Please describe what factors were considered or criteria established that led to the selection of the focal populations to be enrolled in the first three years? (Distinguish between criteria used for each age group if applicable.)

3) Describe how you determined the number of un-served, underserved and/or other persons to be enrolled in each year for each age group.

4) Do the persons identified for enrollment in the first three years include ethnic minorities that have been traditionally un-served or underserved? If so, please explain in detail: (1) whether serving these individuals will address access disparity issues and (2) how many un-served and underserved persons included for enrollment are expected to be ethnic minorities.

5) Describe the situational characteristics of the un-served, underserved and/or other persons to be enrolled in the first three years, by age group.

6) If you have identified persons in the “other” category to be served in any age group, please explain how they are more appropriate for services in the first three years than the un-served or underserved that are at risk, and how serving them is consistent with the purpose and intent of the MHSA.
SECTION V: Identifying Strategies for System Capacity Funding

Direction:
In this section, three-year applications must identify the county’s service needs in order to transform systems into culturally competent, client and family driven, wellness/recovery/resiliency system and to build the necessary capacity to serve a diverse population of clients. In addition, Section 3(c) of the MHSA speaks to the intent of “expanding the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations”. Section 3(e) refers to services that “…are provided in accordance with recommended best practices.”

County requests for system capacity funding must be consistent with the purpose and intent of the MHSA. Counties, working together with clients, family members and other collaborative partners, must select from the following strategies for funding for both enrolled member service funds and general system transformation funds. The strategies are designed to operationalize system transformation and the principles of W&I Code Sections 5801, 5802 and 5806, relating to AB34 and AB2034 programs, and W&I Code Section 5850 et seq. that define the core values and infrastructure requirements for Children’s System of Care. Although these strategies are listed by age group, counties are also encouraged to develop intergenerational strategies, which could include such strategies as programs for families in which a parent has a serious mental illness, programs for transition age youth and their families when the youth continues to live in her/his parental home, and programs for adult children who are caregivers for their aging parents. Counties that request funding for strategies other than those listed in the following pages must describe how their strategies are transformational, how they will promote wellness, recovery, and resiliency, and how they are consistent with the intent and purpose of the MHSA.

All services should be inclusive and take into account the needs of racial ethnic clients, such as language, acculturation levels, ethnic matching of staff to clients, immigration adjustment issues and refugee trauma. Services should also be gender-sensitive and reflect the differing psychologies and needs of women and men.

The following are examples of structural, service, and support strategies necessary for delivering successful community services and supports and qualify for system capacity funding:

CHILDREN AND YOUTH

Structural Strategies

- Wraparound programs as defined in W&I Code Sections 18250-18252 and CDSS ACIN 1/28/99. (The MHSA requires all counties to implement wraparound services or provide substantial evidence that it is not feasible to establish a wraparound program in their county. In the latter case, counties
should explore collaborative projects with other counties and/or identify appropriate alternative strategies.)

- **Child and Family Teams:** Individualized Child and Family Teams (CFT) are part of Wraparound or Children's System of Care (SOC) services. Those programs provide strength-based, family-centered services to children with multiple, complex and enduring mental health and behavioral needs. The CFT organizes, implements and oversees a plan of care as well as taking on the critical tasks needed to support and serve the child and family.

- **Family Partnership Programs** which are operated by family members and include services and activities such as training, information and referral, newsletter or information dissemination, support groups, individual advocacy and support, web-based information, outreach, administrative activities and program oversight, direct services and legislative activities and efforts.

