

California

UNIFORM APPLICATION 2011

STATE PLAN COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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Center for Mental Health Services

Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

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FACE SHEET
FISCAL YEAR/S COVERED BY THE PLAN
X FY2011

STATE NAME: California
DUNS #: 80-888-6063

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Mental Health
ORGANIZATIONAL UNIT: Office of the Director
STREET ADDRESS: 1600 9th Street, Room 151
CITY: Sacramento STATE: CA ZIP: 95814
TELEPHONE: (916) 654-2309 FAX: (916) 654-3198

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Stephen W. Mayberg, Ph.D. TITLE: Director
AGENCY: Department of Mental Health
ORGANIZATIONAL UNIT: Office of the Director
STREET ADDRESS: 1600 9th Street, Room 151
CITY: Sacramento STATE: CA ZIP CODE: 95814
TELEPHONE: (916) 654-2309 FAX: (916) 654-3198

III. STATE FISCAL YEAR

FROM: 07/01/2010 TO: 06/30/2011

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: John Lessley TITLE: Chief
AGENCY: Department of Mental Health
ORGANIZATIONAL UNIT: State Level Programs
STREET ADDRESS: 1600 9th Street
CITY: Sacramento STATE: CA ZIP: 95814
TELEPHONE: (916) 654-3535 FAX: (916) 654-2739 EMAIL: John.Lessley@dmh.ca.gov

Please respond by writing an Executive Summary of your current year's application.

EXECUTIVE SUMMARY (SAMHSA COMMUNITY MENTAL HEALTH BLOCK GRANT)

The California Department of Mental Health (DMH) developed this two-year (Federal Fiscal Years [FFY] 2010) Community Mental Health Block Grant Application in collaboration with the California Mental Health Planning Council (CMHPC). This is an update for year two of California's first multi-year submission.

California has a decentralized mental health delivery system with most direct services provided through the County Mental Health Departments with their local partners. This system of community-based mental health services was initiated through the Short-Doyle Act passed in 1957. The purpose of this Act was to develop a community-based system of services to improve care and encourage deinstitutionalization. The Act requires the DMH to provide leadership in administering, planning, financing and overseeing mental health services, including local programs. Mental health services were funded primarily from state funds, with a required county match for certain services.

A new funding system, commonly known as "Realignment," was implemented in 1991. This transferred financial responsibility and a dedicated funding base (from specified revenue sources), provided for by statute, for most of California's mental health programs from the state to local governments. Thus, counties were permitted to partake in the development and oversight of programs uniquely tailored to their clientele.

In November 2004, the Mental Health Services Act (MHSA) was passed by the California voters and became law in January 2005. The funding for the MHSA is achieved through an additional 1% income tax placed on Californians whose adjusted gross income is in excess of one million dollars. The MHSA was designed to expand mental health services to persons who have serious mental illness (SMI) or serious emotional disturbance (SED) and whose service needs are not being met through other funding sources. It addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system.

California continues to face challenges and issues related to providing and funding mental health services:

1. California's public mental health system has had inordinate demands placed upon it and continues to face fiscal challenges to meet demands for services. Like most public services, funding for mental health services, including MHSA generated revenues has been adversely affected by the recent economic situation.
2. Stigma and cultural bias continue to be major issues impacting access to mental health services. One of the overall goals of the MHSA is to eliminate disparities among ethnic and racial groups, as well as in urban and rural counties. The MHSA envisions a system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children and youth with SED and their families.

3. California also experiences an ongoing shortage of mental health providers, specifically child psychiatrists, community-based counselors and psychiatric nurse practitioners. DMH is currently working with the CMHPC in addressing issues related to the challenges in recruitment and retention of mental health workers as well as reducing the stigma of working in the mental health field. DMH, along with the CMHPC, is committed to increasing the quantity and quality of trained persons available for employment in the mental health system while increasing family and consumer involvement in service delivery and encouraging development of a diverse workforce.

SAMHSA Block Grant funds are allocated to 58 Local County Mental Health Departments. These agencies provide a broad array of treatment services within their local systems of care. DMH's goal continues to be to use the SAMHSA funds to assist participating counties in providing an appropriate level of community mental health services to the most needy residents who have a mental health diagnosis, and/or residents who have a mental health diagnosis with a co-occurring substance abuse disorder.

OVERVIEW OF APPLICATION UPDATE

The DMH is responsible for accepting and distributing the Community Mental Health Services (CMHS) Block Grant funds; DMH received \$53,996,249 in federal block grant monies for FFY 2010 (State Fiscal Year [SFY] 2010-11) and it is anticipated DMH will receive approximately \$53,696,045 for FFY 2011 (SFY 2011-12).

This document is an update to the FFY 2010-11 multi-year application for year two of a two-year grant. This was California's first multi-year submission which provided the state and its partners (including the CMHPC) with greater opportunities to further enhance their collaborative efforts towards improving the access and quality of mental health services in the state. This application contains updated responses to the grant requirements (e.g., State Performance Indicators) and includes the necessary assurance forms and fiscal information.

The application begins with a general overview of California's public mental health system, with a special focus on the identification and analysis of the State's system strengths, needs and priorities for the programs and services targeted to adults with SMI and children and youth with SED. With the MHSAs now almost in full operation, there are many new and exciting developments in the areas of workforce development, prevention and early intervention (PEI), housing, innovations and full service partnerships (FSPs). To a greater extent, California is making advancements in the promotion of wellness and recovery of adults and older adults, and resiliency for children and their families; the expansion of services for transition age youth (TAY); and human resource development in the mental health field.

The CMHPC reviewed the grant application and made recommendations to the DMH for improvements (which were promptly addressed in the application). The application was also made available for public comment.

MAINTENANCE OF EFFORT (MOE) REPORT CLARIFICATION

Please note that in California’s applications prior to this year’s update, MOE Reports were calculated using estimated, rather than actual, expenditures. In all cases, actual expenditures were less than the estimates.

Future applications and updates will include reconciled MOE Reports with the most current actual expenditure data that is available at the time of submission.

Two tables below outline the clarifications for total state expenditures and the Children’s Set-Aside. The figures with the strikethrough indicate the estimated dollar amounts that were included in previous state applications, while the actual figures below indicate the correct actual dollar amount.

State Expenditures for Mental Health Services (source: DMH Budgets)

<u>SFY 2008-09</u>	<u>SFY 2009-10</u>	<u>SFY 2010-11</u>
\$2,098,317,000 (estimate)	\$1,603,946,000 (estimate)	\$1,653,431,000 (estimate)
\$1,805,127,000 (actual)	\$1,554,776,000 (actual)	

Set-Aside for Children’s Mental Health Services (source: DMH Budgets)

<u>SFY 2008-09</u>	<u>SFY 2009-10</u>	<u>SFY 2010-11</u>
\$282,524,955 (estimate)	\$217,217,289 (estimate)	\$213,402,000 (estimate)
\$239,497,005 (actual)	\$208,712,000 (actual)	

FREQUENTLY USED ACRONYMS

AD	Applications Development (Section)
ADP	Alcohol and Drug Programs
ADT	Admission/Discharge/Transfer System
AOD	Alcohol and Other Drug
ASOC	Adult Systems of Care Subcommittee
BHL	Behavioral Health Outreach Liaison
CalHFA	California Housing Finance Agency
CalWORKS	California Work Opportunities and Responsibility to Kids
CBMCS	California Brief Multicultural Competence Scale
CCAC	Cultural Competency Advisory Committee
CCC	Cultural Competence Committee
CC/ESM	Cultural Competence Ethnic Services Manager
CLCC	Cultural and Linguistic Competence Committee
CCM	County Contract Monitoring (System)
CCPR	Cultural Competence Plan Requirements
CDCR	California Department of Corrections and Rehabilitation
CDE	California Department of Education
CFRS	County Financial Reporting System
CFSR	Child and Family Services Reviews
CFTN	Capital Facilities and Technological Needs
CHDP	Child Health and Disability Prevention (Program)
CHIS	California Health Interview Survey
CIMH	California Institute for Mental Health
CIMH CMD	California Institute for Mental Health Center for Multicultural Development
CMD	Center for Multicultural Development
CMHDA	California Mental Health Directors Association
CMHPC	California Mental Health Planning Council
CMMC	California Multicultural Coalition
CMHS	Center for Mental Health Services (Federal)
CMS	Centers for Medicare and Medicaid Services
CNG	California National Guard
CNMHC	California Network of Mental Health Clients (aka "the Network")
COD	Co-Occurring Disorder
COJAC	Co-Occurring Joint Action Council
CONREP	Conditional Release Program
CPES	Collaborative Psychiatric Epidemiology Surveys
CPYP	California Permanency for Youth Project
CRC	Caregiver Resource Center
CRIPA	Civil Rights of Institutionalized Persons Act

CRS	Cost Recovery System
CRTS	Community Residential Treatment Systems
CSI	Client and Service Information
CSS	Community Services and Support
CTF	Community Treatment Facilities
CWC	Child Welfare Council
CYSOC	Children and Youth Systems of Care
DCR	Data Collection and Reporting
DDS	California Department of Developmental Services
DHCS	California Department of Health Care Services
DHHS	U.S. Department of Health and Human Services
DIG	Data Infrastructure Grant
DJJ	California Division of Juvenile Justice
DMH	California Department of Mental Health
DOF	California Department of Finance
DOJ	California Department of Justice
DOR	California Department of Rehabilitation
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSS	California Department of Social Services
DSS/CCLD	California Department of Social Services - Community Care Licensing Division
DVA	California Department of Veterans' Affairs
ECA	Epidemiological Catchment Area
EHR	Electronic Health Records
EMHI	Early Mental Health Initiative
EOB	SD/MC Explanation of Balances
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FAS	Fiscal Automation System
FEMA	Federal Emergency Management Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FSP	Full Service Partner
FY	Fiscal Year
GAF	Global Level of Functioning
GHI	Governor's Homeless Initiative
HCBS	Home and Community-Based Services
HCD	California Department of Housing and Community Development
HFP	Healthy Families Program
IDDT	Integrated Dual Diagnosis Treatment
IDEA	Individuals with Disabilities Education Act

IEP	Individualized Education Plan
IFB	Invitation for Bid
IMD	Institution for Mental Disease
IMR	Illness Management and Recovery
IPC	Inpatient Consolidation System
ITWS	Information Technology Web Server
LEA	Local Education Agency
LEAP	Limited Examination and Appointment Program
LMHD	Local Mental Health Department
LTCS	Long Term Care Services
MBP	Master Billing Project
MDO	Mentally Disordered Offender (System)
MEDS	Medi-Cal Eligibility Data System
MFT	Marriage and Family Therapist
MHLAP	Mental Health Loan Assumption Program
MHRC	Mental Health Rehabilitation Center
MHSA	Mental Health Services Act
MHSIP	Mental Health Statistics Improvement Program
MHSOAC	Mental Health Services Oversight and Accountability Commission
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MRMIB	Managed Risk Medical Insurance Board
NAMI	National Alliance for the Mentally Ill
NCS-R	National Co-Morbidity Study - Revised
NHRA	Nursing Home Reform Act
NIM	New Institutions for Mental Disease
OASOC	Older Adult System of Care Subcommittee
OBRA	Omnibus Budget Reconciliation Act
OBRA-87	Omnibus Budget Reconciliation Act of 1987
OMS	Office of Multicultural Services
OPR	Office of Patients' Rights
OSD	Ombudsman's Services Data (System)
OSHPD	Office of Statewide Health Planning and Development
OSHPD-HPEF	OSHPD Health Professions Education Foundation
OWH	Operation Welcome Home
PAMI	Protection and Advocacy for Individuals with Mental Illness Act
PASRR	Pre-Admission Screening and Resident Review
PATH	Projects for Assistance in Transition from Homelessness
PEI	Prevention and Early Intervention
PHF	Psychiatric Health Facility
PHO	Pharmacy Hospital Operations

PIP	Performance Improvement Project
PM	Performance Measures
POS	Physicians' Orders System
PRV	Provider System
PTSD	Post Traumatic Stress Disorder
QI	Quality Improvement
RD	Reducing Disparities
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration Block Grant (Federal)
SCHIP	State Children's Health Insurance Program
SD/MC	Short-Doyle/Medi-Cal
SED	Severely Emotionally Disturbed
SFY	State Fiscal Year
SHIA	Supportive Housing Initiative Act
SHOES	State Hospital Outcome and Evaluation System
SIT	State Interagency Team
SJAC	Social Justice Advisory Committee
SMHA	State Mental Health Agency
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOC	Systems of Care
SPMI	Severe and Persistent Mental Illness
SPW	Strategic Planning Workgroup
SRC	Statewide Resources Consultant
SSI	Supplemental Security Income
SSP	State Supplemental Payment
STP	Special Treatment Programs
SUR	Service Usage Report
SVP	Sexually Violent Predator
TACS	Trust Accounting Cashiering System
TANF	Temporary Assistance to Needy Families
TAR	Treatment Authorization Request
TAY	Transition Age Youth
TBI	Traumatic Brain Injury
TBS	Therapeutic Behavioral Services
THP-Plus	Transitional Housing Placement Plus Program
TOS	Treatment Outcome System
UACF	United Advocates for Children and Family
USDOJ	United States Department of Justice
UTMB	University of Texas, Medical Branch

WARMSS	Wellness and Recovery Model Support System
WET	Workforce Education and Training
YSS-F	Youth Services Survey for Families
YSS-Y	Youth Services Survey for Youth

Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2011

I hereby certify that California agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State¹ will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

²¹. The term State shall hereafter be understood to include Territories.

- (A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
 - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
 - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
- (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
- (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
- (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
- (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Governor

Date

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
 Office of Grants Management
 Office of the Assistant Secretary for Management and Budget
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE	
APPLICANT ORGANIZATION		DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <div style="display: flex; justify-content: space-between;"> Prime Subawardee </div> <div style="margin-left: 150px;"> Tier _____, if known: </div> Congressional District, if known:		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known:
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
- 10.(a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

PUBLIC COMMENTS ON THE 2011 STATE PLAN APPLICATION UPDATE

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide the opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner as to facilitate comment from any person (including federal or other public agency) during the development of the plan (including any revisions) and after submission of the plan to the Secretary.

To accomplish this goal, California will post the State Plan update on its main website at www.dmh.ca.gov for public review and comments. The public may either download the State Plan update or view it online, and then offer comments via email to an identified contact person from DMH. Agencies that do not have access to a computer or the Internet will be able to request (via First Class mail) one hardcopy of the 2011 State Plan update and forward any comments in writing to the Department.

The document will also be available on WebBGAS for public comment this year.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2009	Estimate/Actual FY 2010
<u>\$160,683,000</u>	<u>\$217,217,289</u>	<u>\$213,402,000</u>

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY X Federal FY _____

State Expenditures for Mental Health Services

Actual FY Actual FY Actual/Estimate FY

2008	2009	2010
<u>\$2,098,317,000</u>	<u>\$1,603,946,000</u>	<u>\$1,653,431,000</u>

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall.

These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

**TABLE 1.
Members**

List of Planning Council

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Abbott, Beverly	Others(not state employees or providers)	Consumer-Relations Advocate	13000 Skyline Blvd. Woodside, CA 94062 PH:(650) 851-8469 FAX:(208) 361-3109	Bjkabbott@aol.com
Allen, Karen	State Employees	Education	1430 N Street Suite 2401 Sacramento, CA 95814 PH:(916) 322-1645 FAX:(916) 327-3706	kallen@cde.ca.gov
Benjamin, MSW, MHA, Lin	State Employees	Social Services	1300 National Dr. Suite 200 Sacramento, CA 95834 PH:(916) 928-7890 FAX:(916) 928-2507	lbenjamin@aging.ca.gov
Black, John	Consumers/Survivors/Ex-patients(C/S/X)		800 Scenic Avenue Modesto, CA 95351 PH:(209) 525-7368 FAX:	jblack@stancounty.com
Boewer, Curtis	Providers		162 E. Carson St Suite A Colusa, CA 95932 PH:(530) 458-0822	cboewer@gmail.com

			FAX:(530) 458-7751
Bukosky, Jorin	Providers		623 58th Street jorinb@yahoo.com Lower Front Flat Oakland,CA 94609 PH:(510) 882-9771 FAX:(415) 776-1018

**TABLE 1.
Members**

List of Planning Council

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Burke, Shebuah	Consumers/Survivors/Ex-patients(C/S/X)		900 S. Beach Blvd., #232 Anaheim, CA 92804 PH:(714) 720-1277 FAX:	shebuah@ochca.com
Cabrera, Sophie	State Employees	Mental Health	1600 9th Street, Room 100 Sacramento, CA 95814 PH:(916) 654-6605 FAX:(916) 654-5591	Sophie.Cabrera@dmh.ca.gov
Cavagnaro, Ph.D., Andrew	State Employees	Other	1600 9th St. Room 330, MS 3-22 Sacramento, CA 95814 PH:(916) 654-2811 FAX:(916) 654-3464	andrew.cavagnaro@dds.ca.gov
Cease, Doreen	Family Members of adults with SMI		2717 Mary Street La Cresecenta, CA 91214 PH:(818) 957-6921 FAX:(818) 249-2061	cease_doreen@lacoed.edu
Cedro-	Others/not state	Consumer	550 South Vermont Ave. , 6th Fl. Los Angeles CA	ahament@dmh.lacounty.gov

Hament, Adrienne	Others (not state employees or providers)	Relations Advocate	Los Angeles, CA 90020 PH:(213) 738-4395 FAX:(213) 386-1297	
Cunningham, Michael	State Employees	Social Services	1700 K St. Executive Office, 5th Floor Sacramento, CA 95811 PH:(916) 322-3563 FAX:(916) 324-7338	mcunningham@adp.ca.gov

**TABLE 1.
Members**

List of Planning Council

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Ford, Nadine	State Employees	Housing	1800 3rd St. Sacramento, CA 95814 PH:(916) 327-3942 FAX:(916) 445-0117	nford@hcd.ca.gov
Fraser, CRC, Lana	State Employees	Vocational Rehabilitation	2000 Evergreen Street Sacramento, CA 95815 PH:(916) 263-8744 FAX:(916) 263-7495	lfraser@dor.ca.gov
Fry, Jr., George	Consumers/Survivors/Ex-patients(C/S/X)		P.O. Box 35 Angels Camp, CA 95222 PH:(209) 736-4868 FAX:(209) 736-4868	beepbeeproadrnr@aol.com
Garcia, Psy.D., Luis	Family Members of adults with SMI		800 South Santa Anita Arcadia, CA 91006 PH:(626) 254-5009 FAX:(626) 294-1077	lgarcia@pacificclinics.org
Hart, Karen	Family Members of Children with SED		291 San Bernabe Dr. Monterey, CA, CA 93940 PH:(831) 373-	khart55@sbcglobal.net

			3966 FAX:(831) 373-3966	
Henning, Patrick	State Employees	Mental Health	1121 L St. Suite 502 Sacramento, CA 95814 PH:(916) 806-0788 FAX:(916) 447-4048	phenning@calaborers.org

**TABLE 1.
Members**

List of Planning Council

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Hunter, Celeste	Family Members of Children with SED		3434 Midway Dr. San Diego, CA 92110 PH:(619) 546-5852 FAX:(619) 546-6251	chunter1247@cox.net
Jordan, MD, Grant	State Employees	Criminal Justice	9825 Goethe Rd. Sacramento, CA 95827 PH:(916) 255-2758 FAX:(916) 255-2806	grant.jordan@cdcr.ca.gov
Lee, Carmen	Consumers/Survivors/Ex-patients(C/S/X)		1633 Sixth Ave., Suite 7 Belmont, CA 94002 PH:(650)592-2345 FAX:	carmensos@aol.com
Lee, Marissa Minna	Consumers/Survivors/Ex-patients(C/S/X)		1200 Wilshire Blvd. Suite 302 Los Angeles, CA 90017 PH:(213) 250-5030 x107 FAX:(213) 250-5040	mlee@achsa.net
Mandel, Ph.D., Susan	Providers		800 South Santa Anita Ave Arcadia, CA 91006 PH:(626)254-5009	smandel@pacificclinics.org

			FAX:(626)294-1078	
Martinez, Ph.D., Art	Providers		P.O. Box 1341 Shingle Springs, CA 95682 PH:(775) 781-0704 FAX:	chumash54@yahoo.com

**TABLE 1.
Members**

List of Planning Council

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Mitchell, Barbara	Providers		P.O. Box 3222 Monterey, CA 93942 PH:(831) 649-4522 FAX:(831) 647-9136	bmitchell@interiminc.org
Montoya, Jennie	Family Members of adults with SMI		1212 N. California St. Stockton, CA 95202 PH:(209) 468-8486 FAX:(209) 468-3516	jmontoya@sjcbhs.org
Mortz, Joseph	Consumers/Survivors/Ex-patients(C/S/X)		756 El Rio St. Apt. B Ukiah, CA 95482 PH:(707) 467-9261 FAX:	joemortz@hotmail.com
Mueller, Ed.D., RN, Dale	Providers		1327 Brookside Ct. Upland, CA 91784 PH:(909) 920-5854 FAX:(909) 920-6046	dmueller@earthlink.net
Nibbio, Jonathan	Providers		3765 S. Higuera St., Ste 100 San Luis Obispo, CA 93401	jnibbio@fcni.org

			PH:(805) 781-3535 FAX:(805) 781-3538	
Nickerson, Gail	Others(not state employees or providers)	Consumer- Relations Advocate	2100 Douglas Blvd. Roseville, CA 95661 PH:(916) 774-7308 FAX:(916) 774-7310	nickergw@ah.org

TABLE 1.

Members

List of Planning Council

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
O'Meara, Ph.D., Kathleen	State Employees	Criminal Justice	501 J St. Suite 400 Sacramento, CA 95811 PH:(916) 323-1163 FAX:	kathleen.omeara@cdcr.ca.gov
Refowitz, Mark	Providers		405 West 5th Street, 7th Fl. Santa Ana, CA 92701 PH:(714) 834-6023 FAX:(714) 834-5506	mrefowitz@ochca.com
Ryan, John	Providers		199 N. Morning Glory Street Brea, CA 92821 PH:(714) 528-2498 FAX:	seasane1@aol.com
Shaw, Daphne	Providers	California Coalition for Mental Health	P.O. Box 690040 Stockton, CA 95269 PH:(209) 461-5170 FAX:(209) 467-6513	dshaw1@sbcglobal.net
Shwe, Walter	Consumers/Survivors/Ex-patients(C/S/X)		24083 Fairway Drive Davis, CA 95616 PH:(530) 746-8360 FAX:	walter@shwe.com
Sperbeck			1600 9th St. Room 460 Sacramento, CA 95811	esperbec@chhs.ca.gov

Supervisor, Erika	State Employees	Other	93014 PH:(916) 651- 6694 FAX:(916) 654- 3343	
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TABLE 1.

List of Planning Council

Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Stout, Linne	State Employees	Social Services	744 P Street Mail Station 11-83 Sacramento, CA 95814 PH:(916) 651-6600 FAX:(916) 651-6239	linne.stout@dss.ca.gov
Thal, MFT, Stephanie	Providers		P.O. Box 2137 Kernville, CA 93238 PH:(760) 376-4448 FAX:(760) 376-6700	steviemft@aol.com
Walker, LCSW, Edward	Providers		50 Van Tassel Court San Anselmo, CA 94960 PH:(415) 453-5023 FAX:(415) 453-9998	epwalker@sbcglobal.net
Wilson, Susan	Family Members of Children with SED		424 Rosewood Dr. Redding, CA 96003 PH:(530) 243-7760 FAX:	swilson@shastacoe.org
Wilson Ph.D., Monica	Others(not state employees or providers)	Consumer-Relations Advocate	2832 Longhorn Street Ontario, CA 91761 PH:(951) 541-1472 FAX:(773) 409-0207	monimarsh@gmail.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	41	
Consumers/Survivors/Ex-patients(C/S/X)	7	
Family Members of Children with SED	3	
Family Members of adults with SMI	3	
Vacancies(C/S/X and Family Members)	3	
Others(not state employees or providers)	4	
TOTAL C/S/X, Family Members and Others	17	41.46%
State Employees	12	
Providers	12	
Vacancies	1	
TOTAL State Employees and Providers	24	58.54%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification

serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

the role of the Planning Council in improving mental health services within the State.

In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL CHARGE (per California Statutes: Welfare and Institutions Code Sections 5571 – 5572)

5771. (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in such a manner as to ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Mental Health shall make appointments from nominees from mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a vice chairperson.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

5771.3. (a) The California Mental Health Planning Council may utilize staff of the State Department of Mental Health, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

5771.5. (a) (1) The chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health programs.

- (b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Mental Health, local boards, and local programs.
- (c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:
 - (1) To review and approve the performance outcome measures.
 - (2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Mental Health and other sources.
 - (3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Mental Health, and the local boards.
 - (4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.
- (d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Mental Health shall investigate and review the finding, and report the action taken to the Legislature.
- (e) To advise the Legislature, the State Department of Mental Health, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.
- (g) To make recommendations to the State Department of Mental Health on the award of grants to county programs to reward and stimulate innovation in providing mental health services.
- (h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.
- (i) To participate in the recruitment of candidates for the position of Director of Mental Health, and provide advice on the final selection.
- (j) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.
- (k) To advise the Director of Mental Health on the development of the state mental health plan and the system of priorities contained in that plan.
- (l) To assess the effect of realignment of mental health services from the state to the counties on the delivery of those services, and report its findings to the Legislature, the State Department of Mental Health, local programs, and local boards no later than January 1, 1995
- (m) To suggest rules, regulations, and standards for the administration of this division.
- (n) When requested, to mediate disputes between counties and the state arising under this part.
- (o) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.
- (p) To accept any federal fund granted, by act of Congress or by executive order, for purpose within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.
- (q) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purpose within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL ROLES AND ACTIVITIES

The CMHPC has been an invaluable instrument for public involvement in mental health planning. It has been particularly effective as a vehicle for the involvement of clients and families. In addition to the federal planning duties, state law includes additional responsibilities and duties that are critically important to the provision of public input, such as system accountability and oversight.

The duties of the CMHPC include:

- Advocating for effective, quality mental health programs;
- Reviewing, assessing, and making recommendations regarding all components of the mental health system, and reporting, as necessary, to the Legislature, the DMH, local boards, and local mental health programs;
- Reviewing program performance in the delivery of mental health services by annually reviewing performance outcome data and reporting findings and recommendations to the DMH, the Legislature, and local mental health programs;
- Advising the Legislature, the DMH, and county boards on mental health issues, policies, and priorities that the State should be pursuing;
- Reviewing the State's data systems and paperwork requirements to ensure they are reasonable;
- Participating in the recruitment of candidates for Director of Mental Health;
- Making recommendations to the DMH on the awarding of grants to county programs to reward and stimulate innovation;
- Conducting public hearings on the State mental health plan, the Mental Health Block Grant, and other topics as needed;
- Assisting in the coordination of training and information dissemination to local mental health boards;
- Advising the Director on the development of the State mental health plan and its priorities;
- Suggesting rules, regulations, and standards for the administration of mental health programs;
- Mediating disputes between the State and counties when requested; and
- Accepting federal or private grants and donations.

The CMHPC conducts its work by convening four three-day meetings per year. In addition to holding committee meetings, the CMHPC holds two half-day sessions of the full body devoted to education of its members, oversight of the State's mental health system, and advocacy for adults and older adults with SMI and children and youth with SED and their families. For a number of years, the CMHPC has organized its meetings around themes for maximum cohesion and impact. Previous themes have focused on increasing the availability of affordable housing and examining the financing structure of the public mental health system, and oversight of implementing the MHSA. The MHSA is California's landmark proposition that is transforming its mental health system from a "fail first" to a "help first" system.

The current theme is "Vital Signs: Critical Issues about the Functions and Performance of the Mental Health System." In working on this theme, the CMHPC has sought input from major mental health constituency groups serving adults, children and youth, and older adults. These organizations have been asked to report on the extent of unmet need for mental health services, major problems with the delivery of mental health services, and major public policy issues on which the organization is focusing. This project has produced a comprehensive set of recommendations that will feed into the strategic planning efforts for the CMHPC committees.

The CMHPC has solicited presentations from the DMH to take the pulse of the public mental health system. These presentations have included information on the prevalence rates of SMI among each of the target populations and the utilization of services, which provided a picture of unmet need, and data on retention in services. The DMH also profiled the effectiveness of the mental health services by reporting on the consumer perception of care surveys and the results of serving mental health clients in FSPs, which represent clients being served by the MHSA.

The CMHPC has examined the fiscal underpinnings of the public mental health system, examining the relative contribution and revenue projections for realignment funds, state General Funds, federal financial participation (FFP), MHSA funds, and other funding sources. The presentations have provided recommendations to increase the stability and flexibility of these funding sources in order to maximize the ability of funding streams to provide needed mental health services.

Presentations have also examined specific crises in the mental health system, such as the shortage of inpatient acute psychiatric beds. The California Hospital Association reported that only 27 out of 58 of California's counties have acute psychiatric hospital beds. Shortages also exist in access to restrictive residential setting for children and youth. As a potential solution for the shortage of adult acute psychiatric beds, a model for providing crisis residential services was presented.

This theme is also examining specific evidence-based practices. One meeting was devoted to the integration of primary care and behavioral healthcare with presentations on a program serving children ages 0-5, on the IMPACT model for serving older adults, and on a rural health clinic to highlight the unique challenges of providing care in that setting. A future meeting will focus on services integrating mental health services with substance abuse treatment.

Future presentations will target underserved populations: foster youth with serious emotional disturbances and adults with mental illness who are criminalized by their contact with jails and prisons.

The CMHPC is organized into five standing committees. Four committees focus on policy issues consistent with the priorities agreed on by the membership: the Cultural Competence Committee (CCC), the Quality Improvement (QI) Committee, the Policy and System Development Committee, and the Human Resources Committee. The fifth standing committee, the System of Care Committee, addresses system of care and treatment issues for children and youth, TAY, adults, and older adults. The CMHPC also will continue to advise the DMH regarding the federal block grant application, including the PL 106-310 State Plan for Comprehensive Community Mental Health Services and the annual Implementation Report.

The CMHPC's committees are currently focusing their energy and attention on a number of projects:

- The CCC is committed to ensuring that cultural competence is embedded into the decision-making process of each CMHPC committee. The promotion of cultural awareness and the value of diversity will be incorporated into the operation of the CMHPC. As one step toward enhancing the cultural competence of presentations at CMHPC meetings, the CCC developed a comprehensive set of guidelines and strategies for speakers for infusing principles, content, and themes related to cultural and linguistic competence into their presentations. The CCC is also charged with increasing the cultural competence of the CMHPC. To that end, it has arranged several experiential exercises for members. One exercise was to access the Project Implicit website to test unconscious sources of bias, and another exercise was the World View exercise where members delved into the various societal influences that shaped their values and beliefs.

The CCC is also monitoring trends in access to and appropriateness of mental health services to racial/ethnic groups. This project includes identifying relevant performance indicators to measure disparities, obtaining data, and determining factors that cause these disparities.

- The QI Committee has several on-going responsibilities that form the foundation of the committee's work: 1) participating in the development of a QI system for the public mental health system, and 2) providing oversight of the DMH and county mental health programs. Developing a QI system relates to a mandate in state law that the DMH develop performance outcome measures to assess whether mental health services improve the quality of clients' lives and are cost effective. The CMHPC has developed an approach to system oversight and accountability that can be found in the *California Mental Health Master Plan: A Vision for California*¹:

One of the CMHPC's other primary responsibilities is to work with county mental health boards and commissions to help them understand and interpret their data collected on performance indicators at the local level and to provide information that can be used for the

¹ This publication can be accessed at the CMHPC publication website:
http://www.dmh.ca.gov/Mental_Health_Planning_Council/Reports.asp

CMHPC to develop statewide reports. The committee is developing a workbook that will provide county mental health boards and commissions with a uniform reporting format. This workbook will also provide specific performance indicators on which they can report with sufficient background information to help boards and commissions better understand and interpret the data within their local context.

The QI Committee's other current projects consist of monitoring the development of the implementation of the MHSA and providing input to the design of the performance measurement system. The CMHPC is mandated in the Welfare and Institutions Code Section 5772(c)(1) to review and approve performance measures (PMs). Consequently, it will have to approve the design of the performance measurement system developed for the MHSA.

- The Policy and System Development Committee is focusing on a number of issues. One of those issues is the fiscal stability of the public mental health system. It is examining the impact of recent budget cuts on county mental health departments' ability to deliver core mental health services. It is also looking at policies governing the funding of the MHSA to see if they can be altered to better integrate the MHSA with core mental health services. The committee is also monitoring how recently proposed changes to the Medicaid regulations will affect mental health services in California. Finally, the committee is monitoring the development of supported housing through a number of programs, including Proposition 46, Proposition 1C, and Proposition 63.
- The Human Resources Committee is continuing its activities on the Human Resource Project, addressing the critical human resources needs of the mental health system in California. This project is discussed in greater detail under Criterion 5: Management Systems for Adults and Children.
- The System of Care Committee's subcommittees each have projects on which they are working:
 - The Children and Youth System of Care Subcommittee (CYSOC) will primarily focus on the benefits of juvenile justice mental health courts in meeting the needs of children and youth. The CYSOC will study the juvenile mental health court model and prepare a final report, which will raise awareness about juvenile mental health courts and assist in advocating for the expansion of juvenile mental health courts throughout California. The CYSOC will also focus on what constitutes adequate continuum of care for youth and ways to maintain those components when the emphasis is on keeping children in their homes and communities with the assistance of wraparound, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, and other programs.
 - The TAY Subcommittee has as its goal to educate its members more fully on the issues and concerns of TAY from the perspective of youth and to move toward inclusion of TAY in every facet of CMHPC activities. The subcommittee is considering work on a number of issues, including hospitalization and incarceration of TAY and the potential of juvenile justice mental health courts to address this issue, outreach to underserved youth. The subcommittee just completed a major report entitled, "Transition Age Youth with

Emotional and Behavioral Disabilities: Toward Self-Sufficiency.” This report makes recommendations on appropriate assessment and referral to vocational and educational services so that TAY do not develop and unnecessary dependence on Social Security Income/State Supplemental Program (SSI/SSP).

- The Adult System of Care Subcommittee (ASOC) is focusing on oversight of the state hospitals and the interface between corrections and community mental health. In its efforts to monitor state hospitals, the ASOC will quarterly review the findings of the recent United States Department of Justice (USDOJ) audit pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The ASOC will also be identifying and promoting promising approaches to serving individuals in the community to prevent initial and repeated involvement with the criminal justice system.
- The Older Adult System of Care Subcommittee (OASOC) continues to advocate for increasing the level of services available to Older Adults with mental health needs in every California County. Utilizing data provided through the MHSA, the OASOC will continue to seek increased service availability for all Older Adults living in California. The subcommittee is dedicating time and energy to study the collaborations between service providers in different counties. The OASOC believes that through collaboration the level of services provided to Older Adults who need mental health services can be increased significantly and fragmentation of services can be reduced. With the number of older Californians projected to increase substantially over the next several years, the subcommittee believes it is imperative to increase services to this under represented group of citizens. The data the subcommittee examines will help identify those areas that need the most urgent attention. With this information, the OASOC will be prepared to continue its advocacy for the Older Adults in California who need help and services.

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of State's Mental Health System

MISSION STATEMENT

“The California Department of Mental Health (DMH), entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.”

ORGANIZATIONAL STRUCTURE

The DMH, located in Sacramento, has oversight of a public mental health budget of approximately \$5 billion, including local assistance funding. The organizational structure follows:

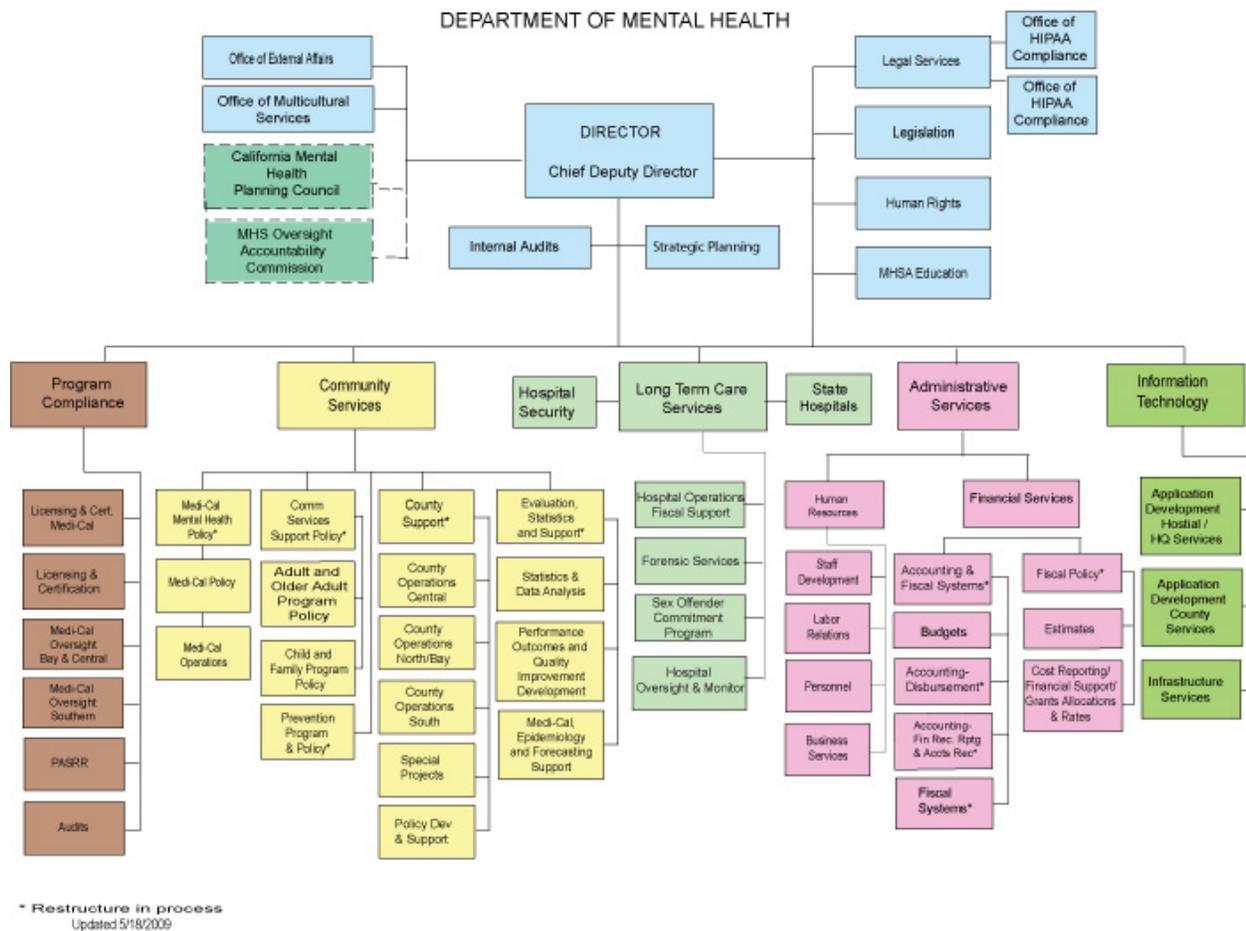
DMH employs approximately 12,000 employees at its headquarters office and at its five state hospitals.

As a state public agency, DMH has worked hard to transform and improve the state's mental health systems of care by working with the mental health constituency to develop a system of partnerships and coordinated interagency efforts. These models have provided the framework for success in developing department programs and coordinating services in the treatment of children and adults who are mentally ill.

Department staff constantly strive to find the most effective use of resources and innovation at all levels – not just in treatment, but in prevention and intervention as well. All programs are designed with the recovery process in mind.

DMH's state hospital programs have passed national rigorous accreditation reviews. Each hospital is staffed by professionally trained clinicians and administrative support team who provide full-time inpatient care to the most serious mentally ill and those incapable of living in the community. These referrals come from county mental health departments, the courts, the Department of Corrections and Rehabilitation (CDCR) and the Department of Juvenile Justice (DJJ). In recent years, the population of the state mental hospitals has shifted to a majority (approximately 90 percent) of forensic patients, and DMH has met this challenge by prioritizing and balancing state-of-the-art treatment and public safety.

The Director and Chief Deputy Director are appointed by the Governor. The DMH is organized into the following four major programs: Administrative Services; Program Compliance; Community Services; and Long Term Care Services (LTCS). DMH also has the following support functions: Legal Services; Human Rights; Legislation; Office of External Affairs; Office of Multicultural Services (OMS); and Office of Strategic Planning.



CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

California's public mental health system has evolved over the last four decades. This evolution has changed the role of the State and local governments in providing care. Mental health services have moved from being predominately hospital-based and provided by the State, to community-based and provided through local governments. Historically, community mental health programs have provided limited services.

Multiple State agencies provide health, mental health and related services. The primary agency for ensuring the provision of mental health services is the DMH. It operates five State Hospitals, oversees county-based mental health services and provides leadership on issues of policy and practice. The Department of Health Care Services (DHCS) is California's lead agency for Medi-Cal, which funds the treatment of some clients. The Department of Alcohol and Drug Programs (ADP), Department of Housing and Community Development (HCD), Department of Rehabilitation (DOR) with multiple others offer services or coordinate programs that are available to mental health clients. The primary public providers of mental health services are California's 58 county mental health agencies and two city agencies (Berkeley and Tri-City).

MENTAL HEALTH REALIGNMENT

In 1991 State legislation, known as Realignment, was enacted. It realigned fiscal and administrative responsibility under county authority, provided a more stable funding base for local mental health programs, appropriately shifted program operation and accountability to the local level, and brought about many changes in State administration of mental health services. Realignment also strengthened the cooperative relationships between the State and counties. As a result, the State now has significant responsibilities to maintain system oversight and integrity, and to facilitate and enable the counties to effectively provide needed mental health services.

In response to the structural changes brought about by realignment, the DMH now focuses its activities on the primary areas of community services, program compliance, and long-term care. State staff interface with counties through provision of technical assistance and consultation. Considerable effort has been dedicated to restructuring and innovative program design and development at the State Hospital campuses.

In summary, the State is responsible for maintaining system oversight and integrity, in order to assist counties in providing effective, critically needed services. Effective local services and coordination of major system changes and improvements are made possible because of the centralized oversight and facilitation roles played by the State.

DEPARTMENT OF MENTAL HEALTH RESPONSIBILITIES

At the State level, the DMH is responsible for:

- Leadership;
- Administration of federal funds;
- System oversight, evaluation, and monitoring;
- Direct services; and
- Administrative support.

Leadership

The primary role of the DMH is to provide leadership to the mental health system including planning, research, technical assistance, education, quality assurance, and program development of a broad array of initiatives for local services. Leadership activities include, but are not limited to:

- Implementing the State mission and goals for mental health services;
- Advocating for quality mental health services for California's citizens with mental illness;
- Maximizing the ability to utilize creative public and private financing opportunities;
- Providing appropriate planning, research, technical assistance, training, and program development;

- Encouraging ongoing collaborative efforts between clients, family members, providers and other members of the mental health constituency as well as interagency and cross-jurisdictional collaboration at the State level; and
- Implementation of the MHSA (Proposition 63), which provides state tax dollars for specific county mental health programs and services at the community level.

Administration of Federal Funds

- The DMH is also responsible for securing and ensuring the continuation of federal funds. All tasks related to the administration of federal funds, such as utilization review, quality management, and cost reporting and settlements are included in this category. This includes the administration of federal funding for the EPSDT benefit; Medi-Cal-funded psychiatric inpatient hospitals; Short Doyle/Medi-Cal (SD/MC); the annual Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant; and the annual Projects for Assistance in Transition from Homelessness (PATH) formula grant.
- The DMH also administers federal funding under the Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program following a Presidential Disaster Declaration and evident need for disaster mental health services that cannot be met through local government or state resources. Over \$71 million in FEMA Crisis Counseling Assistance and Training Program funds have been awarded to California since 1989 to alleviate mental health problems caused by the massive devastation of earthquakes, fires, civil unrest, freeze and winter storms.

The Department also administers a SAMHSA capacity expansion grant to improve the capacity of the DMH and the ADP to respond to all-hazards emergency events.

The DMH Disaster Assistance Coordinator participates on numerous task force and workgroups oriented toward emergency preparedness, response and recovery for both natural disasters and terrorist events.

System Oversight, Evaluation and Monitoring

DMH is responsible for overseeing the delivery of public mental health services in California. The following DMH tasks related to oversight of programs or funds are included in this category:

- Research, evaluation and monitoring of performance outcomes; Medicaid compliance; and all elements of the State system of care for adults and older adults with SMI and children with SED;
- Negotiation of performance contracts and implementation plans with counties for the administration of local mental health programs;
- Licensing and certification of clinics and facilities;
- Rate-setting;
- Assurance of, and monitoring of, patients' rights;
- Operation of the Ombudsman Office;

- Dissemination of data; and
- Oversight of the managed mental health care plan.

Direct Services

DMH provides the following services either directly or through contract:

- Oversight of direct services provided through contracts with public or private entities, or with inter-governmental agreements;
- Direction and monitoring of programs for offenders with mental disabilities conditionally released into the community;
- Administration of programs and activities mandated by the Legislature;
- Operation of the State hospitals for individuals with mental disorders who have been placed either by counties according to the civil commitment statutes, or by courts or prisons in accordance with the Penal Code;
- Operation of the Sexually Violent Predator (SVP) program; and
- Operation of programs in prisons for offenders with mental illness under contract with the CDCR.

Administrative Support

DMH also performs the administrative functions necessary to support its operation. These functions generally include:

- Personnel;
- Labor Relations;
- Financial Management;
- Accounting;
- Budgeting;
- Information Technology; and
- General Office Support.

MANAGED MENTAL HEALTH CARE IN CALIFORNIA

Over the past 15 years, there has been a move nationally to change the orientation of health care from the delivery of episodic treatment of illness to the planned provision of primary care, and other necessary services, in an integrated, coordinated system of service delivery. This coordinated system of care is known as managed care. Managed mental health care for California's Medi-Cal program is administered through a single managed care mental health plan (MHP) in each county. California's managed mental health care program served an estimated 449,505 Medi-Cal eligible consumers in FY 2008-09.

Ombudsman Office

The purpose of DMH's Ombudsman Office is to create a bridge between the mental health managed care system and beneficiaries receiving Medi-Cal by providing information and assistance to help them navigate the system. There are several local resources, including the patients' rights advocate and MHP problem resolution staff, to which beneficiaries can turn for help.

External Quality Review Organization

DMH has contracted with APS HealthCare to be its External Quality Review Organization (EQRO). The purpose of the EQRO is to objectively assess quality, outcomes, timeliness of and access to the services provided by 56 California MHPs that contract with DMH to provide Medi-Cal specialty mental health services (SMHS) to Medi-Cal eligible individuals.

To make this assessment of each MHP, the EQRO conducts annual external quality reviews that include:

- Assessment of DMH-specified PMs;
- Assessment of MHP-selected Performance Improvement Projects (PIPs);
- Periodic evaluation of selected aspects of each MHP's on-going internal QI system; and
- Review of each MHP's health information system capability to meet the requirements of the Medi-Cal SMHS program.

The EQRO prepares an annual report on each MHP. This report comprehensively assesses the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The individual MHP reports utilize the EQRO's own assessment of each MHP in light of the review components described above. The EQRO also prepares an aggregate report for the State based on the information gained in the assessments of the individual MHPs.

The EQRO provides up to four hours of technical assistance and consultation for each MHP annually. The intent of this activity is to meet the individualized QI needs of each MHP and to maximize the utility of the external review activity as a QI learning experience.

Because of the unique nature of the Medi-Cal managed mental health care system, calculation of PMs is done by DMH using claims data obtained from the MHPs. Thus, in order to fully assess MHP performance, the EQRO reviews and assesses various DMH data systems and processes in addition to the MHPs' system for reporting claims data. The EQRO prepares an annual report that comprehensively assesses the overall performance of DMH in this capacity.

The EQRO has utilized protocols for validation of PMs and PIPs and an information system assessment instrument developed by DMH, in addition to any review protocols or instruments developed by the EQRO for use in other areas of the review. The EQRO has recently begun its fourth year of reviews with the focus of those reviews evolving over that period.

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues - See Recent Significant Achievements Section

Adult - Legislative initiatives and changes, if any.

LEGISLATIVE INITIATIVES

California Assembly Bill 710, the Veterans' Substance Abuse and Mental Health Services Fund, would require the California Department of Veterans Affairs (DVA) to submit a grant application to SAMHSA for the purposes of funding community based organizations, certified by DVA, to provide substance abuse and mental health services to veterans. As amended, DMH will be required to do the actual grant writing.

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

DEPARTMENT OF MENTAL HEALTH LEADERSHIP ROLE AND RESPONSIBILITIES

At the State level, the DMH is responsible for:

- Leadership;
- Administration of federal funds;
- System oversight, evaluation, and monitoring;
- Direct services; and
- Administrative support.