- **Single service plan across systems** whose services are needed by youth and their families

- **Interagency service planning teams** which include families

- **Interagency service monitoring teams** which include families

### Service Strategies

- Outreach and screening services which proactively identify children showing symptoms of emotional, behavioral conditions and provide easy and immediate access to mental health services when needed

- **Home and school based services and supports**

- **Mentoring**

- **Family preservation services**

- **Crisis services including:**
  - 24 hour crisis phone line
  - Mobile crisis services
  - Crisis stabilization unit or housing
  - In-home respite services for families

- **Values-driven evidence-based and promising clinical services** that are integrated with overall service planning and child/youth and family goals

- **Education** for youth and family or other caregivers. As appropriate, regarding the nature of medications, the expected benefits and the potential side effects

- **Family support and consultation services,** parenting support and consultation services, self-help groups

- **On-site services** in juvenile halls, ranches and camps

- **On-site services** in child welfare emergency shelters
On-site services in primary care clinics to reach children, youth and families of ethnic cultures who may be more responsive to services in this setting; linkage for these families to the full range of services

On-site services in faith-based communities when culturally appropriate to reach children, youth and families of ethnic cultures who may be more responsive to services in this setting; linkage for these families to the full range of services

Support Strategies

- Childcare
- Transportation
- Respite services for children, youth and parents

TRANSITION AGE YOUTH

In addition to the strategies below, many of the strategies for adults and for children, youth and their families may be appropriate for some transition age youth:

Structural Strategies

- Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate. A single PSC should follow transition age youth as they move from children and youth services into adult services and/or into the community as independent adults. Transfer out of a transition age program should be negotiated with the client and not occur until s/he feels connected with the adult mental health system or successfully moves out of the mental health system altogether
- Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and in operationalizing a wellness philosophy including the concepts of both recovery and resiliency
- Integrated substance abuse and mental health services where youth receive substance abuse and mental health services from one team with one plan for one person; specialized housing to accompany these services when appropriate
- Supportive housing – where young people live in congregate housing, independent scattered site housing, or at home with parents/caregivers, support services are provided and personal service coordinators broker any services that are not available on site
Service Strategies

- Integrated assessment 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 as is in the DSM-IV-R cultural formulation.
- Integrated service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization and independent living skills.
- Values driven evidence-based clinical services that are integrated with overall service planning and support housing, employment, and/or education goals.
- Classes regarding what youth need to know for successful living in the community.
- Supportive employment including development of job options for young people, such as social enterprises, agency, supported positions, and competitive employment options.
- Supportive education services.
- Education for youth and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.
- Trauma-informed services for young women, including young women with co-occurring disorders.
- Youth and family run services including peer support, self-help groups and mentoring programs.
- Services to assist families in supporting youth during this period.
- Crisis services including:
  - 24 hour crisis phone line
  - Mobile crisis services
  - Crisis stabilization unit or housing

Support Strategies

- Development of housing options including:
  - Temporary housing/shelter
  - Transitional housing while youth are waiting for a more permanent housing opportunity.
- Independent Living Programs.
- Transportation (including acquisition of driver’s licenses).
- Recreation.
ADULTS

Structural Strategies

- Integrated service agencies which provide and/or broker all services that a client needs (see list under activities and services)
- Supportive housing – where clients live in congregate housing, independent scattered site housing or at home with parents/caregivers, support services are provided and personal service coordinators broker any services that are not available on site. Housing options should include places for women or men who are caring for their children
- Wellness Recovery Action Planning – In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client’s needs and wants for home, job, friendship and family with the focus on life improvement.
- Integrated substance abuse and mental health services where a client/member receives substance abuse and mental health services from one team with one plan for one person; specialized housing to accompany these services as appropriate.
- Integrated services with law enforcement, probation and courts for the purpose of crises response, alternatives to jail for those with serious mental illness and/or establishing mental health courts for clients who have criminal justice charges. Integrated forensic programs include ones similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program.

Service Strategies

- Outreach services to persons who are homeless or at risk of homelessness that involve persistent, non-threatening, outreach, and engagement strategies. These services should include the ability to provide for the immediate needs of an individual including, physical healthcare, food, clothing and shelter. This may require that service teams have access to immediate cash and/or vouchers for client needs.
- Integrated assessment teams that provide comprehensive mental health, social, physical health and substance abuse assessments which are strength-based and focused on client/member engagement and which can provide cultural specific assessments as is in the DSM-IV-R cultural formulation.
- Assertive community treatment (ACT) teams; ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT
recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year (Source: National Alliance for the Mentally Ill).