Leadership

The primary role of the DMH is to provide leadership to the mental health system including planning, research, technical assistance, education, quality assurance, and program development of a broad array of initiatives for local services. Leadership activities include, but are not limited to:

- Implementing the State mission and goals for mental health services;
- Advocating for quality mental health services for California's citizens with mental illness;
- Maximizing the ability to utilize creative public and private financing opportunities;
- Providing appropriate planning, research, technical assistance, training, and program development;
- Encouraging ongoing collaborative efforts between clients, family members, providers and other members of the mental health constituency as well as interagency and cross-jurisdictional collaboration at the State level; and
- Implementation of the MHSA (Proposition 63), which provides state tax dollars for specific county mental health programs and services.

Administration of Federal Funds

- DMH is also responsible for securing and ensuring the continuation of federal funds. All tasks related to the administration of federal funds, such as utilization review, quality management, and cost reporting and settlement are included in this category. This includes the administration of federal funding for the EPSDT benefit; Medi-Cal-funded psychiatric inpatient hospitals; SD/MC; the annual SAMHSA Block Grant; and the annual PATH formula grant.
- DMH is also administering federal funds under the Data Infrastructure Grant (DIG). This grant supports state efforts to collect and report their mental health services data in a consistent and complete manner. California has been awarded \$142,200 per year for three years, 2008-2010.
- DMH also administers federal funding under the FEMA Crisis Counseling Assistance and Training Program following a Presidential Disaster Declaration and evident need for disaster mental health services that cannot be met through local government or state resources. Over \$71 million in FEMA Crisis Counseling Assistance and Training Program funds have been

awarded to California since 1989 to alleviate mental health problems caused by the massive devastation of earthquakes, fires, civil unrest, and winter storms.

DMH also administers a SAMHSA capacity expansion grant to improve the capacity of DMH and ADP to respond to all-hazards emergency events.

The DMH Disaster Assistance Coordinator participates on numerous task force and workgroups oriented toward emergency preparedness, response and recovery for both natural disasters and terrorist events.

System Oversight, Evaluation and Monitoring

DMH is responsible for overseeing the delivery of public mental health services in California. The following DMH tasks related to oversight of programs or funds are included in this category:

- Research, evaluation and monitoring of performance outcomes; Medicaid compliance; and all elements of the State system of care for adults and older adults with SMI, and children with SED;
- Negotiation of performance contracts and implementation plans with counties for the administration of local MHPs;
- Licensing and certification of clinics and facilities;
- Rate-setting;
- Assurance of, and monitoring of, patients' rights;
- Operation of the Ombudsman Office;
- Dissemination of data; and
- Oversight of the managed mental health care plan.

Direct Services

DMH provides the following services either directly or through contract:

- Oversight of direct services provided through contracts with public or private entities, or with inter-governmental agreements;
- Direction and monitoring of programs for offenders with mental disabilities conditionally released into the community;
- Administration of programs and activities mandated by the Legislature;
- Operation of the State hospitals for individuals with mental disorders who have been placed either by counties according to the civil commitment statutes, or by courts or prisons in accordance with the Penal Code;
- Operation of the SVP program; and
- Operation of programs in prisons for offenders with mental illness under contract with the CDCR.

Administrative Support

DMH also performs the administrative functions necessary to support its operation. These functions generally include:

- Personnel;
- Labor Relations;
- Accounting;
- Budgeting;
- Information Technology; and
- General Office Support.

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

See Adult Plan

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues - See Recent Significant Achievements Section

Child - Legislative initiatives and changes, if any.

None at this time.

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

See Adult Plan

Adult - A discussion of the strengths and weaknesses of the service system.

STRENGTHS AND WEAKNESSES OF THE ADULT AND CHILDREN'S SERVICE SYSTEM

The strength of California's mental health system lies in its goal of delivering culturally competent, client-directed recovery services with local advocacy and program implementation at the county level. California's mental health system maintains a strong commitment to ensure that consumer and family involvement is an overriding value in planning, implementation, and oversight.

California has demonstrated that with effective treatment and support, recovery from mental illness is feasible for most people. California has developed effective models of providing services to children with SED, and adults and older adults with SMI. These successful programs emphasize client-centered, family-focused, and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

The MHSA has provided an opportunity for California to transform its public mental health system. In that effort, DMH has moved in a deliberate, responsible and transparent process, seeking input in open meetings at the state and local levels. From that process, DMH has developed comprehensive guidelines to ensure that county plans correlate with what initiative designers and advocates want – a fundamental change in how mental health services are developed and delivered.

To date, over \$4.7 billion has been made available to counties, including funding for Community Services and Support (CSS) programs approved by DMH in collaboration with clients and family members, and reviewed by the Mental Health Services Oversight and Accountability Commission (MHSOAC). These programs are making a difference in the lives of tens of thousands of people, and include housing and support services for more than 20,000 homeless people with mental illness. Additionally, DMH spent only part of the money allocated in MHSA for administration, returning approximately \$100 million to counties for services through June 30, 2009.

However, even with the implementation of the MHSA, county MHPs have not been able to fully and adequately serve all clients. Forty years of neglect in the larger system left substantive gaps that cannot be easily fixed and declining core funding cannot be restored through MHSA because programs may not be backfilled, a mandate of the MHSA initiative that prevents supplantation.

Although it varies from county to county, relatively small percentages of clients can be fully served. A larger percentage of clients and their families receive some level of services. There also continue to be many individuals who may have SMI and children and youth who may have SED, and their families, who are currently not served. Many individuals who are homeless and incarcerated in jails or juvenile halls fall into this latter category. Certain members of ethnic populations are also in this latter category and these ethnic disparities must be addressed.

Additional weaknesses with the adult and children's service have resulted from this year's budget actions to reduce California's historic budget deficit.

- The Medi-Cal Specialty Mental Health Managed Care appropriation has been reduced from \$227 million to \$113 million without any accompanying change in the responsibilities for services to be provided under the current state plan. This reduction further erodes the base funding for county mental health programs and will adversely affect the availability of services to mental health clients.
- The AB 3632 appropriation to reimburse counties for special education services was reduced from \$104 million to \$52 million. Even the \$104 million originally recommended was inadequate because counties are owed approximately \$500 million in back payment for AB 3632 services that they have provided in previous years. This situation continues to erode funding available for other aspects of the service system because AB 3632 services are a mandated service.

The strength of California's public mental health system is its ability to work collaboratively with local communities, the California Mental Health Directors Association (CMHDA) representing the 58 county mental health departments, the MHSOAC, the CMHPC and other stakeholders. The vision is of a system that integrates MHSAs into the larger mental health system and provides quality services to those in need, while ensuring accountability to the people of California.

Additionally, California has also suffered from a significant shortage of public mental health workers. This is discussed in detail further in California's 2011 Plan.

On May 2, 2006, the USDOJ and the State of California reached a settlement concerning civil rights violations at four California State Hospitals: Metropolitan State Hospital in Los Angeles, Napa State Hospital in Napa, Patton State Hospital in San Bernardino, and Atascadero State Hospital in San Luis Obispo. These hospitals provide inpatient psychiatric care to nearly five thousand individuals committed to the hospitals civilly or in connection with criminal proceedings. DMH has begun extensive reforms required by the five-year "Consent Judgment" that will ensure that individuals in the hospitals are adequately protected from harm and provided adequate services to support their recovery and mental health. The reforms are discussed in more detail under State Priorities to Address Unmet Needs, Significant Achievements and in Criterion 1.

The USDOJ conducted its investigation pursuant to the CRIPA. This statute allows the federal government to identify and root out systemic abuses such as those identified in this case, rather than focus on individual civil rights violations. The State will now address and correct the agreed upon violations identified by the USDOJ.

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

ANALYSIS OF UNMET SERVICE NEEDS, CRITICAL GAPS AND DATA SOURCES

In the report titled *California Mental Health Master Plan: A Vision for California*, the CMHPC states that “a crisis also exists in access to mental health care for persons who are indigent...the availability of services for indigents has only gotten worse.”

The report further states that “this unmet need for mental health services and crisis in access to services is brought into focus when one considers the advancements that have been made in understanding the nature of mental illness over the last two decades. Many effective treatments, both in terms of medication and psychosocial rehabilitation, have been found for major mental illnesses. Innovative programs, such as wrap-around programs and strength-based, family-focused treatment planning, have brought breakthroughs in services to children and their families.”

California has also suffered from a significant shortage of public mental health workers. High vacancy rates exist in certain occupational classifications. There is a recognized lack of diversity in the workforce, poor distribution of existing mental health workers, and under-representation of individuals with client and family member experience in the provision of services and supports. Particularly, severe shortages exist for mental health practitioners with skills to work effectively with such groups as children, older adults and diverse ethnic/cultural populations heretofore unserved or underserved.

The CSS is a component of the MHSA. As part of the CSS process, counties have provided an assessment of the mental health needs of county residents and residents of American Indian Rancherias or reservations within county boundaries, including adults, older adults and TAY who may have or have been diagnosed with SMI, and children, youth and TAY who may have or have been diagnosed with SED. The intent is to recognize all those who would qualify for MHSA services, including those who are currently unserved, underserved or fully served, and identify their age and situational characteristics (e.g. homelessness, institutionalization or out-of-home placement, involvement in the criminal or juvenile justice system, etc.).

In addition, the initial County CSS component plans were summarized and analyzed for potential new MHSA workforce positions, stated needs and challenges, and cultural diversity and language proficiency issues. This preliminary analysis provided a high-level summary of workforce shortages statewide.

In order to accurately assess the extent and complexity of the public mental health workforce shortage in California, DMH has begun development of a more comprehensive and detailed Workforce Needs Assessment to focus on statewide capacities and needs based upon skills and functions. This will provide a useful basis for determining funding and program priorities that have the capacity to create change. DMH continues to seek input from mental health clients and family members/caregivers, the CMHPC, the MHSOAC, the CMHDA, and other stakeholders in the development of this assessment.

Adult - A statement of the State's priorities and plans to address unmet needs.

STATES PRIORITIES AND PLAN TO ADDRESS UNMET NEEDS

The California voters approved Proposition 63 during the November 2004 general election. Proposition 63 became effective on January 1, 2005 as the MHSA. Through imposition of a one percent tax on personal income in excess of \$1 million, the MHSA provides a unique opportunity to increase funding, personnel and other resources to support county mental health programs, and increase access to services for children, TAY, adults and older adults, and their families, with mental health needs. The MHSA also seeks to establish PEI programs and develop innovative programs.

One of the major goals of the MHSA is to reduce the long-term adverse community impacts of untreated mental illness and SED. The MHSA provides both a vision and an opportunity with potential resources to transform California's mental health system. The Act provides a specific list of purposes and intent, including prevention and early intervention services; defines SMI as a priority and prioritizes reducing the long-term impact resulting from untreated SMI. The act also provides for successful, innovative services, including culturally and linguistically competent approaches for underserved populations.

The goal of bringing about change in California's large and diverse publicly funded mental health system is a monumental task. It requires a consensus-based articulation of values and a long-term planning and implementation process that is inclusive of all stakeholders, measured by incremental markers of success and guided by values as well as data. Maintaining the vision and mission, monitoring of process and outcomes, flexibility, and the ability to change strategies when necessary are key factors in the initiative's impact and success.

The purpose of the MHSA is to:

- Define SED among children and SMI among adults and seniors as a condition deserving priority attention, including PEI services and medical and supportive care;
- Reduce the long-term adverse impact on individuals, families, and state and local budgets resulting from untreated SMI;
- Increase the number and span of successful, innovative service programs for children, adults and seniors in California, including culturally and linguistically competent approaches for underserved populations;
- Provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure; and,
- Ensure that all funds are expended in the most cost effective manner and that services are provided in accordance with recommended best practices, subject to local and state oversight, to ensure accountability to taxpayers and to the public.

The MHSA is comprised of five components of services and/or program supports for which the funding established under the MHSA may be spent. The DMH has identified these components as follows: CSS for children, TAY, adults and older adults; Workforce Education and Training (WET); Capital Facilities and Technological Needs (CFTN); PEI; and Innovative Programs. Given the scale of each component, DMH is implementing each component through a sequential

or phased-in approach. These components are discussed throughout California's 2010/2011 Plan.

The first component implemented was CSS. In 2010-11, the DMH plans further implementation efforts for the following MHSAs: WET, CFTN, Information Technology, PEI, and Innovation. These plans are also addressed in the *Recent Significant Events* section.

The WET component addresses the serious shortage of mental health service providers in California. California was already facing a shortage of public mental health workers prior to the passage of the MHSAs. Chapter 814, Statutes of 2000 (SB 1748, Perata) required that a Task Force be formed and identify and address options for meeting the mental health staffing needs of state and county health, human services, and criminal justice agencies. The Task Force found that for core occupations, such as psychiatrists, psychologists, licensed clinical social workers, registered nurses, and psychiatric technicians, vacancy rates were approximately 20 – 25 percent statewide. In rural parts of the state, vacancy rates were far higher.

The MHSAs provide a unique opportunity with funding to increase staffing and other resources that support county mental health programs, increase access to much-needed services, and monitor progress toward statewide goals for serving children, TAY, adults and older adults and their families.

California's mental health system has historically suffered from a lack of diversity in the workforce, poor distribution of existing mental health workers, and under-representation of individuals with client and family member experience in the provision of services and supports. Particularly severe shortages exist for mental health practitioners with skills to work effectively with such groups as children, TAY, older adults and diverse ethnic/cultural populations heretofore unserved or underserved.

The Five-Year WET Development Plan covers a period from April 2008 to April 2013. Subsequent plans will be developed every five years, and each Five-Year Plan will be reviewed and approved by the CMHPC.

The Five-Year Plan provides a vision, values and mission for state and local implementation. It presents measurable goals and objectives, and proposes potential actions, or strategies, to assist in meeting these goals. It proposes principles for funding and governance at both the state and county level, and outlines performance indicators by which impact of workforce strategies can be measured over time. Finally, the Five-Year Plan provides guidance to assist in long-range planning toward an integrated mental health service delivery system.

This Five-Year Plan is intended as the beginning step in an ongoing dialogue between DMH, its partner agencies, clients and family members and other stakeholders to build the capacity of our current and prospective public mental health workforce.

This Five-Year Plan carries forth the vision of the MHSAs to create a transformed, culturally-competent system that promotes wellness and recovery for adults and older adults with SMI, and

resiliency for children and youth with SED and their families. The Five-Year Plan provides the means for developing and maintaining a culturally competent workforce, to include clients and family members, which is capable of providing client- and family-driven services that promote wellness, recovery and resilience, and lead to measurable, values-driven outcomes.

Through its Mission Statement, DMH has pledged to ensure the availability and accessibility of effective, efficient, culturally competent services, and to accomplish this service provision through education, outreach, advocacy, innovation, oversight, monitoring, and the promotion of multi-disciplinary training and QI.

As indicated, DMH has instituted a number of changes in its State Hospitals based upon best practices. Among the changes in progress or already enacted are the development and implementation of policies and procedures based on a recovery model of mental health care that provides effective treatment consistent with generally accepted evidence-based practices of care. These include a person-centered, strength-based, holistic, and recovery-focused assessment and treatment planning system that is based on assessed needs of the individual child or adolescent. Treatment teams review and revise, as appropriate, treatment plans and evidence-based interventions for each patient on a specified schedule based on assessed treatment outcomes.

LTCS continues to implement policies and procedures to eliminate the use of seclusion and physical restraints, and these interventions will be reserved only for emergency use for safety of self, peers, and staff. DMH is committed to creating a general physical environment and therapeutic milieu for treatment that is consistent with its values. This includes developing and implementing plans for enhancing supports and services that will enable patients to be discharged as soon as their mental health and legal issues have been resolved so they can be in a less restrictive level of care. This is being achieved by training staff to provide effective, positive interventions in a kind, caring, and compassionate manner to all in their care. Each discipline has specific targets to ensure better care. Psychiatrists need to assess, diagnose and prescribe medication based on a rational pharmacologic approach integrating information and feedback about psych-social and educational issues. Pharmacists are expected to play a more visible role in medication issues. Psychologists are expected to assess the need for and provide behavior therapy based on a positive behavior supports model and cognitive behavior therapy for the emotional and behavioral disorders experienced by the patients in their care.

In order to address the various staffing shortages at the State Hospitals, particularly shortages with clinical staff, DMH is actively recruiting for all professional clinical, nursing and police services classifications. This includes, but is not limited to: advertising in professional journals, newspapers, specialty web sites, university/colleges, as well as internships, clinical rotations, recruitment and job fairs, participation in community events, upward mobility programs, attendance at professional conferences, tours, locum tenens, and other activities.

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

RECENT SIGNIFICANT ACHIEVEMENTS

The activities described below have been undertaken to address the problem areas identified in the 2009 Plan and constitute the most significant events and accomplishments in SFY 2009-10 that impacted California's public mental health system.

The passage of Proposition 63, the MHSA, in November 2004, provided an opportunity to increase funding, personnel and other resources to support county MHPs and monitor progress toward statewide goals for serving children, TAY, adults, older adults and families with mental health needs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The MHSA provides both a vision and an opportunity with potential resources to transform California's mental health system. The MHSA provides a specific list of purposes and intent, including PEI; and defines SMI as a priority and prioritizes reducing the long-term impact resulting from untreated SMI. The MHSA also provides for successful, innovative services, including culturally and linguistically competent approaches for underserved populations.

The goal of bringing about change in California's large and diverse publicly funded mental health system is a monumental task. It requires a consensus-based articulation of values and a long-term planning and implementation process that is inclusive of all stakeholders, measured by incremental markers of success and guided by values as well as data. Maintaining the vision and mission, monitoring of process and outcomes, flexibility, and the ability to change strategies when necessary will all be key factors in the initiative's impact and success.

The MHSA specifies the major components around which DMH has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the components has been staggered. The state's stakeholder process involves the development of discussion documents, a series of general stakeholder meetings, statewide teleconferences and topic-specific workgroups to provide input on critical issues, and to advise on implementation policies and processes. In addition, the DMH continues to encourage stakeholders to provide input on MHSA-related issues and policies through the general MHSA email address, the toll-free MHSA phone line and the MHSA Website.

In the past year DMH has continued MHSA implementation activities in the following areas:

Community Services and Supports (CSS)

CSS refers to "System of Care Services" as required by the MHSA in Welfare and Institutions Code Sections 5813.5 and 5878.1 to 5878.3. The change in terminology differentiates MHSA CSS from existing and previously existing System of Care programs funded at the federal, state and local levels. 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 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.” Annual updates of the county three-year plan will be required pursuant to MHSA requirements.

The DMH developed plan requirements for the Program and Expenditure Plan for CSS with stakeholder participation in early 2005 and released the final version on August 1, 2005. As of June 2008, 58 county CSS plans were received and 58 plans were approved for funding.

The total funding amount for CSS for FY 2009-10 is approximately \$900 million. The total funding amount for PEI for FY 2009-10 is approximately \$330 million. The total funding amount for Innovation for FY 2009-10 is approximately \$71 million.

These Program and Expenditure Plan requirements are intended to build upon and operationalize the concepts in the Vision Statement and Guiding Principles for DMH Implementation of the MHSA. These requirements look beyond “business as usual” and are intended to start building a system where access will be easier, services are more effective, out-of-home placements, institutional care, homelessness and incarcerations are reduced, and stigma toward those who are diagnosed with SMI or SED no longer exists. These requirements are intended to initiate significant changes including:

- Increases in the level of participation and involvement of clients and families in all aspects of the public mental health system;
- Increases in client and family operated services;
- Outreach to and expansion of services to client populations in order to eliminate ethnic disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates; and
- Increases in the array of community service options for individuals diagnosed with SMI and children/youth diagnosed with SED, and their families, that will allow them to avoid unnecessary institutionalization and out of-home placements.

Essential Elements for All Three-Year Program and Expenditure Plans

There are five fundamental concepts inherent in the MHSA that must be embedded and continuously addressed throughout the Program and Expenditure Plans 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, or among consumer providers,

family member providers, and professionals, that enables that system, agency or those professionals, consumer providers, and family member providers to work effectively in cross-cultural situations.

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. Service providers understand and utilize the strengths of culture in service delivery. 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 services that provide the most effective outcomes and create 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 for older adults, adults and TAY and family driven system of care for children and youth: Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.

Many adults with SMI and parents of children with SED have limited influence over the services they or their children receive. Increasing opportunities for clients and families to have greater choices over such things as types of service, providers, and how service dollars are spent facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self monitoring, and accountability. Increasing choice protects individuals and encourages quality.

- **Wellness focus, including the concepts of recovery and resilience:**

Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means 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 elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.

Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community.

- **Integrated service experiences for clients and their families throughout their interactions with the mental health system:** This means that services are “seamless” for clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family’s needs using the full range of community-based treatment, case management, and interagency system components required by children/TAY/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have co-occurring disorders (COD), including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached and maintained for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state.

These five fundamental concepts combine to ensure that through MHSA-funded activities, counties work with their communities to create culturally competent, client/family driven mental health services and support plans which are wellness focused, which support recovery and resilience, and which offer integrated service experiences for clients and families.

Services for Adults and Older Adults

The W&I Code, Section 5813.5 specifies that MHSA services will be available to adults and seniors with severe mental illnesses who meet the eligibility criteria in the W&I Code Section 5600.3(b)—adults and older adults who have serious mental disorder and (c)—adults and older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence. Some TAY may also be served under these provisions.

The MHSA Program and Expenditure Plan Requirements are based on a logic model that links:

- Community issues resulting from untreated mental illness and a lack of services and supports;
- Mental health needs within the community;
- The identification of specific populations to be served based upon the issues and needs identified;
- The programs and services/strategies to be implemented; and
- The desired outcomes to be achieved.

In addition to a focus on community issues and outcomes, the MHSA also emphasizes the importance of measuring outcomes achieved by specific individuals and families, including but not limited to: hope, personal empowerment, respect, social connections, independent living for adults and safe living with families for children/youth, self-responsibility, self determination and

self esteem for clients and families. Along with other individual and system level outcomes, these individual value-driven outcomes will be incorporated within the outcome measurement system to be developed and implemented under the MHSA. DMH envisions an ongoing process of identifying community issues and unmet needs, focusing upon specific individuals and populations in need based upon these identified issues, developing and implementing state-of-the-art service and support strategies and assessing outcomes: all to ensure that counties are providing the highest level of quality care possible in the most efficient and effective ways. It is further envisioned that as a part of the QI process, data and feedback on the individual, community and system levels are used to refine and improve services and supports. Plans for addressing individual quality of care issues are a part of this ongoing process. Significant effort is being focused on streamlining the state and local plan development and approval processes, integration of the components of the MHSA with each other and into the larger public mental health system and increased focus on indicators. The commitment to transformation of the entire local public mental health system through the use of the MHSA continues.

Specific Populations by Age, Consistent with MHSA and DMH Priorities:

- **Children and youth** between the ages of 0 and 18, or Special Education Pupils up to age 21, who have serious emotional disorders and their families, who are not currently being served.
- **TAY** between the ages of 16 and 25, who are currently unserved or underserved who have SED and who are homeless or at imminent risk of being homeless, youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems and youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization.
- **Adults with SMI**, including adults with a co-occurring substance abuse disorder and/or health condition.
- **Older adults 60 years and older with SMI**, including older adults with co-occurring substance abuse disorders and/or other health conditions – who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services.

There are three service categories to emphasize and track the essential elements of transformation:

- Each individual participating in an FSP must be offered a partnership with the county MHP to develop an individualized services and supports plan that is based on a “whatever it takes” approach;
- Counties may use general system development funding to help transform their core programs and service delivery systems to be more consistent with the five fundamental concepts of the MHSA; and

- Prioritize outreach and engagement to highlight the commitment to reach out to unserved and underserved communities and individuals.

Workforce Education and Training

In the WET component, the MHSa specifies that each county mental health program shall submit to DMH a needs assessment identifying shortages in each professional and other occupational category and a plan to increase the supply of professional and other staff that county mental health programs anticipate they will require. DMH is required to assess and identify the statewide needs for each professional and other occupational category and develop a five-year education and training development plan (Five-Year Plan). Over the past year, DMH has continued to work with stakeholders in all policy and program formulations, including the development of state and county responsibilities in the administration of WET funds and the development of initial budget and funding categories. DMH has established a total funding level of \$210 million through April 2018 for local WET activities. Of this total, \$10 million has been allocated in approved planning requests to 49 counties and an overall total of \$140 million has been allocated to 39 counties. Three additional counties have submitted funding requests for an overall total of \$151 million.