- 24 hour, 7 day a week response by Personal Service Coordinators to consumers, family members, law enforcement or landlords to reduce incidents of hospitalization, incarceration and/or eviction.
- Peer supportive services and client and family run services
- Education for clients and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.
- Classes regarding what clients need to know for successful living in the community
- Supportive employment and other productive activities, including development of job options for clients such as social enterprises, agency, supported positions, and competitive employment options.
- Vocational services
- Supportive education
- Family support, education, and consultation services, parenting support and consultation services, self-help groups and mentoring.
- Values-driven evidence-based clinical services that are integrated with overall service planning and support housing, employment, and/or education goals.
- Trauma-informed services for women, including women with co-occurring disorders
- On-site services in primary care clinics to reach clients of ethnic cultures and others who may be more responsive to services in this setting; linkage for these clients to the full range of services
- On-site services in faith-based communities when culturally appropriate to reach clients of ethnic cultures and others who may be more responsive to services in this setting; linkage for these clients to the full range of services
- Crisis services including:
  - 24 hour crisis phone line
  - Mobile crisis services
  - Crisis stabilization unit or housing
  - In-home respite services for families who are housing and supporting a family member with mental illness
- Client advocacy on criminal justice and child welfare issues
Support Strategies

- Development of temporary housing options including:
  - Temporary housing
  - Transitional housing if the clients are waiting for a more permanent housing opportunity including housing options for parents who are caring for their children
  - Respite housing
  - Child care
  - Transportation

OLDER ADULTS

In addition to adults 60 years of age and over, there are a group of clients in the age-range of 55 through 59 with needs similar to older adults who can best be served with the structures and services outlined below.

Structural Strategies

- Supportive housing – where clients live in congregate housing, scattered site housing or at home with caregivers, support services are provided and personal service coordinators broker any services that are not available on site.
- Integrated substance abuse and mental health services where clients/member receive substance abuse and mental health services from one team with one plan for one person; specialized housing to accompany these services
- Wellness Recovery Action Planning – In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client’s needs and wants for home, job, friendship and family with the focus on life improvement.

Service Strategies

- 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
- Integrated assessment teams that provide comprehensive mental health, social, substance abuse and thorough physical health assessments which are strength-based and focused on engagement of older clients and which can provide culture specific assessments as in the DSM-IV cultural formulation
- Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults
- Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities or other factors
- Education for the client and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.
- On-site services in primary care health clinics and services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services
- On-site services in faith based communities when culturally appropriate to reach clients of ethnic cultures and others who may be more responsive to services in this setting; linkage for these clients to the full range of services
- Education and coordination of primary care providers to increase coordination and integration of mental health and primary care services
- Peer supportive services and client run services including peer counseling programs to provide support and to increase client/member knowledge and ability to use needed mental health services
- Values driven evidence-based clinical services that are integrated with overall service planning and which support housing and other client selected goals
- Home care assistance, including training of caregivers and providers about enhancing the ‘therapeutic environment’ of the home
- Crisis services including:
  - 24-hour crisis phone line
  - Mobile crisis services
  - Crisis stabilization unit or housing
  - In-home respite services for families who are housing and supporting an older adult with mental illness

Support Strategies

- Supportive and independent housing
- Residential care facilities for elderly with therapeutic environments (including a supplemental rate for mental health services)
- Supportive and independent employment or personal growth opportunities
- Supportive and independent education opportunities
- Special services for seniors
  - Senior centers
  - Senior legal aid
  - Adult day health care
  - Adult day care
  - Geriatric assessment centers
  - Private caregiver resource centers
The focus of the MHSA is on wellness, recovery and the reduction of involuntary services. It is also recognized that in some limited circumstances a county may want to use MHSA funds for involuntary services. In those limited circumstances a county must provide a detailed description justifying how their proposal is consistent with the intent of the MHSA, including demonstrating that the needs of the people to be served cannot be met through voluntary services. The proposal must also comply with all existing statutory provisions governing involuntary services.

Planning Checklists
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. Appendices C and D provide Planning Checklists that are intended to be learning tools, 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.