DMH has completed the Five-Year Plan, and it was approved by the CMHPC in April 2008.

Statewide contracts with trainers and consultants are continuing through this FY. These are entities that have a proven track record of providing training and technical assistance as envisioned by the Act. These include:

- **Organizational Change Support**—The California Institute for Mental Health (CIMH) continues its expanded statewide training and technical assistance mission of supporting county mental health programs. This expansion includes ongoing technical assistance for organizational development toward consumer and family member-driven, evidence-based service delivery as envisioned by the MHSa, facilitating regional learning collaborative networks to plan and implement new practices.
- **Financial Incentive Program**— The California Social Work Educational Consortium (CalSWEC) continued its existing stipend program to provide financial incentives for students in master’s level social work programs committed to working in community public mental health. The 2007-08 Cohort had 185 graduates; 2008-09 had 183; and there are currently 183 students enrolled in the 2009-10 Cohort. Approximately \$5.8 million per year has been allocated for this effort.
- **Stipends**— DMH has entered into contracts with seven universities to develop and model successful stipend programs for graduate students that are clinical psychologists, psychiatric mental health nurse practitioners, and MFTs and also commit to working in the public mental health system. These stipends programs have begun to do so by:
 - Increasing the recruitment of individuals who can address the cultural diversity needs of public mental health recipients;

- Encouraging the enrollment and support of individuals with client and/or family member experience in the public mental health system; and,
- Preparing professionals to deliver public mental health services that promote wellness, recovery and resilience.

In FY 2008-09, 84 stipends were awarded to graduate students in marriage and family therapy, psychiatric mental health nurse practice, and clinical psychology. Seventy three percent of the stipend recipients represented a cultural minority and fifty eight percent spoke a language other than English. In FY 2009-10, 163 stipends were awarded to graduate students in marriage and family therapy, psychiatric mental health nurse practice, and clinical psychology. Sixty four percent of the stipend recipients represented a cultural minority and sixty three percent spoke a language other than English.

- **Physician Assistant Training**—DMH has partnered with the Office of Statewide Health Planning and Development (OSHPD) to add a mental health track to the Residency Program for Physician Assistants as a strategy to address the shortage of individuals who can administer psychotropic medications. In FY 2008-09, five Physician Assistant programs that train a total of 383 second-year residents to specialize in mental health were awarded a total of \$500,000 (approximately \$100,000 per program).
- **Mental Health Loan Assumption Program (MHLAP)**—DMH partnered with the Office of Statewide Health Planning and Development—Health Professions Education Foundation (OSHPD-HPEF) to award a total of \$2.5 million to qualified mental health professionals throughout California. The MHLAP was launched in February 2009 and the awardees were selected in May. The MHLAP provides loan assumption awards to pre-licensed as well as licensed individuals in all mental health professions. In its initial cycle, 1,243 individuals applied for this program, requesting over \$15 million. Representatives from DMH, County Departments of Mental Health, experts in the mental health field and OSHPD-HPEF selected a total of 288 applicants from 44 counties. A total of \$2,286,699 was awarded.
- **Statewide Constituency Partnership**—The statewide constituency organizations of the California Network of Mental Health Clients (CNMHC), United Advocates for Children and Families (UACF), and the National Alliance for the Mentally Ill – California (NAMI) have expanded their efforts to reach consumers and family members with self-help technical assistance and train-the-trainer curricula, such as Educate, Equip and Support – Building Hope, Peer-to-Peer, Family-to-Family, and Wellness Recovery Action Planning. These curricula will promote the meaningful inclusion and employment of consumers and family members at all levels of the public mental health system.

Additional state administered programs and activities are in the development stage and DMH is facilitating a stakeholder process to ensure these planned programs and activities adhere to the intent of the MHSA. Proposed county guidelines for developing county administered programs and activities are currently in draft form, and are posted on the DMH web site for public input.

Capital Facilities and Technological Needs (CFTN)

A portion of the MHSA funds were specifically set aside for CFTN in FY 2004-05 through FY 2008-09 to enable counties to support the goals of the MHSA in a manner which is consistent with the County's Three-Year Program and Expenditure Plan. In subsequent FYs, counties will continue to use a portion of their MHSA CSS funding for CFTN. In March 2008, DMH released proposed guidelines for Counties to submit their CFTN Component of the MHSA.

Each County's plan for the use of CFTN funds should support the goals of the MHSA in a manner consistent with the County's Three-Year Program and Expenditure Plan. The County must clearly show how the planned use of the CFTN funds will produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, and expansion of opportunities for accessible community-based services for clients and their families. These efforts should include development of a variety of community-based facilities which support integrated service experiences and an increase in peer support and consumer run facilities.

DMH has designated housing as a service and/or support that is an allowable expenditure under the CSS component funding, rather than CFTN funding. As a result of this policy change, CFTN funding will be utilized to purchase, construct, and/or rehabilitate facilities that provide services and/or treatment for those with SMI, or to provide administrative support to MHSA funded programs.

Mental Health Services Act Housing Program

The MHSA Housing Program was established on August 6, 2007, and is jointly administered by DMH and the California Housing Finance Agency (CalHFA). The program provides funding for the both the capital costs and operating subsidies to develop permanent supportive housing. The impetus for this program was Executive Order S-07-06, issued by Governor Schwarzenegger in May 2006, to establish an interagency collaboration between the CalHFA and DMH, in consultation with County Mental Health Departments, to utilize their combined resources and expertise to address housing for individuals with SMI and their families who are homeless or at risk of homelessness. A total of \$400 million of MHSA funds has been set aside for initial funding of the program, and each County Mental Health Department in California received a portion of the funds that are available for both capital costs and capitalized operating subsidies.

89 applications for MHSA Housing Program funds have been received as of August 1, 2010. These applications will use a total of \$212,599,133 in MHSA funds for both capital and operating subsidies to create 1,411 units of permanent supportive housing for Californians who are homeless or at risk of homelessness and who experience mental illness.

Technological Needs

The MHSA provides funding for county technology projects that will improve the access and delivery of mental health services to the public. DMH is responsible for ensuring that the

MHSA funds are appropriated to county technology projects that are consistent with MHSA goals and objectives. In order to allocate funds appropriately, DMH has a process in which counties submit their technology funding requests for approval in accordance with established DMH guidelines. DMH then works directly with each county technology representative (usually the chief information officer) to develop a comprehensive understanding of the technology project and the anticipated results, and make any required modifications prior to approval. Once the approval is granted, funds are released to the county in support of the project. The DMH then continues to work in an oversight capacity with the county in order to ensure the project's success.

DMH evaluates and approves technology requests within the context of two goals:

- Modernize and transform clinical and administrative information systems to improve quality of care, operational efficiency and cost effectiveness; and
- Increase consumer and family empowerment by providing the tools for secure consumer and family access to health information within a wide variety of public and private settings.

The long-term technology goal of DMH is to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information. This infrastructure will allow different county systems to share information across a secure network environment both inside and outside their respective counties. Counties and their contract providers, hospital emergency departments, laboratories, pharmacies and consumers and their families could all securely access and exchange information through the infrastructure. This long-term goal will be achieved as each county assesses their current state of technology readiness and moves through a continuum of improvements over time.

To facilitate the long-term technology transformation, DMH developed minimum statewide standards for mental health Electronic Health Record (EHR) systems. The EHR system is the foundation for the Integrated Information Systems Infrastructure. It is a secure, real-time, point-of-care, client-centric, information resource for service providers. The ability to share timely, accurate and secure access to the client's health and healthcare information is possible through the use of uniform standards to transfer information from one source to another. To achieve statewide technology transformation, DMH will periodically specify increasingly complex minimum standards so that counties and their vendors will be able to adapt their systems while meeting their current business needs.

Prevention and Early Intervention (PEI)

The MHSA authorizes the DMH to establish program requirements for PEI in California. In addition, the MHSA authorizes the MHSOAC to approve program expenditures for PEI. Because of this unique relationship, the DMH and the MHSOAC worked closely in the development of the program and funding requirements. The MHSOAC approved its proposal for PEI principles and funding criteria in January 2007. This document was based on collaboration with the DMH, MHSOAC, the CMHDA, and the CMHPC. DMH finalized the program

guidelines in 2007 and counties began their local planning process. The MHSOAC approved expenditures of \$36.3 million for community program planning and the development of the counties' PEI Plans.

As of July 2010, 58 counties have submitted their PEI plans for approval and 58 have been approved. The MHSOAC has approved approximately \$353 million for PEI services.

DMH convened a Statewide Advisory Committee which completed a draft California Strategic Plan for Stigma and Discrimination Reduction. The Strategic Plan was completed and adopted by the MHSOAC in June 2009.

The MHSOAC approved expenditures of \$40 million per year for Student Mental Health Initiative, Stigma and Discrimination Reduction and Suicide Prevention statewide efforts. DMH will be the administrator of these programs. Only a small number of counties have assigned their funds to the state to support this effort, therefore the MHSOAC is currently in deliberations to determine the options for moving forward with the Statewide Projects.

Innovation

The goals for the Innovation funding are to increase access to underserved groups; to increase the quality of services, including better outcomes; to promote interagency collaboration; and to increase access to services.

The MHSA authorizes the DMH to establish program requirements for the Innovation component. In addition, the MHSA authorizes the MHSOAC to approve the Innovation program expenditures. Because of this unique relationship, the DMH and the MHSOAC are working closely to craft the program and funding requirements for the Innovation component. The MHSOAC has approved principles for use of Innovation funding. DMH issued the plan guidelines for the counties in January 2009. DMH has the responsibility of reviewing local plans; the MHSOAC will have primary responsibility of approving the plans for the Innovation component. As of August 2010, the MHSOAC has received a total of 24 County Innovation plans. Twenty Innovation plans and one new Innovation plan submitted in an Annual Update have been approved by the Commission for a total of \$75,679,213.

Outcomes Reporting

Counties that have received CSS plan approval are in various stages of implementing MHSA-funded programs and providing services, with a number of counties reporting FSP outcomes and other MHSA services information. In addition, all counties with approved CSS plans have begun submitting Quarterly Reports of targeted and actual numbers of persons outreached and served through the MHSA FSP, outreach and engagement, and system development funding sources. The DMH is creating streamlined data entry, consolidation and analytic processes for statewide aggregation and reporting of this information.

Current Changes to Practices Regarding Hospitalization

LTCS has maintained its commitment to excellence in the provision of services to people with mental illness. To that end, DMH have instituted a number of changes based upon best practices. Quality assurance reviews continue to yield valuable results that are reflected in our approach to services.

Among the changes in progress, or already enacted, are the development and implementation of policies and procedures based on a recovery model of mental health care that provides effective treatment consistent with generally accepted evidence-based practices of care. These include a person-centered, strength-based, holistic and recovery-focused assessment and treatment planning system that is based on assessed needs of the individual. Treatment teams review and revise, as appropriate, treatment plans and evidence-based interventions for each patient on a specified schedule based on assessed treatment outcomes.

LTCS continues to implement policies and procedures to eliminate the use of seclusion and physical restraints, and these interventions will be reserved only for emergency use for safety of self, peers, and staff. LTCS is creating a general physical environment and therapeutic milieu for treatment that is consistent with our values. This includes developing and implementing plans for enhancing supports and services that will enable patients to be discharged as soon as their mental health and legal issues have been resolved so they can be in a less restrictive level of care. This is being achieved by training staff to provide effective, positive interventions in a kind, caring, and compassionate manner to all in their care. Each discipline has specific targets to ensure better care. Psychiatrists need to assess, diagnose and prescribe medication based on a rational pharmacologic approach integrating information and feedback about psych-social and educational issues. Pharmacists are expected to play a more visible role in medication issues. Psychologists are expected to assess the need for and provide behavior therapy based on a positive behavior supports model and cognitive behavior therapy for the emotional and behavioral disorders experienced by the patients in their care.

All of our standards and operational processes are being reviewed and amended to ensure that patients at the state hospitals receive the most beneficial treatment possible in a setting that is committed and conducive to patients achieving the highest possible level of functioning in the shortest possible time.

ACTIONS TO IMPROVE PROGRAM PERFORMANCE

LTCS embraces the concept of continuous QI. Below are program performance improvement actions currently being implemented:

- **Wellness and Recovery Model Support System (WaRMSS):** Completed in July 2009, WaRMSS is real-time software used to assist the state hospitals in the implementation of the Wellness and Recovery model of providing care. WaRMSS allows clinical teams to tailor individualized treatment plans, document goals of individuals served, document progress toward goals, and make changes to individual treatment plans. WaRMSS also allows hospital staff to schedule group treatment, generate group rosters, and record group attendance and participation. Additionally, WaRMSS provides a system for managing

incidents and patient risks, both behavioral and medical. WaRMSS is important for several reasons:

- It enables tracking of the needs of individuals served, treatments applied, and outcomes achieved;
 - It allows DMH to analyze resulting data to ensure that needs, treatments, and outcomes are aligned;
 - It allows DMH to develop policies and clinical practices based on empirical findings; and
 - It provides data that will assist in compliance with the Joint Commission on Accreditation of Healthcare Organizations, licensing, and legal concerns.
- **Seclusion and Restraint:** As part of DMH's commitment to provide treatment services that respect the dignity of individuals served, state hospital staff continually strive to employ effective alternatives to minimize the use of emergency interventions, such as seclusion and restraint. New strategies are being developed to restructure staff philosophy to:
 - Focus on recovery, recognize choices individuals served have regarding treatment and treatment planning, employ safety techniques rather than control techniques, utilize debriefing to assess incidents and improve responses;
 - Improve early intervention practices, including staff training on trauma and how seclusion and restraint lead to increased trauma; and
 - Utilize special individualized behavioral treatment plans for high-risk individuals.

It is anticipated that changes to philosophy and practice to affect a substantial reduction in seclusion and restraint is an on-going effort that will take several years.

The DMH Prevention and Management of Assaultive Behavior Program (PMAB) has been revised to incorporate Wellness and Recovery Principles. This Program has been restructured as "Therapeutic Strategies and Interventions (TSI)," with the focus on enhanced training for staff in strategies to prevent/reduce the escalation of events to the point that restraint or seclusion are used. Safe stabilization techniques are a necessary component of the TSI Program to prevent staff and/or individual injury during an incident.

- **Civil Rights of Institutionalized Persons Act of 1980 (CRIPA):** As a result of an investigation conducted under the authority of the CRIPA, in May 2006, the State of California and USDOJ reached an agreement concerning the treatment of the individuals (patients) in California State Hospitals. The terms of the agreement (Consent Judgment) provide the framework and structure for extensive reforms to the way DMH provides services to those individuals committed to the care and custody of the state hospitals. It is a five year agreement with specific requirements and benchmarks of progress that are measured both internally and with regular visits by a Monitor appointed by the court.
 - There are five state hospitals employing approximately 11,000 staff and providing inpatient psychiatric care to nearly 5,000 individuals committed to the hospitals either civilly or in connection with criminal proceedings. These hospitals are

located throughout the state: Atascadero State Hospital in San Luis Obispo County, Coalinga State Hospital in Fresno County, Metropolitan State Hospital in Los Angeles County, Napa State Hospital in Napa County, and Patton State Hospital in San Bernardino County. (The terms of this agreement do not cover Coalinga State Hospital, as it was not open at the time of the original investigations. Despite Coalinga State Hospital's exclusion from the Consent Judgment, DMH is applying the Wellness and Recovery Model concepts accordingly in order to ensure enhanced treatment across the entire state hospital system.)

- The DMH has determined that implementation of the Wellness and Recovery Model of service delivery will ensure that individuals in the hospitals are provided appropriate behavioral treatment and interventions, in combination with medications, to support their recovery and manage their mental health.
- The Court Monitor visits each of the four impacted hospitals twice yearly to assess progress towards compliance with the Consent Judgment. DMH is providing oversight and direction in its efforts to achieve consistency across the system, although each facility has specific recommendations relative to its particular pace of progress. A copy of the Consent Judgment, which includes all of the required accountability and monitoring provisions, as well as the Court Monitor's reports, may be found at:

http://www.dmh.ca.gov/Services_and_Programs/State_Hospitals/CRIPA/default.asp

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

PUBLIC MENTAL HEALTH SYSTEM ENVISIONED FOR THE FUTURE

DMH envisions a public mental health workforce, which includes clients and family members, sufficient in size, diversity, skills and resources to deliver compassionate, safe, timely and effective mental health services to all individuals who are in need, and their families and caregivers, and contributes to increased prevention, wellness, recovery and resilience for the people of California.

Strength-based mental health service delivery that embodies the principles of wellness, recovery and resilience is being recognized as essential to preventing costly and often involuntary treatment. It also enables individuals to live, work, learn, and fully participate in the communities of their choice.

Significantly expanding the role of individuals, families and the community in the recovery process is an effective strategy to address workforce shortages, as the focus shifts to competencies that can be learned and utilized by many individuals who do not have advanced degrees, credentials or licenses.

The additional resources provided by the passage of the MHSA present the potential for new and expanded services to enable a full spectrum of care. The MHSA will provide the resources to facilitate the expansion of multi-disciplinary training which takes into account the diverse needs of racial and ethnic minorities and other unserved and underserved populations such as children and youth, TAY, adults and older adults.

Cultural competence and the inclusion of the viewpoints and experience of individuals who have received services and their families/caregivers are an integral part of all goals, objectives and actions of the Department. All goals and objectives are intended to support the vision and values of the MHSA. All WET programs funded use methods and promote outcomes consistent with the values and priorities expressed in the MHSA.

The objectives are intended to develop a mental health workforce trained to provide services to an ethnically diverse population across the lifespan that can respond to the unique needs of children and youth, TAY, adults and especially those of older adults, who comprise an increasing percentage of the overall population.

The DMH, in unison with its employees, clients, families, and business partners, continues to embrace the following vision and core values of California's public mental health system where all of our customers' needs are met:

- Clients live, work and learn in their community in the least restrictive setting;
- The community is safe and industrious;
- Relationships are primary among employees, clients, families, and business partners;
- Cultural diversity is appreciated as a source of strength and balance;
- Society is aware of and appreciates the realities of mental illness;
- Success is determined through evidence- and performance-based outcomes;

- The DMH meets challenges through partnerships, creativity, flexibility, innovation and research;
- Client and family needs drive the creation of public policy; and
- Everyone takes responsibility for continuous QI of the mental health system.

California Department of Mental Health Vision Statement and Guiding Principles for Implementation of the Mental Health Services Act

Introduction

The MHSa includes a clear set of challenging goals for all stakeholders to hold in common as the MHSa becomes reality. Within the context of those common goals, the DMH developed, in partnership with stakeholders, a Vision Statement and Guiding Principles to use as it implements the CSS component of the MHSa.

Most of the language and concepts included in the Vision Statement and Guiding Principles document were originally presented to MHSa stakeholders on the DMH website and at a public meeting in Sacramento in December 2004. At that time it was entitled “DMH Vision Statement.” Since then, in response to stakeholder comments and DMH policy clarification, this document has become a Vision Statement and Guiding Principles for DMH to hold for itself and stakeholders as it implements the CSS component of the MHSa.

As a designated partner in this critical and historic undertaking, DMH dedicated its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with SMI and resiliency for children with SED and their families. In its implementation responsibilities under the MHSa, DMH pledges to look beyond “business as usual” to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with SMI or SED no longer exists.

Beyond the goals in statute for the MHSa as a whole, DMH has developed, with stakeholder input, a set of Guiding Principles. These Guiding Principles will be the benchmark for DMH in its implementation of the MHSa. DMH will work toward significant changes in the existing public mental health system in the following areas:

Consumer and Family Participation and Involvement

- Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system including but not limited to: planning, policy development, service delivery, and evaluation;
- Increases in consumer-operated services such as drop-in centers, peer support programs, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services; and

- Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race/ethnicity, culture, concerns and motivations.

Programs and Services

- Changes in access and increased geographic proximity of services so that clients will be able to receive individualized, personalized responses to their needs within a reasonable period of time and to the extent needed to enable them to live successfully in the community;
- Elimination of service policies and practices that are not effective in helping clients achieve their goals. Ineffective treatment methods will be replaced by the development and expansion of new values-driven, evidence-based and promising practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures and produce more favorable outcomes;
- Increases in the array and types of available services so that children, TAY, adult and older adults, clients and their families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals in their individualized plans; and
- Integrated treatment for persons with dual diagnoses, particularly SMI and serious substance use disorders, through a single individualized plan, and integrated screening and assessment at all points of entry into the service system.

Age-Specific Needs

- For children, youth and their families, implementation of specific strategies to achieve more meaningful collaboration with child welfare, juvenile justice, education and primary healthcare, in order to provide comprehensive services designed to enable youth to be safe, to live at home, to attend and succeed in school, abide by the law, be healthy and have meaningful relationships with their peers;
- For TAY, programs to address the unique issues of this population who must manage their mental health issues while moving toward independence. This should include a person as a point of contact who would follow youth as they transition from the youth systems into the adult system or move out of the mental health system. To meet the needs of these youth, programs need to include specific strategies for collaboration between the youth and adult systems of care, education, employment and training agencies, alternative living situations and housing and redevelopment departments;
- For adults, implementation of specific strategies to achieve more meaningful collaboration with local resources such as physical health, housing, employment, education, law enforcement and criminal justice systems in order to promote creative and

innovative ways to provide integrated services with the goals of adequate health care, independent living and self-sufficiency;

- For older adults, implementation of specific strategies to increase access to services such as transportation, mobile and home-based services, comprehensive psychiatric assessments which include a physical and psychosocial evaluation, service coordination with medical and social service providers and integration of mental health with primary care. The ability to reside in their community of choice is a fundamental objective; and
- For all ages, reductions in the negative effects of untreated mental illness including reductions in institutionalization, homelessness, incarceration, suicide, and unemployment.

Community Partnerships

- Significant increases in the numbers of agencies, employers, community based organizations and schools that recognize and participate in the creation of opportunities for education, jobs, housing, social relationships and meaningful contributions to community life for all, including persons with mental illness. Care must be collaborative and integrated, not fragmented.

Cultural Competence

- Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of mental health services; and
- Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.

Outcomes and Accountability

- Expanded commitment to outcome monitoring including developing/refining strategies for evaluation of consumer outcomes, and system and community indicators, using standardized measurement approaches whenever possible. Data needs to be readily accessible and viewed as an essential part of program planning;
- Development and implementation of policy and procedures to ensure that changes in service array in the future are based on intended outcomes. This may necessitate increased training and support for the mental health workforce; and
- Achievement of the MHSA accountability goals necessitates statewide adoption of consistent, effective service delivery approaches as well as standard performance indicators, data measurement and reporting strategies.

Child - A discussion of the strengths and weaknesses of the service system.

See Adult Plan

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

See Adult Plan

Child - A statement of the State's priorities and plans to address unmet needs.

See Adult Plan

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

See Adult Plan

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

See Adult Plan

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

ADULT/OLDER ADULT ORGANIZED COMMUNITY-BASED SYSTEM OF CARE

The DMH has presented in past plans, descriptions of activities focused upon the implementation of integrated systems of care for children, adults and older adults. These activities include finance reform and the application of new measures of accountability, including the development of performance outcomes. The current phase of these efforts may best be characterized by their integration with each other within the domain of public human services.

Today, adult and older adult systems of care efforts provide variations on recovery-based, comprehensive, and integrated service models. These service models are tailored to each client's full range of needs, as identified by the direct consumer. These needs are generally addressed within the service agency's internal array of services, and if not, are met by an outside agency with the assistance and support of the primary agency.

These models incorporate "community support program" concepts by directly involving the consumer, family members and friends as appropriate, and staff in long term planning. The array of services includes those addressing mental health, substance abuse, education, or other needs that allow the direct consumer to become a stabilized, self-managed, and productive member of the community. An important aim is to reverse the trend of isolating and institutionalizing clients in two ways:

- By ensuring that client priorities are met through services that are accountable on an individual outcome basis; and
- By making the client the priority of the service, recognizing total living needs rather than addressing symptoms of mental illness only.

In the field of mental health, the present description of the recovery model has four fluid stages: hope, empowerment, self-responsibility, and having a meaningful role in life. Put together as a coherent series, these stages can provide a roadmap of the process of recovery generally, and can be applied specifically to the work of helping people recover from the destruction of SMI.

Characteristics of local efforts include dedication to providing recovery-based comprehensive services, team models that rely heavily on interagency collaboration and cooperation to meet clients' needs, voluntary participation of clients in each service identified in a personal service plan, and provision of services on a 24-hour basis to meet all members' needs, including housing, supported and competitive employment, socialization, education, rehabilitation, legal assistance, money management, mental health treatment, physical health care and dental care. Some programs include strong components that provide information, counseling, respite, and other services for relatives of clients. These efforts parallel increased awareness that when mental health needs of adults are not effectively met in the mental health system, the result is usually increased costs to other human service delivery systems, including health care, substance abuse services, social services, and criminal justice.

In California, counties are largely financially responsible for human service delivery systems, and are also designated as the local mental health managed care entity, or MHP, for Medi-Cal beneficiaries in their geographic areas. Therefore, it is at the county and city level that ASOC

development and implementation are taking place. To this end, the CMHDA has established the ASOC Committee to provide the structural link between DMH efforts and local efforts in establishing effective systems of care for adults. The DMH continues to collaborate in a variety of training programs, consultations, conferences, policy formulation, and services planning associated with adult services.

Another point recognized at the local level is that effective services are usually those that are specifically designed with respect to an individual client. These services can enhance the focus on cultural, gender, and age-related issues central to understanding the individual client. Since counties and cities are the entities with the financial responsibility in California's public mental health system, the system must also provide an environment in which to manage the risk presented by the SMIs of its residents.

Further, Systems of Care must represent a coordinated service delivery structure that:

- Ensures timely and appropriate access to all of the services its members need;
- Has partnerships with clients, families, and essential agencies and organizations;
- Produces measurable outcomes and client satisfaction; and
- Enhances clinical and cost effectiveness.

Staff training in personal service planning, recovery-based service philosophy, co-occurring mental health and substance-related disorders, cultural competency, supported housing and employment, family engagement and respite services has proven invaluable in helping staff develop the skills and expertise to recognize the value of, and provide, recovery-based, comprehensive and integrated services. The DMH has expanded its training program to include consultation and technical assistance to county mental health programs and service agencies in California. Additionally, the training program, which has been enhanced and expanded through an interagency cooperative agreement with the DOR, assists county mental health programs in replicating the models described above or enhancing traditional programs by adding individual program components or service elements from those models.

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

SERVICE COORDINATION AND ACCOUNTABILITY TO THE CLIENT AND FAMILY

The DMH, in conjunction with the CMHPC, supports service coordination principles stated in the California Mental Health Master Plan. Service coordination should be viewed as "personalized helping" and as the "human link between the client and formal service delivery." This means establishing personal relationships of trust and respect, which requires developing more collaborative and respectful relationships between staff and clients.

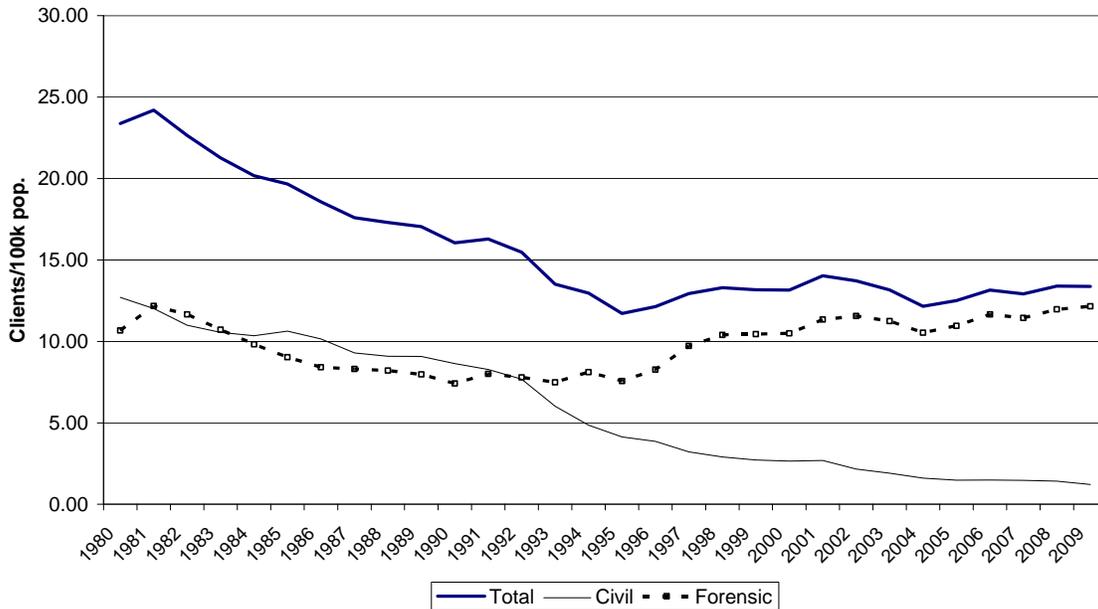
All service coordination activities in the counties include some or all of the following elements:

- Case-finding methods to identify clients;
- A comprehensive assessment of each client;
- A comprehensive service plan;
- Coordination and linkage of services;
- Provision of client advocacy to assure income protection;
- Documentation of service delivery;
- Money management;
- Promotion of self-help resources; and
- Progress reports on service plans.

RATES OF HOSPITALIZATION

The State Hospital population peaked in 1956 with over 37,000 people in the State Hospitals at that time. The population steadily decreased for the next four decades until about 1996 when it began to increase slightly. The following graph shows the number of state hospital clients per 100,000 total State population from 1980 through June 2009. The lowest point was in 1995 when the State Hospital population on June 30 of that year was 3,788, or a rate of 11.71 people per 100,000 population. The graph also shows that the population who is voluntary or civilly committed continued to decrease while the forensic population has been increasing during the same period.

**State Hospital Population
Clients per 100,000 Total State Population
June 30th, 1980 - 2009**



There are several reasons for these changes. First, in 1991 the State enacted the realignment legislation, which altered the fiscal and administrative responsibilities as well as the State and County relationship regarding the provision of mental health services. A significant component of realignment was the transfer of State funds used for state hospital services for civilly committed clients to the counties. Before realignment, the State allocated to each County a historically determined number of beds for voluntary and civil commitments. The Counties had little financial stake in, or programmatic control over, these beds. Realignment shifted the bed funding to counties along with the discretion over how to spend the funds to serve the needs of persons with SMI. Counties could contract for state hospital beds or use the funds locally to hire staff and/or contract for services. The results have been dramatic in terms of the impact on the state hospital population. Although the number of civil commitments was already decreasing, realignment hastened that decline from 8.28 people per 100,000 population in June 1991 to 1.22 individuals per 100,000 population in June 2009. This dynamic is shown in the above graph.

While civil commitments are decreasing, forensic commitments have increased. This is due to an increase in the number of persons judged incompetent to stand trial, persons not guilty by reason of insanity, and mentally disordered offenders. In addition, California enacted a Sexually Violent Predator (SVP) law in 1995. This accentuated the increase in the forensic population with longer commitments. In order to manage the increasing forensic patient population, the DMH opened its fifth state hospital in September 2005, Coalinga State Hospital, which houses and provides treatment primarily for SVP individuals. It is likely that the forensic population will continue to increase. Current statistics show that 12.16 of every 100,000 Californians reside in a DMH state hospital under a penal commitment. Overall the combined rate of Californians institutionalized in DMH hospitals at the end of SFY 2008-09 was 13.38 per 100,000 population.

RESIDENTIAL ALTERNATIVES TO HOSPITALS

Several types of residential alternatives to State and local hospital services have been developed. Included are:

Community Residential Treatment Systems (CRTS)

CRTS' are Social Rehabilitation Programs that provide a wide range of alternatives to institutional care based on the principles of residential community-based treatment. Facilities are to resemble a normal home environment as much as possible. Medi-Cal reimbursement is available if the facilities have 16 beds or less, which provides an incentive for establishing smaller facilities. Three types of residential programs fall into the CRTS category:

1. Short-term Crisis Residential - 30-day maximum stay;
2. Transitional Residential - 1 year stay; and
3. Long-term Residential - 18 month stay.

Numerous services, including vocational and other ancillary services, are provided in these facilities. DMH reviews, monitors, and certifies Social Rehabilitation Programs in CRTS. Certification by DMH, and licensure by the State Department of Social Services (DSS), are requirements for CRTS facilities.

90 CRTS FACILITIES 1,141 BEDS

Community Treatment Facilities (CTF)

CTFs are residential treatment facilities that provide mental health treatment services to adolescents, diagnosed as SED and have the capacity to provide secure containment. The CTF is designed to provide an alternative to state hospital or out-of-state placement, and to enable children with mental health needs to receive treatment in less restrictive, more appropriate settings, closer to their families' homes. The services provided include, but are not limited to, outpatient therapy, family counseling, case management, family preservation efforts, and special education classes, or non-public schooling.

CTFs are licensed through the DSS Community Care Licensing Division (DSS/CCLD), as a special designation, CTF. The special designation is because CTF are locked facilities. DSS/CCLD is in charge of licensing inspections, which oversee the construction and engineering aspects of the facility as well as basic staffing standards and health and safety concerns. DMH is in charge of reviewing the mental health treatment program in the facility. MHP components are subject to program standards pursuant to Section 4094 of the Welfare and Institutions Code.

3 CTF FACILITIES 86 BEDS

Special Treatment Programs (STP) / Skilled Nursing Facility (SNF)

In 1974, California established the STP for those individuals in nursing homes who have mental illness, as part of its Medi-Cal services programs. STPs were developed to provide services to clients with chronic and persistent psychiatric illness who require 24-hour care and supervision. Clients who receive program services in STP have moderate to severe mental illness, with a history of long-term illness that precludes them from being treated in an independent living setting or in other lower levels of care. These clients require ongoing supervision and may be expected to benefit from an active rehabilitation program designed to improve their adaptive functioning or prevent any further deterioration of their adaptive functioning. Currently, there are 28 SNF (licensed by Department of Public Health) in California having STPs. The DMH is responsible for overseeing the programmatic aspects of the STP in these 28 facilities, for developing appropriate statewide program policies and standards, and for providing technical assistance and consultation to the STP/SNF.

28 FACILITIES 2,291 BEDS

Mental Health Rehabilitation Centers (MHRC)

An MHRC is a 24-hour program, licensed by the DMH, that provides intensive support and rehabilitative services designed to assist persons 18 years or older with mental disorders who would have otherwise been placed in a State Hospital or another mental health facility. MHRCs are designed to help individuals develop the skills to become self-sufficient and capable of increasing levels of independent functioning within a psychosocial rehabilitation model.

Chapter 678, Statutes of 1994 (SB 2017), added Section 5675 to the Welfare and Institutions Code (WIC). This addition required the DMH to promulgate emergency regulations to establish the standards for a pilot project for Placer County and up to six other surrounding counties. The participating counties were to develop a shared 24-hour MHRC for the provision of alternative community care and treatment for persons who otherwise would be placed in a State Hospital or another mental health facility. This legislation also provided that DMH consider MHRC proposals from other counties.

Emergency regulations were adopted in August 1995. Permanent regulations were adopted in August 1997. In addition to the original Placer County MHRC pilot project, over the last decade many other MHRCs have been established under the provisions of the regulations. There are currently 20 DMH-licensed MHRCs statewide.

20 MHRC FACILITIES 1,427 BEDS

Psychiatric Health Facility (PHF)

The PHF, which provides non-medical acute inpatient psychiatric care, was established in 1978 as a low cost, high quality alternative to acute hospitalization. PHFs (in addition to MHRCs) comprise one of only two types of facilities actually licensed by DMH. As a prerequisite to licensure by the DMH, PHFs are required to keep their costs or charges to approximately 60

percent of the costs or charges for similar services provided in a psychiatric or general acute care hospital. PHFs that are federally certified or accredited by a nationally recognized commission, and public facilities that are federally certified and serve a specified proportion of Medi-Cal patients, may apply to DMH to increase their per diem to 75 percent of the average costs or charges of a psychiatric or general acute care hospital.

The DMH currently licenses 21 PHFs, 11 of which are owned and operated by private organizations; local governments operate the remaining 10 PHFs.

21 PHF FACILITIES 451 BEDS

Pre-Admission Screening and Resident Review (PASRR)

The Nursing Home Reform Act (NHRA), enacted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) and effective January 1989, revised federal laws governing nursing facilities (NFs). OBRA-87 requires that all individuals initially entering a NF must be screened to determine if they have a developmental disability, a mental health diagnosis or suspected of having a mental illness. On admission to a NF, a Preadmission Screening and Resident Review (PASRR) Level I Screening Document is completed for any individual expected to stay 30 days or more. The PASRR Level I Screening Document comes to PASRR from Medicaid nursing facilities on the required DHCS form (DHS 6170) and is stored in PASRR and/or forwarded to the Department of Developmental Services (DDS), as appropriate, for an independent clinical field evaluation (PASRR Level II).

For individuals identified as having, or suspected of having, an SMI, a referral is made for the PASRR evaluation for Mental Illness (MI). PASRR/MI Level II evaluations are conducted through an independent contract administered by DMH, the State Mental Health Authority (SMHA). With the approval of DMH, the contractor recruits, trains and sub-contracts with licensed clinical evaluators throughout the State to conduct these evaluations. DMH PASRR reviews and approves their credentials, and issue a numbered identification badge for each evaluator, once trained. The Level II is designed to evaluate the level of care needed based on physical, psychosocial, and psychological needs; recommend specialized mental health services when necessary; and also recommend other less-than-specialized mental health services from which the individual might benefit. Each field evaluation is reviewed, revised, and certified by the contractor's Medical and Quality Assurance Directors before it is transmitted to DMH.

DMH PASRR clinicians review the findings of the field evaluators and reach a decision that becomes the SMHA final determination. The individual evaluated is sent a letter explaining the conclusions. Copies are mailed to the individual, to the individual's record or chart, the treating physician, the conservator (if one has been appointed by the court), and the local mental health plan. An Individual Request for Review form is attached to enable the individual, the facility staff, or the conservator to ask questions about or disagree with the recommendations made for placement or services. A copy of each determination letter is mailed to the DHCS Medi-Cal Field Office to aid them in reviewing and approving NF treatment authorization requests (TARs) for individuals eligible for Medicaid reimbursement.

DMH clinical and administrative staff dialog with contractor staff (i.e., Quality Assurance and Medical Directors, Contract Manager) and NF staff about PASRR Level I screenings, Level II evaluations, and DMH PASRR final determinations. On request, DMH PASRR clinicians consult with individuals, NF staff members, conservators, and family members (who have a Release of Information from the individual being treated). The PASRR Section Chief consults with the DHCS Medi-Cal Field Office managers and staff when necessary. Consultation given includes activities that address problematic behaviors, encourage therapeutic interactions with other individuals and staff, and what is needed to meet the individual's mental health needs.

A new, expanded, and more consumer-interactive version of the PASRR/MI Level II evaluation was implemented in August 2004. A new PASRR contractor training includes a section on community placement alternatives, so that new evaluators are familiar with each alternative prior to conducting evaluations. In addition, the DMH PASRR final determination letters have been expanded to reflect the additional community alternatives for the consideration of the individual's treating professionals and reflect a strength based recovery interactive model with the individual.

SUPPORTIVE HOUSING

Over the past ten years, DMH has put forth a consistent effort to expand the availability of safe, affordable housing with accessible services for individuals with SMI. This effort has involved significant collaboration and mutual education among agencies (both public and private), State Departments, County Departments, and many committed individuals along the way. The experience gained through the Supportive Housing Initiative Act (SHIA) and AB 2034 Integrated Services Program, as described in previous SAMHSA reports, has been beneficial.

In January 2005, the MHSAs provided a new funding source for services and supports that promote wellness, recovery and resiliency for adults and older adults with SMI and for children and youth with SED and their family members. Safe, affordable housing was recognized as a critical element for recovery, and during the past three years a range of housing services and supports have been included in the initial implementation of MHSAs programs throughout California. In addition to housing services and supports that have been developed through MHSAs county mental health plans, the following describes two statewide housing initiatives focused on expanding permanent supportive housing resources for persons with SMI.

Governor's Homeless Initiative (GHI)

The GHI created a housing finance model that ties together State HCD capital funding (Proposition 46) and MHSAs funds to encourage development of supportive housing projects that target chronically homeless individuals with SMI. This initiative offers a non-traditional centralized loan and application approval process. With the goal of leveraging resources to meet the housing needs of individuals with SMI, county mental health department collaboration is a requirement for projects applying for funding under this program, and one of the conditions for approval is the county mental health department commitment to fund the supportive services.

From 2005 to date, over \$25 million in HCD funds have been committed to GHI projects, and \$1.3 million in MHSAs funds have been utilized for rent subsidies. Of the 151 units developed in 2010, 71 of these are designated for mentally ill homeless and 48 units are designated for chronic homeless. During FY 2009-10, DMH participated in funding four new GHI projects in Los Angeles County: NoHo Senior Village, in Hollywood, CA., 28th Street YMCA, in Los Angeles, CA., Osborne Place Apartments, in Pacoima, CA., and the Horizon Apartments, in Venice, CA.

MHSA Housing Program

Safe, affordable housing was identified by stakeholders as a critical element for recovery throughout MHSAs program planning and implementation. As a result, housing with on-site services and community supports has been developed with MHSAs funding and county mental health departments have more fully integrated housing as a service. On August 6, 2007, the application for the MHSAs Housing Program was released. This program provides funding for the development of housing with services and supports that promote wellness, recovery and resiliency for adults and older adults with SMI and for children and youth with SED and their family members. The MHSAs Housing Program is jointly administered by DMH and the CalHFA. The program has been developed through an interagency collaboration between the CalHFA and DMH, in consultation with County Mental Health Departments, with the goal of utilizing their combined resources to address homelessness for individuals and their families.

The MHSAs Housing Program provides funding for the capital costs and operating subsidies to develop permanent supportive housing for persons with SMI who are homeless, or at risk of homelessness and who are eligible for services under the MHSAs, and county mental health departments commit to providing the supportive services. As of June, 2010, DMH has received and approved 93 applications for funding from the MHSAs Housing Program. County Mental Health Departments are central to project development and approval, and 28 County Mental Health Departments have submitted successful applications. Over 4,522 affordable housing units have been approved, and 1,377 of these units have been designated for the MHSAs target population. To date, nearly \$203 million have been leveraged to access over \$1.5 billion in support of the 93 housing developments. MHSAs funds represent thirteen percent of the financing leveraged to complete the 93 housing developments.

DMH also continues to be committed to providing training and technical assistance to County Mental Health Departments through a comprehensive program designed to support counties with project development and the MHSAs Housing Program application process. In collaboration with CalHFA, this partnership has assisted with the development and approval for 84 Rental Housing Developments and 9 Shared Housing Developments. As referenced above, 1,377 units of affordable housing have been designated for MHSAs eligible tenants who are homeless or at risk of homelessness. Specifically, within the approved projects, 207 of these units are designated for older adults, 80 units are designated for TAY, and the remaining units are intended to serve all populations or a combination of the MHSAs targeted groups.

OLMSTEAD VS. L.C. DECISION

The Supreme Court ruled in its 1999 Olmstead decision (Olmstead v. L.C., 527 U.S. 581 {1999}) that under the Americans with Disabilities Act (ADA), public services for people with disabilities must be provided in the most integrated setting possible, giving them the opportunity to live independently in the community and not segregated in institutional settings. The New Freedom Initiative is the federal effort to implement the Olmstead decision. It is a comprehensive plan that represents an important step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, make choices about their daily lives and participate fully in community life.

In 2003, California conducted a six county, two-year statewide study to look at Institutions for Mental Disease (IMDs) utilization in California and to analyze and evaluate the use of IMD and State Hospital resources. The study was titled “Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases.” Selected findings from the study were:

- Individuals who are placed in IMDs have significant current disabling issues;
- Counties that adopt comprehensive coordinated efforts are able to reduce their utilization of IMD resources by reducing admissions and/or reducing lengths of stay;
- A clinical/treatment vision that sees IMD placement within a system that is dedicated to client-directed services and recovery facilitates change;
- Effective supporting structures and processes are necessary to make changes;
- Variations in county implementation of civil commitment procedures can greatly influence IMD usage;
- Cooperation among all stakeholders promotes effective management of IMD use; and
- A recovery vision and an individualized orientation are not infused in IMD services.

As a result of these findings, DMH applied for and was granted the initial SAMSHA grant to develop the IMD training manual and implement the initial Illness Management and Recovery (IMR) program in an IMD.

DMH has continued to receive funding through SAMHSA’s New Freedom Initiative to develop a recovery-oriented, culturally competent assessment, treatment and discharge planning curriculum and training program for staff of IMDs, and for community mental health staff serving as liaisons to these facilities. The training, a modification of SAMHSA’s IMR Toolkit, was designed to facilitate successful transitions of people residing in these institutions into local communities, with a focus on fostering a partnership between the IMD, the county mental health system and other relevant county partners.

During FYs 2007 through 2009, DMH contracted with the CIMH. The project funded under this second grant had two major components:

- Enhance the IMR model within Los Angeles County by providing support and consultation through a learning community approach, including the hiring of a mental

health education and training coordinator designated to work with facilities to implement the IMR program; and

- Introduce the IMR program to a second county (the Orange County Healthcare Agency was selected out of five applicants).

In addition to the development of the IMR/IMD manual, two additional documents were developed. The first is titled “Crosswalk Between Title XXII STP Service Requirements and the IMR Program”, and the second is titled “Recommended Modifications of Content in the IMR Program Adapted for Some Clients in IMDs.” Both of these documents have been incorporated into IMD/IMR manual revisions.

DMH decided that the application for Years 4 and 5 (SFY 2009-10 and 2010-11) should include the opportunity for more counties to have access to the IMR training. SAMHSA subsequently approved DMH’s proposal to implement a recovery-based practice model that focuses on:

- Statewide dissemination of the IMR Program Model in IMDs;
- Training of IMD staff via distance learning;
- Similar in-house IMR training for appropriate DMH staff;
- Providing online access to the IMD training and related resource on the DMH website;
- Promotion of the IMR model at statewide mental health-related conference; and
- Promoting partnerships among IMDs, county and local mental health systems, and other partners.

For the third three-year grant, DMH intends to contract with the California State University, Sacramento (CSUS) who shall provide trainings to help DMH move toward statewide dissemination of the IMR model which includes the IMD Training Manual. CSUS will work closely with DMH and its partners on training the IMDs and creating interest and motivation among counties to learn more about the IMR model.

PROGRAMS FOR ADULTS WITH COGNITIVE IMPAIRMENT AND THEIR FAMILIES

California families are over two times more likely to encounter cognitive brain-impairing conditions than other mental disorders, according to current incidence data. Landmark legislation responded to this need by creating two programs, the Statewide Caregiver Resource Centers Program and Traumatic Brain Injury (TBI) Services of California.

Statewide Caregiver Resource Centers

Under the Comprehensive Act for Families and Caregivers of Brain-Impaired Adults (Welfare and Institutions Code Section 4362 et. seq.), the DMH established the Caregiver Resource Center (CRC) System in 1984. This is a statewide program consisting of 11 non-profit centers serving all 58 counties in California. The CRCs provide a range of support services for families and caregivers caring for adults with debilitating cognitive impairments including Alzheimer's; multi-infarct disease or other dementias; cerebrovascular diseases such as stroke or aneurysm; degenerative disease which causes both physical and cognitive impairment such as Parkinson's,

Huntington's, multiple sclerosis and amyotrophic lateral sclerosis; brain injury due to trauma or infection; brain tumor; and HIV-related dementia.

Services are designed to deter institutionalization, allow caregivers to maintain a normal routine, and promote quality care. The range of services for family caregivers includes specialized information and referral, in-home assessment of caregiver needs, family consultation and care planning, respite care, support groups, legal/financial consultation, caregiver education and training, counseling, home modifications, emergency response, and advocacy.

Additionally, the law established a Statewide Resources Consultant (SRC) to:

- Operate a statewide information clearinghouse on caregiving and brain disorders;
- Conduct education, training and applied research;
- Implement program and policy development;
- Maintain a statewide database on CRC clients served; and
- Provide technical assistance to CRC sites.

In SFY 2007-08, the 11 CRC sites and the SRC were funded \$11,347,013 of state general funds. In SFY 2008-09, funding for the CRC sites was reduced to \$10,547,000 million, resulting in increases in the number of individuals in waiting lists for respite care, counseling, and legal services.

The CRCs reported 5,729 caregivers received at least one CRC service. This represented a decrease of 1,109 from FY 2006-07. Some of these caregivers were new to the CRCs and received intake services and basic information but wished no further assessment or service. The most-used services caregivers used were: family consultations (13,143 families), respite care (1,734), support groups (1,109), and psycho educational groups (712). A total of 2,311 caregivers for all 11 CRC sites were added to the wait list for respite services. This represented an increase of approximately forty-four percent of caregivers on the wait list. The total of caregivers on the wait list for respite is 5,239.