Response:

1) Identify all of the structural, service, support or collaboration strategies the county has chosen to implement with MHSA funds to expand system capacity. Select from the list given for each age-based group and identify by age group to be served. Counties may identify multiple strategies for each age group. If your county intends to implement intergenerational strategies please identify and explain.

2) Discuss how the strategies chosen will assist in meeting the needs of ethnic consumers, such as language, acculturation levels, ethnic matching of staff to client, immigration adjustment issues and refugee trauma.

3) Describe how the strategies shall be used in a manner that is gender-sensitive and reflect the differing psychologies and needs of women and men.

4) Describe how service needs will be met for individuals residing out-of-county.

5) Describe how the Planning Checklists were used in your planning process.
6) If your county has selected a strategy to implement with MHSA funds that is not listed in this section, please describe that strategy in detail including how it is transformational and how it will promote wellness/recovery/resiliency and is consistent with the intent and purpose of the MHSA.

7) If the proposal includes a request for funding of any involuntary services, please describe consistent with the intent of the MHSA, complies with all existing statutory provisions governing involuntary services and is consistent with the goal to reduce involuntary care.

SECTION VI: Assessing Capacity

Direction:

Current Service Capacity

The MHSA requires that “the department shall evaluate each proposed expenditure plan and determine the extent to which each county has the capacity to serve the proposed number of children, adults and seniors…” This will be accomplished through review of this application and expenditure plan which includes workplan and budget detail.

As part of the capacity assessment, counties will develop or update their organizational and service provider assessment.

Response:

1) Complete Exhibit 1, Current Staffing Capacity

2) Provide the following data

   a) For county staff, specify ethnicity, bilingual staff (specify language), and staff proficiency in a language other than English (specify language)
      i) By Function
         (1) Administration/management
         (2) Direct Services
         (3) Support Services
         (4) Interpreters
         (5) Staff who have voluntarily self-identified as consumers

   b) For contract agency staff, specify ethnicity, bilingual staff (specify language), and staff proficiency in a language other than English (specify language)
      i) By Function
         (1) Administration/management
         (2) Direct Services
         (3) Support Services
(4) Interpreters
(5) Staff who have voluntarily self-identified as consumers

3) Provide an analysis of the human resources composition by location data in contrast to the population needs assessment data for each population category and conclusions drawn in terms of designing and planning for the provision of appropriate and effective mental health services.
   a) Identify any objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population and human resources assessment.
   b) Identify disparities between all populations served and the cultural, ethnic and linguistic diversity of the county’s direct service providers
   c) Compare the percentages of culturally, ethnically and linguistically diverse direct service providers to the same characteristics of the client population served in the county.

4) Describe the system strengths and primary barriers to expansion for enrolled services and system capacity for each age group.

SECTION VII: Developing a Workplan with Timeframes

Direction:

Detailed workplans that describe how you intend to implement proposed uses of MHSA funds for Enrolled-Member Services and System Capacity are required. The level of detail required throughout this application and in these workplans is essential to analyzing each county’s capacity to implement MHSA services consistent with local planning decisions and the intent and purpose of the MHSA and establishing some of the measures for the performance contract. Periodic progress reports will be required.

Response:

Provide workplans and complete required forms to describe how you propose to use MHSA funding (1) Enrolled Member Services and (2) System Capacity funds for children/youth, transition age, adults and older adults

1) ENROLLED MEMBER SERVICES—Provide the following information for each focal population described in Section IV.
   a) Enrolled Member Services Face Sheet, Exhibit 2.
   b) Staffing Detail Worksheet, Exhibit 3.
   c) Structural, Service and Support Strategies Checklist for
      i) Children and Youth, Exhibit 4.
ii) Transition Age Youth, Adults and Older Adults, Exhibit 5.

d) Provide the following information:
   i) Number and age category of persons to be enrolled and served for each fiscal year.
   ii) Identify the persons above by un-served, underserved/“at risk of”, or “other” underserved.
   iii) Which of the following community issues will be addressed in this program?
       (a) Describe the situational characteristics of the individuals to be served.
   iv) Describe what service strategies and specific services will be provided in this program by using the checklist included as Exhibits 4 and 5. (If this is a children’s program the MHSA requires all counties to implement wraparound services or provide substantial evidence that it is not feasible in the county in which case counties should explore collaborative projects with other counties and/or appropriate alternative strategies.)
       (a) If expanding an existing program, explain what structural, service and support strategies are provided in the existing program and how that will change under through this proposal.
       (b) Will this program have services provided by consumers and/or family members? Please describe.
       (c) Describe in detail all collaboration strategies with other stakeholders, including law enforcement, that have been developed. Explain how they will help to transform and improve system services and outcomes for individuals.
   v) Describe how services will be provided to individuals living out-of-county.
   vi) Does this program address ethnic disparity issues identified in your updated cultural competence assessment and analysis? If so, please describe the strategies to be employed to address these issues. Identify all staff with specific skill sets such as reading, writing and speaking in a second language.

e) Provide critical implementation dates.

2) SYSTEM CAPACITY—Provide the following information for each new program described in Section V.
   a) Staffing Detail Worksheet, Exhibit 3.
   b) Provide the following information for each new or expanded program by type of service:
      i) Number and age category of persons to be served for each fiscal year.
      ii) Describe the situational characteristics of the individuals to be served.
      iii) Describe what service strategies and specific services will be provided in this program—consistent with the structural, service and support strategies outlined in Section V.
          (1) If expanding an existing program, explain what structural, service and support strategies are provided in the existing program and how that will change under through this proposal.
(2) Will this program have services provided by consumers and/or family members? Please describe.

(3) Describe in detail all collaboration strategies with other stakeholders, including law enforcement, that have been developed. Explain how they will help to transform and improve system services and outcomes for individuals.

iv) Describe how services will be provided to individuals living out-of-county.

v) Does this program address ethnic disparity issues identified in your updated cultural competence assessment and analysis? If so, please describe the strategies to be employed to address these issues. Identify all staff with specific skill sets such as reading, writing and speaking in a second language.

c) Provide critical implementation dates.

SECTION VIII: Developing the Budget

Formats and instructions to be provided in mid-March 2005

Budgets will be required for each focal population under Enrolled Member Services and each new program under System Capacity.

SECTION IX: Local Review and Public Hearing

Direction:

The MHSA requires that county draft plans be circulated for review and comment for at least 30 days. At the end of that period, the mental health board is required to hold a public hearing. The mental health board shall review the adopted plan and make recommendations to the county for revisions. The adopted plan shall include a summary and analysis of any substantive recommendations for revisions.

Response:

1) Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.

2) Provide documentation of the public hearing by the mental health board or commission.

3) Provide the summary and analysis of any substantive recommendations for revisions.
REQUIRED

EXHIBITS
## Exhibit 1
### Current Staffing Capacity

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<th>Column 3</th>
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Enrolled Member Services Program
Face Sheet

County Name: _______________________________________________________

Name of Program: __________________________________________________

Please check all applicable:

☐ County Operated
☐ Contract Operated Name of Contractor: ________________________________

Focus Population: ___________________________________________________

Is this: (please check one)

☐ An Existing Program to be Expanded with MHSA Funds
☐ A New Program to be Established with MHSA Funds

County Point of Contact for this Program

Name: ______________________________________________________________

Address: _____________________________________________________________

____________________________________________________________________

Phone: ______________________________________________________________

E-mail: ________________________________________________________________

Fax: __________________________________________________________________
Identified all Program Staff (Both Current & Proposed) | Function | Current Existing FTE | New or Additional MHSA Proposed | MHSA Total FTE only

| Classification | | | Redirected | Non-Redirected |

| Consumer/ Family Staff | | | |

| Total MHSA Staff | | | |

* All staff must be identified individually to permit analysis of partial FTEs and redirection of staff.
Exhibit 4
STRUCTURAL, SERVICE AND SUPPORT STRATEGIES CHECKLIST
For Children and Youth

Name of Program/Focus Population _______________________________________

Please identify all the structural, service, support and collaboration strategies to be used in this program. Check all that apply.