The governor's SFY 2009-10 revised budget reduced funding for the CRC sites by \$7.029 million to a total funding level of \$2.918 million. This funding reduction will necessitate further service reductions, the extent of which are still being analyzed.

The projected plan includes, but is not limited to, exploring other efforts to reduce the increased wait list for individuals for respite care services.

Traumatic Brain Injury Services of California

This program for adults with TBI was initiated with the passage of Senate Bill 2232 (Chapter 1292, Statutes of 1988), which was later amended by Assembly Bill 1492 (Chapter 1023, Statutes of 1999). This legislation establishing the TBI services is set forth in Welfare and Institutions Code Section 4354 et. seq. The purpose of the project is to "demonstrate the effectiveness of a coordinated service approach which furthers the goal of assisting individuals with TBI to attain productive, independent lives which may include paid employment."

In October 2007, the California Legislature passed Assembly Bill 1410, informally referred to as the TBI Bill. The TBI Bill (Appendix D) details the following:

- Requires DHCS to apply to the federal Centers for Medicare and Medicaid Services (CMS) for a Home and Community-Based Services (HCBS) waiver application or amendment of the state plan for HCBS, to serve at least 100 Medicaid (Medi-Cal) eligible adults with TBI who otherwise would require care in an institution such as a nursing facility; and
- Allows the seven TBI sites in California to offer services to more people and to offer new services with the additional federal support. The services include various kinds of assessments and rehabilitative therapies, supported living, and case management services, including supported employment. Uses existing funds – from the TBI Fund – to serve as the state match for the federal money (thus no state general funds are needed for this match to pay for TBI services). General funds would only be needed to administer the program.

A second bill affecting persons with TBI was recently signed into law. On October 12, 2009, Governor Schwarzenegger signed Assembly Bill 398, (Appendix E) which impacts TBI services and programs. One of the significant changes outlined in the bill is the transfer of the administrative duties and oversight of the California TBI Program, effective January 1, 2010, from DMH to DOR. The bill requires DHCS to submit a HCBS waiver application or amendment of the state plan by March 1, 2011, an extension of the original due date.

The seven TBI sites form the basis for the state's formal TBI service system. All seven sites receive funding from the California TBI Fund, established by Section 1464 of the Penal Code. The legislation stipulates that 0.66% of the state penalty funds imposed upon every fine, penalty, or forfeiture collected by the courts throughout the state for criminal and vehicular offenses be contributed to the TBI Fund. Fines collected for violation of California's seat belt law also support the TBI Program. A cap on the TBI Fund was lifted in 2000, after Senate Bill 2232 was amended. In FY 2009-10, the Fund total was \$1.05 million (approximately \$150,000 per site). Below are the seven sites, and the counties they serve.

- **Betty Clooney Foundation**
Los Angeles County
- **Central Coast Center For Independent Living "New Options"**
Santa Cruz County & Monterey Counties
- **Janet Pomeroy Center "San Francisco TBI Network"**
San Francisco County
- **Making Headway Center**
Humboldt, Mendocino & Del Norte Counties
- **Mercy General Hospital "Coordinated Care Project"**
Sacramento, Placer & El Dorado Counties

- **Options Family Services**
San Luis Obispo & Santa Barbara Counties
- **St. Jude Medical Center “St. Jude Brain Injury Network”**
Orange County

The core services provided by the TBI sites (outlined in Senate Bill 2232 and further detailed in the sites contract project objectives) include the following:

- **Community Reintegration Services** - services needed by participants that are designed to develop, maintain, increase, or maximize independent functioning, with the goal of living in the community and participating in community life;
- **Family and Community Education** - provision of information designed to improve overall understanding of the nature and consequences of TBI, including public and professional education designed to facilitate early identification of persons with TBI, prompt referral of these persons to appropriate services, and improvement of the system of services available to them;
- **Service Coordination Services** - may include provision of information and resources for participants, advocacy, participant and family education about options, liaison for participants among service providers, problem-solving with participants, and monitoring and following-up on well-being and progress;
- **Vocational Supportive Services** - a method of providing vocational rehabilitation and related services to targeted individuals not served or underserved by existing vocational rehabilitation services; and
- **Supported Living Services** - services designed to increase a participant’s independent living skills, includes supervision, support, and training in the participant’s place of residence or other settings.

Despite site-by-site variation in the provision and delivery of core services, influenced by each site’s unique organizational-funding structure and geographic location, all sites provide similar core services, employing a coordinated continuum-of-care model that focuses on case management and service coordination services. In 2008-09, the seven sites served a total of 975 participants, of which 160 were new intakes. Although the sites primarily focus their staff time and resources on persons with TBI, each site also provides information and assistance services and addresses the needs of caregivers. Several have contracts or Memoranda of Understanding (MOUs) with local CRCs to provide supportive services to family members and other caregivers.

The target population for this project is persons 18 years of age or older with an injury that was sustained after birth from an external force to the brain, or any of its parts, resulting in psychological, neurological, or anatomical changes in brain functions.

CO-OCCURRING SUBSTANCE ABUSE AND MENTAL DISORDERS (DUAL DIAGNOSIS)

The increasing awareness and acknowledgement of persons exhibiting co-occurring substance abuse and mental disorders, or dual diagnosis, is an issue of national concern. It is estimated that

approximately 60 percent of persons with a serious mental illness also have a substance abuse problem, and that up to 90 percent or more of the highest cost users of mental health services, including forensics consumers, also abuse substances.

ADP and DMH have long recognized the critical need of working cooperatively to provide quality treatment services to individuals with CODs. Building on the efforts that have taken place since 1995, DMH and ADP, in collaboration with the County Alcohol and Drug Program Administrators Association of California, the CMHDA, the Alcohol and Drug Program Institute, and the CIMH, convened the Co-Occurring Joint Action Council (COJAC), which meets quarterly.

The Council's joint vision statement — "One Team with One Plan for One Person" — states that "Each individual receives a comprehensive assessment that results in the formation of an interdisciplinary and possibly interagency team that will develop one individualized treatment plan for that person within a reasonable period of time. This plan will specify all necessary services and supports to be delivered by the single interdisciplinary service team that has all the needed skill sets and the right members in place from each agency. The individual client will have a strong voice in shaping the plan in development and implementation. The plan is expected to evolve as needed as that person progresses."

The COJAC recognized that in order to achieve its objectives it was necessary to have additional staff support from the two state agencies sponsoring this effort. The passage of the MHSA provides the opportunity for DMH to make available increased funding, personnel and other resources to support county MHPs, including COD services, and monitor progress toward statewide goals for children, TAY, adults, older adults and families.

The COD office within the ADP continues to receive funds from the MHSA to provide for the functions and tasks listed below. Other functions and tasks may be added as determined by the COJAC, the DMH, and the ADP.

- Collaborate with the COJAC, the DMH, and others in recommending policies, programs and projects addressing COD;
- Provide assistance to policy makers who are providing leadership to the COD State Action Plan for California;
- Assist counties and other providers who are addressing persons with COD or those at high risk of the disorder;
- Recommend workforce development training for counties and other providers addressing COD issues;
- Provide technical assistance by conducting COD related research, collecting and disseminating data; and
- Assist the DMH and the ADP to blend their respective services into local programs that will effectively serve persons with COD.

Additional efforts by the DMH in the area of CODs include the following:

- The DMH has permanently set aside \$8,059,000 of its annual SAMHSA Block Grant for allocation to counties to support existing efforts in providing integrated treatment services for adults with CODs. Counties are required to submit to DMH expenditure plans describing their intended use of the additional funds for the DMH's review and approval.

Resource-Building Treatment Strategies

Youth with CODs need special resources to overcome each of their disorders. The following are resource-building treatment strategies developed by the CMHDA, Children's System of Care/Adult System of Care, TAY Subcommittee, published April 29, 2005:

There should be no wrong door as an entryway to treatment. Whatever agency the youth uses to request help must ensure that the youth has access to services from partner agencies. These services may include mental health and substance-related treatment as well as housing, training, rehabilitation resources, and therapeutic courts. This is critical because when the youth needs help, it must happen in the moment or the opportunity may be lost. With the youth's permission, there should be collaboration and coordination of the youth's treatment plan. Substance abuse programs, from the continuum of abstinence to harm reduction, recognize that recovery is incremental and the road to recovery has its ups and downs. Providers should strive to reduce barriers to the provision of appropriate, coordinated, and integrated services for TAY youth, which include different funding streams, philosophical differences, lack of cooperation and collaboration, and the lack of cross training.

Once the youth acknowledges the substance use problem, and agrees to receive support, all significant social supports of the TAY youth should be involved in the treatment planning process including the youth, his or her family, school, social services or probation, mental health, and Alcohol and Other Drug (AOD) providers as well as other members of the youth's support network. Providers must acknowledge that the youth is the holder of the privilege, and thus he or she must agree to how the treatment is organized. In the event the youth does not acknowledge the need for services, all providers and members of the support system should continue to encourage the individual until engagement and maintenance in treatment occurs.

Youth who are homeless or otherwise without stable living conditions will find it difficult to embrace recovery from substance use. Therefore, ensuring that basic needs are met is a critical step in providing care to these youth. This is especially true for TAY with a background in the foster care system whose priorities may be focused on obtaining the basic necessities of living.

Because of TAY's age-appropriate need for independence, providers should work to balance client-driven treatment planning with a solid supportive structure to prevent the individual from becoming "lost" in the process of recovery.

Foster youth are most vulnerable to treatment failure because they may not have the financial and emotional resources to support them in recovery. The youth who suffered trauma from growing up in a domestically violent or an abusive or negligent home is especially vulnerable. If appropriate, family support services can strengthen the youth and the entire family system. By

building on the strengths of the youth, his or her family, and his or her support system, counselors can draw on the resources that each participating party brings to the intervention. Using a strength-based approach, the treatment team can develop and implement a realistic, attainable plan for recovery that improves the functioning of each participant.

Treatment Strategies

- Place a strong emphasis on family involvement. Youth need to feel secure and feel the support of his or her immediate family members and broader social network. No matter what the circumstances of the relationships within the family are, the youth and the family should be engaged in securing solutions to a better relationship. For a variety of reasons, some youth have disengaged from their families and/or support groups and will not have functioning social networks. In these situations, efforts should be made to help the youth build natural supports as part of the treatment process;
- Develop an individualistic case plan. Each client has unique circumstances with individualized sets of goals and objectives. A “cookie cutter” or “one size fits all” approach will not be effective. As Dr. Pablo Stewart has noted, there are instances where the substance use is a manner of self-medicating for long standing untreated mental illnesses. It is for this reason that MH and AOD staff need to work closely together and use a universal chart where entries from both Departments are available to the other and to additional participants of the treatment team;
- Explore the strengths of the youth. Recovery based goals will be founded upon the youth’s vision of his or her future. The treatment planning team will need to focus the discussion in a hopeful and supportive manner;
- Providers need to consider that what is happening for the youth may in fact be a “system issue,” meaning that the youth may be acting out symptoms for other family members or for a significant other. By including the whole family group and/or the significant other, there is a greater likelihood that a true solution will be found. A youth’s crisis is an opportunity for the family constellation to enhance communication and improve functioning for the future; and
- Woman and girls with co-occurring disorders often come from a background of family violence, and the sequelae of trauma endured may be what is driving the mental illness or substance involvement.

ELIMINATING MENTAL HEALTH DISPARITIES TO RACIAL, ETHNIC, AND CULTURAL POPULATIONS: MOVING TOWARDS CULTURAL AND LINGUISTIC COMPETENCE SOLUTIONS

The DMH OMS continues to work with multiple partners at the state, local and community and university levels to address the disparities in services to California’s diverse racial, ethnic and cultural communities. Only through true partnership can progress be made to eliminate the disparities in mental health outcomes. California is one of the most demographically diverse

states in the nation. California's population has grown by over 30 percent since 1990. California is now a multicultural majority state. Multicultural populations now comprise more than 51 percent of the State population. The State's Hispanic/Latino population has nearly doubled, from 7.7 million in 1990 to nearly 14.2 million in 2009, followed by the Asian/Pacific Islander population, up over 74 percent from 2.7 million to 4.4 million in the same time period. The Hispanic category includes all persons who indicated Hispanic or Latino in the 2000 Census. The remaining categories include only those persons who did not identify themselves as Hispanic or Latino. In the 2000 census, California's combined ethnic and racial populations became the majority; this trend continued in 2009. These changes make it imperative that mental health policies, services, and planning are designed with this growing diversity in mind.

TOTAL POPULATION 2009

BY RACE AND AGE GROUP

California Department of Finance- July 1, 2007

RACE/ETHNICITY	Total	AGE GROUP		
		0-17	18-64	65+
Total	38,688,293	9,992,333	24,394,369	4,301,591
White	16,433,317	3,062,442	10,691,898	2,678,977
Hispanic	14,182,666	4,921,886	8,499,964	760,816
Asian/Pacific Islander	4,745,770	1,017,185	3,164,140	564,445
Black	2,279,118	575,538	1,487,190	216,390
American Indian	235,471	46,522	163,025	25,924

The following table shows the distribution of the unduplicated clients served in the State during Fiscal Year 2007-08. The client population reflects the diversity of the State population although not all groups are represented proportionally to the State population.

UNDUPLICATED CLIENTS BY RACE / ETHNICITY AND AGE GROUP							
FISCAL YEAR 2007-2008							
DEPARTMENT OF MENTAL HEALTH							
ETHNICITY/RACE	Total	Age Groups					Age Unknown
		0-8	9-17	18-59	60-64	65+	
Total	670,966	53,817	163,318	410,246	22,313	21,012	260
White	191,284	11,092	34,613	130,602	7,502	7,436	39
Hispanic	129,484	18,522	46,916	60,109	1,859	2,002	76
Black or African American	62,585	5,808	18,253	36,250	1,241	1,014	19
American Indian and Alaska Native	4,730	416	1,187	2,929	108	89	1
Asian *	27,058	1,092	3,563	18,456	2,122	1,820	5
Native Hawaiian or Other Pacific Islander **	1,575	131	509	888	25	22	0
Some Other Race	15,885	1,624	3,675	9,413	530	623	20
Unknown/Not Reported	238,365	15,132	54,602	151,599	8,926	8,006	100

*Includes Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Mien, Vietnamese, and Other Asian.

** Includes Guamanian and Samoan.

The DMH is working towards developing the most effective, efficient mental health service system that will meet the diverse cultural and linguistic needs of the State's population. Both access to, and effectiveness of, care are affected by the level of culturally competent mental health care that State and local mental health providers are able to deliver. Providing culturally competent care is viewed as an overall quality of care issue. California has taken a developmental approach to moving culturally competent services forward. In 1998 DMH has assumed a leadership role by establishing the OMS at the Director's Office level. Since 1998 the OMS has grown to employ six full time employees.

For the past ten years, the DMH OMS has had in place an active Cultural Competency Advisory Committee (CCAC) to provide assistance and advice in developing culturally competent mental health services. The CCAC is chaired by the Chief of the OMS and CCAC is composed of representatives from the CMHDA, consumers and family members of adults and minor children, community organizations and their representatives, County Ethnic Services Coordinators, and the academic community. The membership of the CCAC is ethnically and racially diverse.

Since the release of the 2001 U.S. Surgeon General's *Supplemental Report on Mental Health: Culture, Race, and Ethnicity*, and the 2003 DHHS report, *The President's New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America*, the DMH OMS with the CCAC has been working to incorporate information and recommendations into state and local level cultural competence policies and planning. Since 1998, the OMS has worked with several new partners who have joined the DMH, CCAC to address statewide mental health reducing disparities issues. These partners include the CIMH, Center for Multicultural Development and the CMHPC Cultural Competence Committee. With the passage of Proposition 63 and the development of the MHSA, the Oversight and Accountability Commission has developed a CLCC to help them ensure inclusion of addressing disparities issues in the implementation of the MHSA. The DMH OMS supports these efforts and works with these and other state level committees and stakeholders.

The DMH continues to be actively engaged at several levels with current mental health reducing disparities efforts that exist in our state for multicultural communities. The MHSA, which California voters approved in November of 2004, provides an opportunity to transform the mental health system in California. Through the MHSA, DMH is addressing Goal 3 of the President's New Freedom Commission on Mental Health Report "to eliminate disparities to racial ethnic communities in mental health." In addition, DMH's Vision Statement and Guiding Principles for MHSA implementation states that "as a designated partner of this critical and historic undertaking, the DMH will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system." The OMS help to include developing culturally competent programs be one of the transformative principles of the MHSA. Following is a list of activities that demonstrates the efforts of the OMS in partnership with multiple community and state partners to address the reduction in disparities in access, quality of care and outcomes for racial ethnic and cultural communities in our state.

- Embedding cultural competency into program policy and planning is a key role of the OMS. A major focus of this office since the passage of the MHSA in 2004 has been to integrate policies and standards in the roll out of the MHSA programs and services that are being developed with these new mental health resources. The OMS has played an active role in the development of the guidelines for the MHSA, including guidelines and requirement for three major components of the Act, CSS, PEI, WET. New follow up regulations to MHSA includes a comprehensive and expansive definition of cultural competence and efforts to require improve engagement of underserved and unserved racial ethnic and cultural communities in the local stakeholders planning process for local MHSA programs.

Activities for Fiscal Year (FY) 2008-09

- The OMS is an active member of the newly formed MHSOAC CCLC. The OMS played an active role in development of the CCLC work plan. The primary role of the Cultural and Linguistic Competence committee is to ensure the MHSOAC has access to experts in the three core principles of the MHSA: (1) cultural and linguistic competence to reduce disparities, (2) inclusion of multicultural client and family involvement in shaping MHSA policy, and (3) improvements in development of outcomes and accountability that include tracking disparities. The MHSOAC CCLC serves at the pleasure of the MHSOAC and

consists of individuals with expertise in a systems approach to cultural and linguistic competence, mental health stigma and discrimination reduction, reducing disparities in access to services and quality of mental health outcomes among unserved, underserved and inappropriately served communities in California. The MHSOAC CCLC is charged with ensuring that the MHSOAC has an ongoing focus on reducing and eliminating disparities in the area of access, quality of care, and outcomes in mental health service provision to unserved, underserved and inappropriately served communities. Currently, OMS is working closely with MHSOAC CLCC on developing new disparities outcomes measures.

- The CMHPC Cultural Competence Committee's mission is to reduce disparities in the mental health system. One of its objectives is to identify performance indicators that measure disparities, generate data for those indicators; determine causes of disparities, and to develop solutions for this problem. The committee is also involved in monitoring the implementation of the State's Cultural Competence Plan requirements and plans to identify county mental health programs with best practices in developing their local plans.
- The OMS has gained support in its' efforts to reduce disparities in programs and services by adding to OMS resources by contracting with additional state cultural competence experts in the field of Mental Health and cultural competence to support the OMS work in the review of county MHSA plan submissions and in increasing training opportunities for state staff.
- The OMS developed a subject specific Cultural Brokers committee made up of mostly Community based Organization and other providers who work with underserved racial ethnic and cultural communities to address two issues of the MHSA Community Services and Support roll out of first the FSP programs for SMI and SED adults and children. Second issues pertaining to the integration of MHSA programs and projects with the rest of the mental health system
- The OMS continues to provide training and support to consumer and family members organizations for inclusion of more multicultural engagement in their planning and embedding of cultural competency in their planning;
- This year the OMS has issued a contract for more than \$150,000 to translate state mental health materials to improve language access for limited English speakers. The web site and many DMH documents have been translated this year into Spanish and Vietnamese, the states two threshold languages.
- The OMS has completed it's partnership with University La Verne and CMHDA in the development of the CA Brief Multicultural Competence Scale (CBMCS) and training programs curriculum. It has been completed and is now available for purchase by Sage publishing company at www.cbmcs.org web page. Some counties through their MHSA WET Plans have purchased this multicultural training curriculum and have begun using it to train mental health staff. This is an Evidence Based Training program consisting of 4 training modals of eight hours each for 36 hour training program for mental health providers. This training tool includes a provider assessment tool that is directly tied to the

curriculum.

- DMH OMS has partnered to support the completion of a second curriculum with the National Latino Behavioral Health Association and has completed a pilot and evaluation of a mental health training program for interpreters in fiscal year 2008. The training curriculum was geared towards training bilingual persons to become train interpreters in the mental health field. Currently, various counties have taken the initiative to use this training curriculum to increase their capacity for having trained bilingual persons. County mental health have the opportunity to purchase and use this curriculum.
- Currently under MHSA PEI guidelines, \$60 million dollars have been targeted over four years for a state administered program to address reducing disparities for racial ethnic populations. OMS is working with community partners to develop a strategic plan for the development of programs and services under this targeted state program. DMH has legislative authority to use \$1.5 million of State administrative MHSA funds to support this project.
- There will be three RFP's that will be funded by the \$1.5 million of State administrative MHSA funds. One RFP will be awarded to fund a MHSA Multicultural Collaborative. The second RFP will be awarded to fund up to five contracts to develop strategic plans specific racial/ethnic/cultural recommendations/solutions for reducing disparities to five targeted populations with histories of disparities in mental health. Third RFP will be awarded to fund a contract to coordinate, facilitate, and compile the input and recommendations into one comprehensive strategic plan.
- These three RFP's will be developed by DMH Community Programs/State level projects and OMS. The second RFP is in response to the disparities that exist in mental health care for five targeted populations. The reducing disparity strategic planning RFP was released in mid-June 2009. DMH will award up to five separate contracts to establish five Strategic Planning Workgroups, each corresponding to one of the following populations: African Americans, Asian and Pacific Islanders, Latinos, Lesbian, Gay, Bi-sexual, Transgender, Questioning, and Native Americans. These Workgroups would identify population-focused, culturally competent recommendations/solutions coming from these communities for reducing disparities in mental health services, and seek to improve outcomes by identifying community-defined evidence, strength-based solutions and strategies to eliminate barriers in the mental health systems. These strategic plans will to help design the \$60 million (approximately) PEI statewide project.
- Disparities in access to care for Ca Native American communities are a complex and difficult challenge. This year OMS contracted with a Native American organization called the Inter-Tribal Council of CA to work with OMS and CMHDA to improve collaboration and inclusion of CA tribal communities in local mental health planning to improve relationships and communication between county programs and local Native American communities at the county. A resources guide is in process of being completed and a report of a survey developed by Inter-Tribal Council of CA was completed.

- The DMH contracted with the University of California Davis Health System, Center for Reducing Disparities, Office of Continuing Medical Education to provide a 2-day state-wide conference on identifying, measuring and tracking mental health disparities as part of the debate and discussion on the transformation of Ca mental health system. The conference title was “Mapping Progress in Mental Health Disparities in a Transformed California Mental Health System”. This statewide conference was held in Sacramento, CA on May 21-22, 2009. This conference provided information on the many special populations in California mental health system, and identified statistically sound and cost-effective methodologies for measuring need. The over arching message of the conference was that different populations may require different methodologies for measurement and assessment in obtaining optimal mental health care strategies for reducing barriers to treatment and access. Measuring the effectiveness of existing and new mental health treatment programs is important for program assessment and for tracking improvements in retention and quality of care over time. Some of the topics at the conference included:
 - Should the focus be on mental health status (prevalence rates), service use (patterns of service utilization), or quality of care (outcomes)?
 - What mental health indicators should be measured and how are they best measured?
 - What outcome measures should be the focus for mental health disparities data collection and analysis?
 - How do issues of data quality affect the choice of measures?
 - How are populations being measured? Are there issues of undercounting of some populations?
 - Challenges of assessing special populations such as Native Americans, LGBTQ, and the homeless.
 - Whether available healthcare data systems (e.g., CSI and Medi-Cal) should be analyzed to assess disparities in a complex manner (e.g., using complex statistical models at the census tract level). and
 - Whether data collection protocols and the reporting of measures should be standardized across counties.

Lastly, Norman Sartorius, MD, PhD, past Director of the Division of Mental Health of the World Health Organization and past President of the World Psychiatric Association was the key note speaker for the conference. He is a world renowned expert on issues related to mental disorders in developing countries and a leader in the field of combating stigma of mental illness and its consequences.

- The DMH OMS has been invited to be a member of the CMHDA, newly formed SJA committee. The CMHDA has formed the SJA Committee. The purpose of the SJA Committee is to advocate for equity and full inclusion of vulnerable populations and secure social justice as measured by access to necessary quality services that promote mental health, wellness, resiliency and recovery in California’s communities. The CMHDA will foster and develop trust and rapport to establish, maintain and expand partnerships with all local, state and federal organizations/groups that impact, or will engage in joint ventures that increase, quality of life for persons at risk of or experiencing mental illness.