1. **Structural Strategies**

Children/Youth TAY • Wraparound programs as defined in W&I Code Sections 18250-18252 and CDSS ACIN 1/28/99. (The MHSA requires all counties to implement wraparound services or provide substantial evidence that it is not feasible to establish a wraparound program in their county. In the latter case, counties should explore collaborative projects with other counties and/or identify appropriate alternative strategies.)

Children/Youth TAY • Child and Family Teams: Individualized Child and Family Teams (CFT) are part of Wraparound or Children’s System of Care (SOC) services. Those programs provide strength-based, family-centered care to children with multiple, complex and enduring mental health and behavioral needs. The CFT organizes, implements and oversees a plan of care as well as taking on the critical tasks needed to support and serve the child and family.

Children/Youth TAY • Family Partnership Programs which are operated by family members and include services and activities such as training, information and referral, newsletter or information dissemination, support groups, individual advocacy and support, web-based information, outreach, administrative activities and program oversight, direct services and legislative activities and efforts.

Children/Youth TAY • Single service plan across systems whose services are needed by youth and their families.

Children/Youth TAY • Interagency service planning teams which include families
Additional Structural Strategies for TAY

**Children/Youth TAY**
- Interagency service monitoring teams which include families
- Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate. A single PSC should follow transition age youth as they move from children and youth services into adult services and/or into the community as independent adults. Transfer out of a transition age program should be negotiated with the client and not occur until s/he feels connected with the adult mental health system or successfully moves out of the mental health system altogether
- Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and in operationalizing a wellness philosophy including the concepts of both recovery and resiliency
- Integrated substance abuse and mental health services where youth receive substance abuse and mental health services from one team with one plan for one person; specialized housing to accompany these services when appropriate
- Supportive housing – where young people live in congregate housing, independent scattered site housing, or at home with parents/caregivers, support services are provided and personal service coordinators broker any services that are not available on site

2. **Service Strategies**

**Children/Youth TAY**
- Outreach and screening services which proactively identify children showing symptoms of emotional, behavioral conditions and provide easy and immediate access to mental health services when needed
- Home and school based services and supports
### Additional Service Strategies for TAY

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- Mentoring
- Family preservation services
- Crisis services including:
  - 24 hour crisis phone line
  - Mobile crisis services
  - Crisis stabilization unit or housing
  - In-home respite services for families
- Values-driven evidence-based and promising clinical services that are integrated with overall service planning and child/youth and family goals
- Education for youth and family or other caregivers. As appropriate, regarding the nature of medications, the expected benefits and the potential side effects
- Family support and consultation services, parenting support and consultation services, self-help groups
- On-site services in juvenile halls, ranches and camps
- On-site services in child welfare emergency shelters
- On-site services in primary care clinics to reach children, youth and families of ethnic cultures who may be more responsive to services in this setting; linkage for these families to the full range of services
- On-site services in faith-based communities when culturally appropriate to reach children, youth and families of ethnic cultures who may be more responsive to services in this setting; linkage for these families to the full range of services
- Integrated assessment 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 as is in the DSM-IV-R cultural formulation
### Additional Service Strategies for TAY

**Children/Youth TAY**

- Integrated service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization and independent living skills

**Children/Youth TAY**

- Values driven evidence-based clinical services that are integrated with overall service planning and support housing, employment, and/or education goals

**Children/Youth TAY**

- Classes regarding what youth need to know for successful living in the community

**Children/Youth TAY**

- Supportive employment including development of job options for young people, such as social enterprises, agency, supported positions, and competitive employment options

**Children/Youth TAY**

- Supportive education services

**Children/Youth TAY**

- Trauma-informed services for young women, including young women with co-occurring disorders

**Children/Youth TAY**

- Youth and family run services including peer support, self-help groups and mentoring programs

### 3. Support Strategies

**Children/Youth TAY**

- Childcare

**Children/Youth TAY**

- Transportation (including acquisition of driver’s licenses)

**Children/Youth TAY**

- Respite services for children, youth and parents

**Children/Youth TAY**

- Development of housing options including:
  - Temporary housing/shelter
  - Transitional housing while youth are waiting for a more permanent housing opportunity

**Children/Youth TAY**

- Independent Living Programs
Additional Support Strategies for TAY

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1. **Structural Strategies**

- **Integrated service agencies which provide and/or broker all services that a client needs (see list under activities and services)**

- **Supportive housing – where clients/ youth live, in congregate housing, independent scattered site housing or at home with parents/caregivers, support services are provided and personal service coordinators broker any services that are not available on site. Housing options should include places for women or men who are caring for their children.**

- **Wellness Recovery Action Planning – In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client’s needs and wants for home, job, friendship and family with the focus on life improvement.**

- **Integrated substance abuse and mental health services where a client/member/youth receives substance abuse and mental health services from one team with one plan for one person; specialized housing to accompany these services as appropriate.**

- **Integrated services with law enforcement, probation and courts for the purpose of crises response, alternatives to jail for those with serious mental illness and/or establishing mental health courts for clients who have criminal justice charges. Integrated forensic programs include ones similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program.**
Additional Structural Strategies for Older Adults

Adults TAY Older Adults

- Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and in operationalizing a wellness philosophy including the concepts of both recovery and resiliency

Adults TAY Older Adults

- Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate. A single PSC should follow transition age youth as they move from children and youth services into adult services and/or into the community as independent adults. Transfer out of a transition age program should be negotiated with the client and not occur until s/he feels connected with the adult mental health system or successfully moves out of the mental health system altogether

2. Service Strategies

Adults TAY Older Adults

- Outreach services to persons who are homeless or at risk of homelessness that involve persistent, non-threatening, outreach, and engagement strategies. These services should include the ability to provide for the immediate needs of an individual including, physical healthcare, food, clothing and shelter. This may require that service teams have access to immediate cash and/or vouchers for client needs.

Adults TAY Older Adults

- Integrated assessment teams that provide comprehensive mental health, social, physical health and substance abuse assessments which are strength-based and focused on client/member engagement and which can provide cultural specific assessments as is in the DSM-IV-R cultural formulation.
Additional Service Strategies for Older Adults

- Assertive community treatment (ACT) teams; ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, 7 days a week, 365 days a year (Source: National Alliance for the Mentally Ill).

- 24 hour, 7 day a week response by Personal Service Coordinators to consumers, family members, law enforcement or landlords to reduce incidents of hospitalization, incarceration and/or eviction.

- Peer supportive services and client and family run services

- Education for clients and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.

- Classes regarding what clients need to know for successful living in the community
Additional Service Strategies for Older Adults

- Supportive employment and other productive activities, including development of job options for clients such as social enterprises, agency, supported positions, and competitive employment options.

- Vocational services

- Supportive education

- Family support, education, and consultation services, parenting support and consultation services, self-help groups and mentoring.

- Values-driven evidence-based clinical services that are integrated with overall service planning and support housing, employment, and/or education goals.

- Trauma-informed services for women, including women with co-occurring disorders

- On-site services in primary care clinics to reach clients of ethnic cultures and others who may be more responsive to services in this setting; linkage for these clients to the full range of services

- On-site services in faith-based communities when culturally appropriate to reach clients of ethnic cultures and others who may be more responsive to services in this setting; linkage for these clients to the full range of services

- Client advocacy on criminal justice and child welfare issues
Additional Service Strategies for Older Adults

- Crisis services including:
  1. 24 hour crisis phone line
  2. Mobile crisis services
  3. Crisis stabilization unit or housing
  4. In-home respite services for families who are housing and supporting a family member with mental illness

- Integrated service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization and independent living skills

- Youth and family run services including peer support, self-help groups and mentoring programs

- Services to assist families in supporting youth during this period

- Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities or other factors

- Education and coordination of primary care providers to increase coordination and integration of mental health and primary care services

- Home care assistance, including training of caregivers and providers about enhancing the ‘therapeutic environment’ of the home
3. **Support Strategies**

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- Development of temporary housing options including:
  1. Temporary housing
  2. Transitional housing if the clients are waiting for a more permanent housing opportunity including housing options for parents who are caring for their children
  3. Respite housing
  4. Child care
  5. Transportation
  6. Independent Living Programs
  7. Recreation
  8. Supportive housing