- DMH OMS in partnership with CCAC has been working this year and has now completed the final draft of the revised DMH CCPR; the first CCPR was issued in 1997 and revised and reissued in 2000, the third revision will be issued after June 2009

Activities for Fiscal Year (FY) 2009-10

- Roll out the Reducing Disparities RFP identified in 2008-09 above and fund five population groups to develop statewide strategic plan. Also, roll out the other two RFPs for reducing disparities for racial ethnic populations will be posted in FY 2009-10. The next RFP to be released will be the Multicultural Collaborative and the third RFP will be the facilitator/writer.
- It is anticipated that the 2009 revised DMH CCRP will be released and distributed to all counties by summer 2009. County Mental Health plans will have 6 months to complete and submit their CCPR to the State OMS for review and scoring. These plan submission will include strategies to address disparities across all funding sources. The CCPR requires County mental health systems to do local disparities analysis and includes eight criterion areas that each county must respond to in their plan submission. These focus areas include the following:
 1. County Mental Health system commitment to cultural competence;
 2. County Mental Health system Updated Assessment of Service Needs;
 3. Reducing Racial, Ethnic, Linguistic and Cultural Mental Health disparities;
 4. Client/family member/community committee: Integration of cultural competence committees within county mental Health systems;
 5. County Mental Health system cultural competent training Activities;
 6. County Mental Health system commitment to workforce hiring and training cultural competent staff;
 7. County Mental Health system Language capacity; and
 8. County Mental Health system Adaptation of Services.

These eight criterion areas include, but are not limited to, requirements for counties to provide report and analysis of population disparities, analysis of the organization and service provider workforce strengths and limitations in terms of capacity to meet the needs of racially and ethnic diverse populations in the county. This analysis must address the bilingual staff proficiency for threshold languages.

There are other specific requirements for counties to compare and include an assessment of the percentages of culturally, ethnically and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county, and the total population currently served in the county.

There are specific requirements for counties to provide an analysis and include a discussion of the possible barriers their system will encounter in implementing the programs for which funding is requested and how counties will address and overcome these barriers and challenges. Current work on the performance outcomes in both the individual and system level performance

outcomes will include attention to data collection to inform future planning to eliminate mental health disparities.

In addition to the above activities, the DMH provided funds to local mental health agencies for training on cultural and language competency. The DMH, local CMHDA Ethnic Service Managers/Coordinators (ESM), and the CCAC have been working collaboratively with the CIMH CMD to address ongoing statewide planning for growing local leaders to address disparities and develop local culturally competent programs and services. The OMS will:

- Continue plans to train DMH on cultural competence;
- Continue to work on most of the committees identified in 2008-09 and noted below as part of this report;
- As funding is available Continue to seek contracts for translation of documents;
- Seek support to continue work with state cultural competent consultants to support the ongoing work of the office; and
- In 2009-10 review and score the county mental health cultural competence plan submission and provide feedback and technical assistance where appropriate.

Other partnerships the DMH OMS will continue to engaged include serve as the State liaison and consultant to multiple programs to address health disparities, including CA CMHDA ESM, social justice committee; the State Medi-Cal Compliance Advisory Committee; MHSOAC, CLCC. The State Department of Social Services State Interagency Team (SIT), the OMS chairs the SIT Eliminate Racial, Ethnic Health Disparities in Children's programs committee is made up of over six state level departments efforts to address disparities ; the Women's Mental Health Policy Council; CIMH Spiritually committee, The MHPL CCC, the CMHDA ESM, Statewide Planning Committee for Cultural Competence and Mental Health Summits; and liaison to the CIMH, Center for Multicultural Development.

PATIENTS' RIGHTS ADVOCACY PROGRAM

In 1991, California law was amended to bring it into conformance with the Protection and Advocacy for Individuals with Mental Illness (PAMI) Act. Californians with mental illness, and who are receiving voluntary or involuntary treatment in mental health facilities, are guaranteed numerous rights under State and federal law, including the right to be free from abuse and neglect, the right to privacy and dignity and the right to basic procedural protections in the commitment process.

Current statute, Chapter 546, Statutes of 1995 (SB 361), requires DMH to contract out the patients' rights advocacy services with a single nonprofit agency on a multiple-year basis for a term of up to three years. Effective January 1, 2005, DMH renewed a three-year contract with Protection and Advocacy, Inc. (PAI) to provide mental health advocacy services through the Office of Patients' Rights (OPR). The OPR staff provides direct advocacy and investigative services in each of the State Hospitals, and training and technical assistance for all patients' rights advocates in the counties. The OPR is also responsible for responding to second level complaint appeals that could not be resolved at either the county or State Hospital level.

MEDICAL AND DENTAL SERVICES

The majority of children served by the mental health system (approximately 70 percent) are eligible for California's Medi-Cal (Medicaid) program, which provides essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions for children and their families on public assistance, or whose income is not sufficient to meet their medical needs. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment. California's program provides services in all major disciplines of health care.

EDUCATION ACTIVITIES FOR ADULTS

Supported education activities are an integral part of recovery principles and are reflected in the training and technical assistance opportunities available through the DMH/DOR Cooperative Program. At the request of local educational, mental health and rehabilitation programs, community college consultants provide training and/or technical assistance on building collaborations with to establish best practices in using mainstream educational resources as part of client's employment goals.

As part of this program, several consultants created through a collaborative effort, a guide outlining the process of developing Human Services Certificates and/or Degree programs to train, retrain and certify local human service workers. Input from Advisory Committees and data from job market analyses and research all indicate increasing need for trained human service workers who are skilled in providing employment-focused, customer-driven services. The guide also discusses supported education and recommends that communities create these supports at their community colleges in conjunction with local mental health and vocational rehabilitation partners.

REHABILITATION AND EMPLOYMENT SERVICES

The importance of rehabilitation and employment services, within an effective consumer-directed system of care, is supported by the values and principles of the recovery and psychosocial rehabilitation models. The DMH has maintained and strengthened its role in providing employment services for persons with severe psychiatric disabilities by recognizing and building upon the interdependence of key State and local agencies. The DMH has taken a leadership role in creating employment strategies, services, and systems development at both the State and county level through its collaborative partnership with the DOR.

The State-level Interagency Agreement between DMH and DOR provides the administrative support, training, and technical assistance for the 27 local cooperative programs to develop, expand, and/or improve their interagency employment services. Local mental health/rehabilitation cooperative programs provide the employment and support services for persons with severe psychiatric disabilities. These employment services are consumer-driven so that consumers are central to all decision-making and service selections. These programs closely adhere to the values of comprehensive service linkages, consumer career choice, placement in a competitive and integrated environment, and proactive ongoing support. In SFY 2008-09, 7,465 persons with severe psychiatric disabilities were provided services in these 27 programs, with 852 persons meeting

DOR's defined outcome of becoming successfully employed. 2,901 new referrals for service were received during this time period.

Training and technical assistance are the key tools used to develop the local employment programs that support the consumer's choice to work. Training is customized to meet the individualized needs of the local programs and their communities. Training sessions can be delivered by topic or can be developed in a customized series that addresses the skill development needs of the local partners. Subject matter specialists are contracted through DMH and the training is funded by the interagency agreement between DMH and DOR to provide statewide training and technical assistance. The subject areas address the values and principles of the recovery model as the basis for building programs and systems for employment services. All trainings are provided at no cost to the local partnership communities.

The subject areas for training and technical assistance for FY 2008-09 were: Building System/Community Capacity for Employment; From Vision to Transformation-Management Level Training and Organizational Building; Shifting to the Recovery Culture: Program/Line Staff Level Trainings and Cooperative Team Building; How to Engage the Employment/Business Community; Utilization of Mainstream Educational Resources in the Design of Your Program; Benefits Planning; Connecting Employment with Recovery; The Client's Perspective—Supporting Education and Employment Goals; System/Program Assessment, Planning and Development; Transition Age Youth; Job Retention for Clients in Employment; Developing and Implementing Technical Assistance and Customized Training. These trainings are funded through the Interagency Agreement between DMH and DOR and are available statewide at no cost to the local programs. During SFY 2008-09, 19 counties utilized the training and 71 training days were provided.

An Outcomes Tracking Program has been developed to gather comprehensive information from the statewide Cooperative Employment program participants after they have begun working. Long term employment outcomes and satisfaction data is collected by local Outcome Tracking Technicians through a series of personal interviews with consumers. The Outcome Tracking Technician positions are transitional work experiences for employees who are recipients of mental health services and clients of DOR. As former recipients of services these Outcome Tracking Technicians add a highly effective peer-to-peer expertise to the interview process. This program has developed systematic long-term tracking of job retention, benefits, and career status, health and life changes, and other outcomes needed to improve evaluation, accountability and program development.

To support the Outcome Tracking Technicians, the program was further developed to include Outcomes Tracking Trainer Analysts, who provide training to Outcomes Tracking Technicians throughout the State to establish an outcomes tracking department at a cooperative employment agency. They will train the Outcomes Tracking Technicians to interview and collect data from consumers who became employed while working with a cooperative program. The Outcomes Tracking Trainer/Analyst also coordinates with DMH and DOR under the auspices of the MHSA for program development, data analysis and analytical reports writing and distribution. The Outcomes Tracking Trainer/Analyst position is designed to be an employment opportunity for a

person recovering from a severe psychiatric disability who is a current or former recipient of public mental health agency and DOR services.

LIMITED EXAMINATION AND APPOINTMENT PROGRAM (LEAP)

LEAP provides an alternative to the traditional methods of the civil service examination and appointment process to facilitate the hiring of persons with disabilities.

The DMH currently provides funding to the State Personnel Board in support of the LEAP process and refers LEAP employment lists to hiring supervisors who recruit for job vacancies. The DMH uses several job classifications that are also administered under LEAP.

CALIFORNIA WORK OPPORTUNITIES AND RESPONSIBILITY TO KIDS (CalWORKS)

The California Work Opportunities and Responsibility to Kids (CalWORKs) program is the state's Temporary Assistance to Needy Families (TANF) program. CalWORKS was established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform legislation). It provides cash aid, employment services, and other benefits to needy families. CalWORKs is sometimes referred to as TANF. CalWORKS replaced the Aid for Families with Dependent Children (AFDC) program in 1998. CalWORKs generally gives cash aid to adults for 60 months. Children continue to receive cash aid after the 60 month limit.

The major focus of CalWORKs is to prepare clients for work and assist them in obtaining and maintain employment so they can effectively support their families. The State Legislature determined that mental health and substance abuse treatment are necessary components of CalWORKs and included the provision for these services into the law. To the extent that funding is available, counties provide for the treatment of mental or emotional difficulties and substance abuse issue that may limit or impair a client's ability to make the transition from welfare to work or retain employment over a long period of time. Available mental health services must include assessment, case management, and treatment and rehabilitation services.

CalWORKS requires county welfare departments and the county alcohol and drug departments collaborate to ensure an effective system is available to provide for evaluations and substance abuse treatment. In addition to ongoing technical assistance, DSS maintains oversight of the funding through reports submitted by the county welfare departments. The DMH provides assistance by participating in interagency meetings with ADP, DSS, and other State agencies. This interagency workgroup is dedicated to sharing information about new financial support sources, technical assistance, research, and program and policy development.

The primary funding source for the CalWORKS program is the federal TANF block grant. The Deficit Reduction Act of 2005 extended funding for the TANF block grant through FFY 2010. CDSS is the lead agency that draws down and distributes the federal funds to county welfare departments. There is a State and County MOE for the TANF block grant. General Funds (GF) for CalWORKs substance abuse services and mental health services for FY 2007-08 were \$48,268,000

and \$60,146,000 respectively, FY 2008-09 was \$ 50,244,000 and \$68,211,000 and FY 2009-10 is \$54,342,000 and \$70,322,000.

The Amended Budget for 2009-10 states that Counties will have more latitude to focus employment training and supportive services such as child care and transportation on clients who are meeting state and federal work requirements. It also allows counties to re-direct substance abuse and mental health funding toward employment and supportive services.

The California Governor's Budget May Revision 2010-11, dated May 14, 2010, proposes the elimination of the CalWORKS program, effective October 1, 2010. However, on May 26, 2010, the California Assembly and the Senate Budget Committees rejected the Governor's proposal. The passage of California's budget is at an impasse; therefore, it is unknown whether CalWORKS will be eliminated.

SELF-HELP

DMH assists clients and families in the "development and strengthening of community support and self-help networks," as specified in the WIC, Section 4340. Self-help is defined as a mutual support effort by a group of people who come together to share common concerns about problems that disrupt personal life. Group members help one another to cope more effectively by providing psychological support and by exchanging information and resources.

Self-help can take many forms. In addition to mutual support groups, mental health consumers have established self-help centers that offer a variety of services to mental health clients, including clients who are homeless or have recently been discharged from a state hospital. These programs are not directly funded by the State; however, many receive funds from county mental health programs as well as federal grants.

To aid self-help and peer support initiatives, DMH provides funding through contracts to support organizational efforts of the CNMHC, NAMI and UACF. DMH supports the CNMHC annual statewide client forum. The purpose of the forum is to educate and share information with the members on current mental health issues. CNMHC is organized by region. The regional approach ensures broad and active participation of CNMHC membership in determining its direction and goals, and in facilitating necessary changes to the by-laws and election of local representatives to the CNMHC Board. To support the regional process and ensure participation, each region submits a self-help proposal to the CNMHC Board for review, approval and funding.

In FY 2007-08, the following regional projects were implemented:

- Housing Advocacy Training;
- Training on community organizing strategies and strengthening and promoting the client voice;
- A peer developed resource booklet on "Alternatives to Medication";
- How to Shift Attitudes in Advocacy and Employment: Moving to a Trauma-Informed System; and
- Training conference with topics such as including the therapeutic value of art in mental health recovery and advocacy in MHSA WET.

This expansion of self-help services to clients throughout the State reflects the goal of a consumer-driven system based on empowerment. DMH also supports the CNMHC in their Public Education and Policy and MHSA Client Involvement Projects. , This contract was recently renewed for three years (SFY 2010-11 through 2012-13). The total budgeted amount for this three year contract is \$1,643,000.

NAMI California implements the *Family-to-Family* program, which provides two components. One is a 12-week educational series to describe the disorders, medications, treatment and coping skills for families of persons with SMI. The second is the Support Group component, which trains participants to facilitate family support groups that reinforce coping skills, practical information, and the knowledge that they are not alone and that there is hope. The program relies on volunteer family members as educators and peer support group facilitators to provide practical and emotional support for family members who must cope with the difficulties of their ill relatives. Training sessions are held in both Northern and Southern California. This contract was recently renewed for three years (SFY 2010-11 through 2012-13). The total budgeted amount for this three year contract is \$1,909,000.

In an effort to strengthen the commitment and capacity, statewide, to ensure that mental health care is consumer- and family-driven, DMH also contracts with UACF. UACF trains parents and caregivers to become certified family partners and trainers for the Equip curriculum to promote authentic partnership and shared decision making regarding care, planning and treatment. UACF has recently expanded its scope of work to include outreach to primary care physicians and to families of veterans.

The organization works to increase family members, TAY and children's potential to influence the activities of the MHSA policy and appropriation decisions. UACF supports this potential by increasing their participation in the activities, stakeholder meetings, task forces, committees, and the MHSOAC. Due to the increased demand placed upon UACF, a \$210,000 amendment was made to this contract, extending it through FY 2010-11.

DISASTER SERVICES UNIT

The DMH Disaster Services Unit serves an important role in coordinating with various county, state, federal and other disaster response agencies relative to its emergency and disaster mandates.

The following agencies are key agencies DMH frequently collaborates with during disaster planning and response: FEMA; SAMSHA CMHS; California Emergency Management Agency (CalEMA); Department of Public Health (CDPH); ADP; DSS; Emergency Medical Services Authority (EMSA); and the American Red Cross (ARC).

The DMH provides technical assistance to County Mental Health Departments responding to emergencies and disasters through a variety of services that include: problem solving; assisting with mutual aid needs; completing the FEMA Crisis Counseling Program grant application to obtain crisis counseling grant funding for Counties; and implementing projects.

ADULT AND OLDER ADULT PERFORMANCE OUTCOMES

California continues to participate in performance measurement design at the national level including the Uniform Reporting System (supported in part through the DIG) and the National Outcome Measures (NOMs) and to align the measurement of performance outcomes for adults and older adults with the recovery/wellness-based philosophies reflected in the President's New Freedom Commission Report on mental illness, the Institute of Medicine's Six Aims for Improvement and California's MHSAs.¹

During SFY 2009-10, DMH continued to use the Web-Based Data Reporting System (WBDRS) to collect data using a point-in-time method to target all adult and older adult consumers receiving face-to-face mental health services. The DMH elected to suspend its twice per year Consumer Perception Survey in order to conduct a pilot survey based upon a stateside random sampling methodology. The purpose of the pilot is to test the validity of the method to include a detailed analysis of the costs and administrative barriers. The results of the pilot are scheduled for release in February 2011.

In addition to the CPS, California's MHSAs continue to support the transformation of California's mental health system by providing a more comprehensive approach to the development of community based mental health services and supports for the residents of California. With respect to performance outcomes, the Department has recently completed an initial analysis of FSP outcomes collected through the Data Collection and Reporting (DCR) System. This analysis indicates that the lives of individuals participating in FSP programs and services are improving in several key areas including increased housing stability and reduced criminal justice involvement. More information regarding this initial FSP Outcomes Analysis, the FSP assessment methodology and the DCR system is available on the DMH website.²

EXTERNAL QUALITY REVIEW ORGANIZATION

The California EQRO began its work in July, 2004 and is still active today. Following a competitive Request for Proposal (RFP) process, on July 1, 2009 APS Healthcare was again awarded a three year contract with two annual extensions by DMH.

During the past five years, the EQRO conducted programmatic, clinical and information systems reviews of 56 MHPs throughout California. The overarching principle during the process is the continued focus on the use of data to guide decisions regarding quality and performance improvement. Of the 56 reviews, 46 included a site review by a team of EQRO staff and consultants and each team included a consumer/family member representative and ten reviews consisted of document/phone reviews.

The following is a brief summary of EQRO pre-site, site and post-site review process:

¹ http://www.dmh.ca.gov/MHSA/docs/meeting/12-17-2004/Mental_Health_Services_Act_Full_Text.pdf
² <http://www.dmh.ca.gov/poqi/> and <http://www.dmh.ca.gov/MHSA/default.asp>

- **Review scheduling process**

CAEQRO staff develops an initial review schedule in January and February. Although the goal is an annual review for each MHP, the EQRO's practical objective is to ensure no more than 14 months and no less than 10 months between reviews. In February and March, staff consults with each MHP and issues a draft schedule by the third week of March. The EQRO finalizes the schedule and posts it on the EQRO Web site by the middle of April. During the year, the EQRO stays flexible to adjust review dates as necessary.

- **Pre-site review process**

At least 60 days prior to the site review, the lead Reviewer sends each MHP director and QI manager a notification packet that includes a notification letter listing the documents required in advance of the site review. For example:

- Each MHP receives instructions on the specific demographics and/or targeted areas for consumer/family focus group(s).
- These areas reflect Consumer/family focus groups' feedback requiring follow-up from the prior year, as well as input from the MHP staff that particular consumer services or MHP sites warrant specific attention.
- Each MHP receives a report detailing its claims data for the calendar year.
- The EQRO requests that the MHP make any amendments to its prior year's Information Systems Capability Assessment (ISCA) survey tool.
- Templates, such as the basic notification letter, are available on the EQRO web site, so that any MHP can review them prior to its scheduled review date.

- **Site review process**

The EQRO's site review approach has the following two primary goals:

- Follow-up on issues identified in the prior year.
- Evaluate issues affecting access, timeliness, outcomes and quality.

The EQRO conducts site reviews over the course of one to four days, depending upon the size of the county and the complexity of the MHP's information systems. The EQRO begins each review with a session focusing on significant performance management issues, and requests broad MHP representation and participation. The EQRO schedules small group interviews with MHP staff to discuss a wide variety of functions.

- **Post-site review process**

The site review is followed by a CAEQRO team meeting and an extensive process to write a report that conveys findings from various team members and includes the most significant issues. The EQRO submits a draft report to the MHP and DMH providing the MHP with a two-week time frame to respond with any feedback or

concerns. When an MHP has questions regarding the draft report, the EQRO team carefully evaluates each issue prior to releasing the final report with a memo explaining why changes were or were not made to the draft.

VETERANS SERVICES

Through the MHSA, the DMH has MOUs with the CNG, DVA, and ADP, that enhance system coordination and collaboration on veterans mental health issues. Below are specific initiatives supported by these MOUs:

The California National Guard (CNG)

Seven percent of the nation's Guard and Reserves reside in California, the highest of any state. Nearly 16,000 CNG members are in the deployment cycle at a given time. This is a constantly rotating cycle, resulting in re-deployment of this number of soldiers every two years. Guard members may be at higher risk of service-related mental health issues than the active duty military. Guard members return to their communities without access to the support structure of a military base and residence within military communities. The transition of these "citizen soldiers" back to community life is complex, and their communities are unevenly prepared to assist with the transition.

CNG has launched a pilot program to provide enhanced outreach and referral to behavioral health services for Guard members. The program has hired three Behavioral Health Outreach Liaisons (BHLs) that attend events and reach out to communities to educate Guard members about behavioral health issues and refer them to services where appropriate. BHLs also provide training in military cultural competence for county behavioral health providers to enhance the capacity of the system to appropriately serve Guard veterans and their families. This MOU was executed in 2009.

The California Department of Veterans Affairs (DVA)

California has the highest number of veterans of any state. Each year over 30,000 veterans return to California from military service. There is a need to connect veterans and servicemembers to benefits and services in their communities. DVA is the agency lead on a statewide initiative to developing a statewide network for mental health supports and referrals for veterans and their families seeking mental health assistance. The DVA has developed a comprehensive resource guide and directory for veterans, promotes and coordinates efforts at the county level, collaborates with the Department of Defense to support the Yellow Ribbon Reintegration Program for California's veterans, issues Public Service Announcements (PSAs) in multiple media to educate veterans on Post Traumatic Stress Disorder (PTSD) and TBI, and convenes state and local partners to promote veterans' courts in California. This MOU was executed in 2008.

In 2010 DMH is participating in the SAMHSA Policy Academy on Returning Veterans. The Policy Academy provides opportunity for cross system partnership to leverage ongoing change

and potential for a policy steering committee to oversee the progress of this grant and enhance its long-term sustainability.

California Governor Arnold Schwarzenegger is implementing Operation Welcome Home (OWH), a statewide network that provides infrastructure to reach out and enhance access for veterans to a broad range of services, including mental health, education, employment, health, and housing. This effort is being led by the DVA, and DMH is an active partner.

The passage of AB 1571 in 2009 will encourage growth of veteran mental health services in MHSA programs. AB 1571 requires counties to include representation of veterans and their families in community planning processes for MHSA, and requires the DMH to notify the DVA whenever county PEI and Innovation plans include projects that focus on veterans or their families. California is one of only two states with a Veterans Network of Care that links veterans to mental health and other services in their communities, and DMH is working to ensure that all of California's 58 counties fully participate in this service.

Through the collaborations above, the DMH is working with system partners to develop a shared database where de-identified information is compiled to better understand and meet the service needs of California's veterans and their families.

DMH HEADQUARTERS COUNTY TECHNICAL ASSISTANCE SECTION

From a broad perspective, the primary goals and objectives of the DMH County Technical Assistance Section include assisting and supporting California's county-organized community mental health programs in meeting their programmatic goals to provide high quality public mental health care. This assistance and support occurs primarily through collaborative relationships with ongoing close communication between state staff and the administrative staff of each county mental health program. State staff serve as the primary contact point between DMH and the counties. In day to day functioning, state staff provides consultative and technical assistance services to county mental health programs in a wide variety of subject areas, from managed Medicaid ("Medi-Cal") mental health to SAMHSA, from policy, fiscal, and regulatory consultation to issues regarding the implementation of the MHSA. In the event the questions or issues raised by the county indicate a need for coordination or connecting/brokering to other resources, state staff also serves the important liaison role of connecting county staff to the appropriate DMH resources of people and/or information best suited to assist the county.

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

CALIFORNIA'S DEFINITION OF TARGET POPULATION

California's Welfare and Institutions Code, Section 5600.3 (b) (2) defines "serious mental disorder" as follows:

“For the purposes of this part ‘serious mental disorder’ means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.”