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- Residential care facilities for elderly with therapeutic environments (including a supplemental rate for mental health services)

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- Supportive and independent employment or personal growth opportunities

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- Supportive and independent education opportunities

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- Ethnic specific social or community groups or other culture-based partners

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- Special services for seniors
  1. Senior centers
  2. Senior legal aid
  3. Adult day health care
  4. Adult day care
  5. Geriatric assessment centers
  6. Private caregiver resource centers
  7. Multi-Service Senior Programs
  8. Senior volunteer programs
  9. Foster Grandparents
  10. Senior nutrition centers

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- Grief/loss support groups

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- Community self help groups (i.e. COPD, Overeaters Anonymous, Hospice, cancer, asthma, pain, Parkinson’s, Alzheimer’s, Alanon, AA, NA.)
County Readiness Self-assessment for Implementation of the MHSA 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 (MHSA), 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 may want to (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 consumer 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. Consumer materials
         6. Client records
         7. Staff language and interactions with consumers
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 severe 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 severe 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?

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 a 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?
iv. Estimate what percentage of county clients in each of the categories below are:
   1. Adequately served (they are getting the amount and type of service that both they and their mental health provider believe is sufficient)
   2. Underserved (the client and the mental health provider agree that either they need a different type of service or the amount of service they are currently getting should be increased, but the service is not available)

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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 consumer 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.
Appendix B

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 “enroll” clients for whom they are requesting MHSA funds and track the services they receive throughout the mental health system.

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:

- Housing
- Criminal 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

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, enrollment and new services/programs/supports pertinent to the MHSA, evidence-based practices, and process between various levels of care and/or disengagement from the mental health system. 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 promotion, fidelity to evidence-based 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 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.
Appendix C

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 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 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 consumers, 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:
   - Focus on increasing skills and competencies for both children and their parents/caregivers
   - 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 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.

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:

- 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 element 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.
Appendix D

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 consumers, 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
   - Consumers 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 consumers 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 and 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 treatment 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
- Supervision of 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, i.e. 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 should be identified through a single plan and personal service coordinator
- Clients have access to and availability of staff who are aware of them 24/7 by phone, in person, or e-mail as appropriate
- 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
## COUNTY OPERATIONS NORTH & SOUTH REGIONAL LISTING

**DEPARTMENT OF MENTAL HEALTH**

### NORTH/BAY

<table>
<thead>
<tr>
<th>Region</th>
<th>Chief</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Bay Region</td>
<td>JoAnn McLevis</td>
<td>(916) 654-6605</td>
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</table>

- **Ruth Walz (Regional Lead)**
  - Bay Region
  - Phone: (707) 252-3168
  - Contra Costa, San Mateo, Solano, *Sacramento*

- **Peter Best**
  - Phone: (916) 657-3487
  - Alameda, Monterey, Napa, San Benito, San Francisco, *Fresno*

- **Douglas Mudgett**
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  - Marin, Santa Clara, Santa Cruz, Sonoma, *San Joaquin*

### Northern Region

- **Kathleen Carter (Regional Lead)**
  - Phone: (916) 651-6613
  - *Butte* *Colusa*, Del Norte, Inyo, Lake, Lassen, Mendocino, *Modoc*, Nevada, Plumas, Trinity

- **Harold Curtis**
  - Phone: (916) 654-1206
  - Glenn, Humboldt, Shasta, Siskiyou, Tehama *(Sierra – see Central / Lori Hokerson)*

### SOUTH/CENTRAL

<table>
<thead>
<tr>
<th>Region</th>
<th>Chief</th>
<th>Phone</th>
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<tbody>
<tr>
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- **Lori Hokerson (Acting Lead)**
  - Phone: (916) 651-6296
  - Amador, El Dorado, Merced, Placer *(Sierra MHP)*, Stanislaus, Sutter-Yuba, Tulare, Yolo

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- **Eddie Gabriel (Regional Lead)**
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- **Troy Konarski**
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*Temporary Assigned Counties*