PREVALENCE METHODOLOGY

A number of needs assessment methodologies have been used in the past by the DMH. In the late 1980s, the DMH contracted for a needs assessment study with Dr. Ken Meinhardt and his collaborators. They used rates from the Epidemiological Catchment Area (ECA) Study and applied them based on the demographics of California's counties. This resulted in a rate for major mental disorders of 6.15 percent for adults. In 1993, the DMH again contracted with Dr. Meinhardt for a prevalence study based on the criteria for the target population that were specified in law. They were very restrictive and defined the target population based on diagnosis, functioning level, duration of disorder, and likelihood of being eligible for public assistance. This resulted in a rate of 1.6 percent, which was used for several years. However, since then, the DMH and county mental health programs have taken on increased responsibility to serve populations beyond the target population. For example, with the consolidation of Medi-Cal mental health specialty services, clients who meet medical necessity must be served. Also, CalWORKs has provided funding for mental health services needed to assist in employment.

Currently, the DMH uses prevalence data developed by Dr. Charles Holzer an epidemiologist from the University of Texas, Medical Branch. These data are based on the Collaborative Psychiatric Epidemiology Surveys (CPES) and show the number of youth who have SED and the number of adults who have SMI. Dr. Holzer has worked at the national and state levels on issues relating to epidemiology of mental illnesses for over 30 years. His methodology uses information from the ECA studies, the National Co-Morbidity Study (NCS), and rates of SED for youth published in the Federal Register based on a compilation of prevalence studies for youth ages 9 through 17 years. He applied these rates to all youth. The prevalence rates of SMI and SED were applied to each county based on the demographic characteristics that correlate with differential rates. Further information is available at the following site:

<http://Charles.Holzer.com>.

There are some limitations in using only the household population since some of the mental health client population is in skilled nursing facilities, residential treatment facilities, or board and care homes that are not considered households. However, Census data are not available in sufficient detail to identify only those facilities. In addition, Census data would not identify

those persons who are placed out of county. There is a Census report that is available by county showing the total number of persons in “institutional and group quarters” by type of residence. This report can be referenced at the following website:

<http://www.dof.ca.gov/search/demograpquery.htm>.

CMHS contracted for a study of the prevalence of mental disorders among children and youth. The results of this study were published in the 1999 *Federal Register* and indicated prevalence rates of 9 to 13 percent for youth with a SED and substantial functional impairment, and 5 to 9 percent for SED and extreme functional impairment. The study recommends using the higher end of the ranges for areas with higher poverty rates. Data reported later use the midpoints (seven percent and eleven percent) of the ranges and show both prevalence rates although the higher rate is more consistent with the broader population that county mental health programs serve. These rates apply only to persons aged 9 through 17 years old. There are not sufficient studies on the population from infancy through 8 years old to reliably provide prevalence rates for the youngest population.

STATE POPULATION TO BE SERVED

The DOF estimated that in 2009 the population of persons over 18 years of age in California was 28,242,702. Based on the above rates from the *Federal Register* and this population data, it is estimated that there are 712,208 adults and older adults in the State with SPMI, and 1,479,204 adults and older adults with SMI. California, primarily through contracts with its 58 counties and two city mental health programs, expects to serve 453,334 adults and older adults in SFY 2008-09. The following table shows the total state population, number of clients, and prevalence by age group for SFY 2007-08 and estimated data for SFY 2008-09:

CALIFORNIA POPULATION ESTIMATES, CLIENTS SERVED AND ESTIMATED PREVALENCE OF PERSONS WITH SPMI, SMI AND SED

	<u>Total</u>	<u>0-8</u>	<u>9-17</u>	<u>18-64</u>	<u>65+</u>
<u>FISCAL YEAR 2007-08</u>					
State Population	37,810,582	4,832,236	5,175,265	23,705,767	4,097,313
Clients Served	670,944**	53,815	163,307	432,552	21,010
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,088,945	NA	362,269	616,350	106,530
Estimated Population with SMI/SED 11% SED and 5.4% SMI	2,079,582	NA	569,279	1,280,111	221,255

**Total includes clients of unknown age, and therefore does not equal the total among the age categories.

<u>FISCAL YEAR 2008-09</u>	<u>Total</u>	<u>0-8</u>	<u>9-17</u>	<u>18-64</u>	<u>65+</u>
State Population	38,246,598	4,881,060	5,122,836	24,044,666	4,198,036
Estimated Clients to be Served	670,944	50,383	167,227	432,404	20,930
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,092,909	NA	358,599	625,161	109,149
Estimated Population with SMI/SED 11% SED and 5.4% SMI	2,088,618	NA	563,512	1,298,412	226,694

It is estimated that the number of persons to be served in FY 2009-10 is expected to remain approximately the same as the number of persons served in FY 2008-09 given normal county reporting. California is once again facing a large budget deficit. The MHSA has been of help in past FYs. Its passage helped provide new and innovative mental health services in California counties. While it did not replace lost funds, it did augment services that could be provided to mental health consumers. However with a severe statewide budget shortfall, the impact on county services is expected to be profound. Since MHSA funds cannot be used to offset reductions or supplant, we estimate that there will be no net gain over the next FY.

STATE-LEVEL REFINEMENTS OF PREVALENCE RATES AND SMI/SED DEFINITIONS

With the implementation of the MHSA there is increased pressure for California to refine the national prevalence rates. Counties have submitted a CSS plan which must be data-driven. It is fortunate that over the last year workgroups comprised of county, provider, and client and family stakeholders have been meeting around issues that have emerged as the result of the need to redesign DMH's data system to capture data elements to meet new federal requirements. The DIG has served to promote the State's refinement of SMI/SED definitions and to develop State and county specific prevalence rates.

For several years, California has provided estimates of the SMI/SED population according to the method described above. While useful for the State as a whole, DMH was not able to respond to requests to provide prevalence rates of race/ethnicity by county. In 2003, DMH contracted with Charles Holzer, Ph.D., and an epidemiologist from the University of Texas, Medical Branch (UTMB) to develop California specific prevalence rates. Dr. Holzer had done studies for several of the western States using a synthetic estimate model that applied prevalence rates developed from surveys conducted in the 1990's to the 2000 census data. Dr. Holzer used this same model for California and provided prevalence rates by county and selected demographic characteristics. As updates are available, the data are posted to the DMH website.

DMH has maintained an ongoing relationship with Dr. Holzer and he has provided California specific data from the recently completed National Co-Morbidity Study-Revised (NCS-R). As revisions are available, the data are posted on the DMH website.

The following table shows the California SMI/SED population using the Holzer method and updated with more recent Census data:

**COMPARISON OF STATE POPULATION, SMI/SED POPULATION,
AND CLIENTS BASED ON HOLZER METHODOLOGY
2000 CENSUS WITH 2007 UPDATE**

	Total	Youth	Adult	18-64	65+
Census	TOTAL POPULATION - 2000				
Total Population	37,810,180	9,697,088	28,113,092	23,938,299	4,174,793
Household Population	36,889,731	9,632,453	27,257,279	23,264,418	3,992,860
Household Population Below 200% of Poverty	12,498,882	4,216,179	8,282,702	7,120,314	1,162,388
	SMI/SED POPULATION				
Total Population	2,474,202	734,235	1,739,967	1,535,345	204,622
Household Population	2,323,921	724,052	1,599,868	1,438,873	160,995
Household Population Below 200% of Poverty	1,090,756	375,608	715,148	646,552	68,595
	PERCENT SMI/SED POPULATION				
Total Population	6.5%	7.6%	6.2%	6.4%	4.9%
Household Population	6.3%	7.5%	5.9%	6.2%	4.0%
Household Population Below 200% of Poverty	8.7%	8.9%	8.6%	9.1%	5.9%
	CLIENTS SERVED FY 2007-08				
Clients*	670,944**	217,122	453,562	432,552	21,010

SMI/SED is the estimated number of adults who have a serious mental illness or youth who have a serious emotional disturbance.

**Total includes clients of unknown age, and therefore does not equal the total among the youth & adult age categories.

The above table shows the population and estimated prevalence for the total population, the household population, and the household population below 200 percent of the poverty level.

DMH's Statewide Quality Improvement Committee has adopted the policy to focus on the population below 200 percent of the poverty level to be used in determining penetration rates. However, there are some limitations in using that population because it includes persons in

households only. Many of the persons served by county mental health programs reside in board and care facilities, or residential programs that are not included as households.

Another critical aspect of using the prevalence data to calculate penetration rate is the fact that the prevalence rates focus on the SMI/SED population. While the DMH uses diagnosis only to estimate the number of persons who are SMI/SED, it is not satisfied with using diagnosis as the single factor for determining SMI/SED. Both diagnosis and level of functioning are usually considered when determining if a person is SMI/SED. However, the reporting of functioning level has been incomplete. The DIG utilized the workgroup process to address, among other things, the quality of reporting and the data elements it is using to estimate the SMI/SED client population. The DIG recommendations resulted in changes to the DMH's Client and Service Information (CSI) system which were implemented beginning July 2006. DMH has changed to a DSM IV TR five axis diagnosis. Since this includes Global Level of Functioning (GAF) scores, it is expected that this will give DMH a more accurate estimate of the number of clients who are SMI/SED.

The data provided by Dr. Holzer is based on the 2000 census. Updates have not been done for more current years because the household population below 200 percent of poverty is not a subgroup of the population that is updated annually. This is only collected on a sample basis at the time of the Census, which is every ten years. The population at lower income levels is growing at a higher rate than average, so the DMH is exploring alternative data sources or methodologies that could be used to update the prevalence data for persons below 200 percent of the poverty level annually.

The DMH believes that the estimates provided by Dr. Holzer showing prevalence rates by demographic characteristics and county are an improvement over using national rates. However, more work needs to be done to update the data, to include parts of the non-household population that would receive mental health services from county mental health, and to refine the data elements that are used to estimate the number of clients who are SMI/SED.

State-Level Performance Indicator Description

In May of 2004, prior to the passage of the MHSA, DMH presented county level prevalence data to all California counties. Since that time the data has been used extensively by counties as they develop their Service Plans for how they will use their MHSA funds.

Beginning in 2006, DMH, at the recommendation of CMHS, DMH began a partnership with CDPH to add to the mental health content of Centers for Disease Control's (CDC) Behavioral Risk Factors Surveillance Survey (BRFSS). In an Interagency Agreement with CDC, CMHS was able to fund the addition of the Public Health Questionnaire 8 (PHQ-8), which measures anxiety and depression, to the BRFSS. CMHS also gave states that applied an administrative supplement to cover their costs. This initial work has fostered an on-going relationship between DMH and CDPH. We are now active partners with other California state departments in the yearly survey development. In 2007 the Kessler 6 (K-6), which measures psychological distress, was added and in 2008, the PHQ-8 was added again. This allowed DMH to combine samples for a more powerful analysis of mental health issues in California.

In its continuing efforts to aid counties to refine estimates of their target service population, DMH also participates in an additional California specific survey, the California Health Interview Survey (CHIS). This survey is conducted by the University of California, Los Angeles Health Policy Institute. As a public health survey, the CHIS is done every two years and has always contained mental health content. However, beginning in 2005, DMH paid for the K-6 to be added. The sample size is over 50,000, which allows DMH to use it on a county level and help refine previous prevalence estimates. In 2007, DMH modified the K-6 to include questions about the respondents' worst month, about access and utilization of mental health services, stigma, and adolescent access and utilization of mental health services. DMH is in the planning stages for the 2010 survey and anticipates a continuing partnership with CHIS which provides a comprehensive look at the health and mental health of California's population. DMH has received detailed data from the survey and plans to make it available to counties for their on-going MHSAs planning process.

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

OVERVIEW OF CALIFORNIA'S DATA SYSTEMS

There are several automated systems at the State level that contain client, service and fiscal data from State Hospitals and county mental health programs. The data systems for State Hospitals have been developed around the Admission/Discharge/Transfer (ADT) System, which is an on-line real time system for State Hospitals. The system includes basic demographic characteristics of all clients, dates in and out of the hospital, dates and types of legal class changes, and dates of ward changes. The function that tracks legal class and ward changes allows for billing and fiscal reporting since there is a daily rate established for each ward. Data from the ADT system are linked with the Cost Recovery System (CRS) to generate billing data. A number of other functions have been automated that tie to the ADT system, such as the Trust Accounting Cashiering System (TACS), Pharmacy, Laboratory, and the Physician's Orders System (POS). There are plans to continue data system development to support increased efficiency in State Hospital operations.

Wellness And Recovery Model Support System (WaRMSS)

WaRMSS is a comprehensive computer software program that records each patient's assessed needs as derived during initial treatment team planning sessions, patient-generated life goals, goals for each treatment session or class, available types and providers of treatment, a schedule and rosters of patients assigned to treatment sessions, degree of patient achievement of each treatment goal, changes in goals, and measures of progress in treatment. WaRMSS is deployed system-wide allowing DMH to monitor and summarize data concerning amounts and types of treatments provided and the effectiveness of these treatments. The system is consistent with the wellness and recovery models of mental health that place special emphasis on client-driven treatment goals and services and in which services are often provided in treatment malls with a campus atmosphere and flexibility in tailoring available treatment to individual needs.

Recovery-Model Outcome Reports (formerly "SHOES")

LTCA will combine data generated by the WaRMSS system with other centrally gathered data to write reports that were formerly conducted as part of the State Hospital Outcome and Evaluation System (SHOES). The SHOES project was redesigned in the past year to be consistent with the Recovery Model of mental health treatment that DMH has adopted. LTCS will write monitoring and evaluation reports that expand upon the current "Questions and Answers About the Safety and Effectiveness of California State Hospital Services" report series begun in September 2004 to answer questions including:

- What proportion of patients met their goals for mental health recovery?
- What treatments were provided to patients who met and did not meet goals?
- What system results are achieved (reductions to length of stay and return rates)?

While the operational data systems for State Hospitals have been developed by and are maintained by DMH staff, county mental health programs each develop their own systems and send extracts from their systems to DMH in specified formats. There are two primary data systems used for county mental health data. The CSI system is a statistical reporting and includes client and service information about all persons served in county mental health

programs. The Medi-Cal system is actually composed of several files that include all persons who are eligible for Medi-Cal, and the Medi-Cal claims that have been paid for SMHS.

Both of these systems are used extensively by DMH staff to calculate indicators for the Statewide Quality Improvement Committee, for program planning, monitoring, and to respond to requests from the legislature, state and federal agencies, county programs, consumers, family members, and other interested stakeholders.

In addition to client level data systems, there are two other systems that include county data. The County Financial Reporting System (CFRS) is a year-end cost report of all costs expended by county mental health programs. Costs are reported in the same categories that are used for statistical reporting. The Provider and Legal Entity File identifies the actual provider site as well as the legal or corporate entity, or county, that “owns” the provider. The CSI system is based on provider reporting while the CFRS is based on legal entity reporting. Through the Provider and Legal Entity file, costs reported to the CFRS by legal entity can be linked to services reported in the CSI by provider. Through this linkage process it is possible to estimate the cost of services provided to specific groups of individuals, such as youth, or people with certain diagnoses. Preliminary efforts to link the data sets for several projects have proven to be challenging. There are frequently minor differences in spelling of names or transpositions of dates that cause records not to match when they should. DMH staff will continue to work in this area to improve the matching process so that the benefit of linking the data systems can be realized.

As the data systems are fully implemented and integrated, their use is increasing. With the increasing use of the data, the importance of complete and accurate data also increases. The DMH will be developing a data quality program focusing on CSI to ensure the accuracy of the data.

DMH’S APPLICATIONS DEVELOPMENT SECTION

DMH’s Applications Development (AD) Section is divided into three units: Hospital Services, County Services and Headquarters Services. The following is a brief description of some of the systems each unit is responsible for:

State Hospital Services

This unit responds to the diverse business needs of the staff working in various capacities throughout the five State Hospitals. The systems they develop and maintain facilitate key hospital functions to assist in the care and treatment of approximately 5,000 patients. These systems are deemed mission critical by the DMH and interface with systems in other agencies. The following are Hospital Services systems that are either maintained or under development by the AD section:

Admission Discharge and Transfers (ADT) - The ADT System performs State Hospital census functions. Statistical information from this system is used for management reporting and research purposes. The system provides transactions to the DDS for billing purposes. ADT contains the patient file, which is the foundation for all patient care-related hospital systems, and vital criminal and clinical history data. The system has over 500 screens and 400 standard

reports. When a patient is transferred from one hospital to another, patient data is available to the new hospital. This is essential for both the patient and staff at the hospitals.

Master Billing Project (MBP) - Provides a mechanism to capture Fee-For-Service (FFS) billing information within existing and future DMH applications. An automated Patient Progress Note (PPN) will help facilitate the doctors completing the documentation that is required for billing. After validation of billing this information will be passed to the DDS CRS for billing.

Additionally, it will enhance the Master Formulary and create Drug Utilization Review tables for the PHO system and the POS (described below). This will allow for much needed order validation using the patient's diagnosis, medical condition, and medication regimen for indications and contraindications, appropriate dosing levels and duration of therapies as well as other valuable special conditions and precautions.

Pharmacy Hospital Operations (PHO) - The PHO system processes medication orders and recurring non-medication orders. It generates monthly Physician Orders for renewal and information that supports unit-dose order filling functions; this includes pick lists, Medication Administration Record forms and an electronic file for the Baxter automated unit-dose dispensing machine. All medication orders are checked for Drug-to-Drug Interactions, allergies, over maximum-dose, and approval for non-formulary items. When a patient is transferred, his/her medication orders are visible to the new hospital and can be utilized by the new physician as baseline current medications for the new episode. This greatly benefits the staff and minimizes patient risk. PHO also has over 500 screens.

Physicians' Orders System (POS) - POS automates physician order entry and transmission of physicians' orders to the service provider. This reduces order turnaround time and errors, and promotes more timely and effective patient treatment. This system uses extremely complex client/server architecture to provide the user with the easiest, friendliest interface possible.

Service Usage Report (SUR) - The SUR is used to collect data from the ADT system and maintain files of county usage of beds at the hospitals. The system runs twice a day and produces summaries of daily, monthly and fiscal YTD bed usage totals. This system supports the County Contract Monitoring (CCM) System, which reports over-contract use of State Hospital beds, and the Fiscal Automation System (FAS) reports, which the hospital accounting offices use to comply with certain CALSTARS cost reporting requirements.

Treatment Outcome System (TOS) - The State Hospital TOS schedules patients into treatment activities, records patient and staff attendance at those activities and produces reports for managers at the hospitals. TOS reports have been used to support departmental testimony at the yearly legislative budget hearings.

Trust Accounting Cashiering System (TACS) - The TACS accounts for patients' financial assets and associated transactions. The system records receipt from patients, their families, conservators, Social Security, etc., and disburses funds for patients' personal use and for reimbursing the cost of their care.

The Canteen subsystem within the TACS allows the canteen operators to scan bar coded patient identification cards, determine patient account balances, apply purchases and other transactions saving operators' time.

County Services

This unit supports, enhances and develops automated systems to facilitate oversight and program decisions for the 58 counties providing services to mental health consumers. The systems also perform billing, payment and report processing for Medi-Cal services and federal reporting requirements. The unit's primary customers are the System of Care staff at DMH Headquarters and the county program and technical staff. In addition to DMH systems support, the units also develops county-level applications, file extractions, responds to technical questions, and fosters DMH and county program and technical relationships.

To further the modernization of the county systems, the unit is also developing a decision support system that includes data from all related county and State systems to provide management reporting on access, cost and outcomes of mental health services across the entire continuum of mental health care. The unit is using the newest Internet technologies to securely provide confidential mental health information to all its business partners.

The county technical staff is viewed as both customers and suppliers of these systems. All systems under construction are directed by the input of county technical staff, consumers and the county vendors. Although this is a more difficult approach than previously used, there is greater county buy-in and improved county reporting.

Client and Services Information System (CSI) – The CSI system collects, edits, and reports on client demographic and service encounter information on the entire California public mental health population of approximately 500,000 people receiving 7.5 million services per year. This system works via a web browser to provide data entry and correction screens, processes batch files and returns errors with error identity, and passes data to and from the counties via the Information Technology Web Server (ITWS). The CSI data will be integrated with other data sources to facilitate decision support.

Data Collection and Reporting System (DCR) – Currently, the DCR supports the collection of repeated-measures for the initial PMs for the MHSA FSP outcomes assessment. The DCR is aligned within the State's vision for a comprehensive, interoperable electronic mental health record system. By leveraging Extensible Markup Language (XML) technology, DMH will be able to exchange, manage, and integrate data, as well as distribute information system changes. This solution offers both a centralized, web-based application and methods that ensure interoperability between disparate county/provider systems.

Information Technology Web Server (ITWS) – Allows for the counties to pass data files for SD/MC, the Medi-Cal Eligibility Data System (MEDS), PODS, CSI, etc. electronically to DMH as well as receive them from DMH. This greatly decreases the time required for handling and errors in the initial processing steps.

Inpatient Consolidation System (IPC) - Allows counties to view and report the inpatient claims data files provided by the fiscal intermediary (EDS) under Managed Care Phase I. Counties use this information to verify realignment offsets by DMH and reconcile paid claims with their associated TARs. DMH Managed Care and Accounting use this system to resolve county inpatient claim issues and calculate the realignment offset.

Medi-Cal Eligibility Data System (MEDS) – This file is provided to DMH monthly by the DHCS. The DMH in turn provides county mental health programs with these files to conduct analyses of their risk under capitation or block grant contracts, plan allocation of their resources, identify clients who are eligible for Medi-Cal, and identify their third party insurance coverage, if any. This system also provides counties with non-resident beneficiary information upon submission of a MEDS ID. Currently, staff are analyzing a county request to perform real-time queries of the MEDS information from their county-based integrated systems.

New Institutions for Mental Disease (NIM) - The DHS is required to provide the federal CMS information on Medi-Cal beneficiaries in IMDs. This requirement is to ensure compliance with Medicaid requirements involving FFP and Fee-For-Service/Medi-Cal (FFS/MC) ancillary services. In order to facilitate this requirement, this system collects the IMD information from the counties.

Omnibus Budget Reconciliation Act (OBRA) System – This system is federally mandated to refer, track and maintain the data to determine the placement and treatment for seriously mentally ill residents in SNFs (i.e. whether they require nursing care, mental treatment, both or neither). The PASRR Section receives Level I screening documents from the facilities and determines which ones warrant the more thorough Level II evaluation. Based on the evaluation, an appropriate letter is sent to the resident, facility, physician and field office informing them of the treatment recommendations.

Provider System (PRV) – This is an on-line application for inquiry and update of provider and legal entity data, including Medi-Cal certification information; furnishing provider validation information to the CSI system; and generating reports and files required by external entities such as EDS, DHS and all county mental health plans.

Short-Doyle/Medi-Cal System (SD/MC) - This system processes claims submitted by the counties, and initiates corrections and applicable approval processes. The volume of claims processed by SD/MC exceeds \$1.5 billion annually.

SD/MC Explanation of Balances (EOB) – This is an application to view the EOB files, which contain detailed adjudicated claims information. This application was developed and is widely used by numerous counties.

Web-Based Data Reporting System (WBDRS) – The WBDRS is an integrated technology solution which was designed to improve data quality and ease the reporting of performance measurement data by counties to DMH. This system allows for direct, on-line data entry, scanning and local data verification, and batched data upload. The submitted data are used to

evaluate the quality and increase the effectiveness of mental health services for California's clients and their families.

DMH Headquarters Services

This unit supports multiple divisions at Headquarters through the development of stand alone and server-based applications to facilitate tracking efforts and increase efficiency of day-to-day operations. Below are a few of the systems supported by the AD section:

Conditional Release Program (CONREP) - The CONREP system records patient data, provider contract information, and services received. This information is used to reimburse service providers, monitor service units and dollars, track patients and treatment compliance, and evaluate the effectiveness of the program that provides community-based services for the judicially committed. An interface with the Department of Justice (DOJ) provides access to criminal history data. Statistical reports are used to notify the Legislature of program status, as well as for program monitoring and fiscal planning.

Jamison/Farabee Program - The Jamison/Farabee system was developed to track court-ordered quarterly medication reviews of patients who have been diagnosed as "Gravely Disabled." The database contains both patient and quarterly review data. The monthly statistics report summarizes the monthly review data by Review Type and Review Status. Monthly compliance checks, certified competent to consent and Rx Review counts are also included in the report. The Print Reviews report is a report of patient reviews that were completed within a date range. The report includes Reviewer Name, Review Date and Patient Name, Patient ID, Unit # and Patient's Physician. The Non-Participant report is a list of all patients who have been terminated from the Jamison/Farabee review process.

Mentally Disordered Offender System (MDO) - The law requires that a prisoner who meets six specific MDO criteria shall be ordered by the Board of Parole Hearings to be treated by the DMH as a condition of parole. The MDO system provides a comprehensive method of tracking MDO patients from CDCR referral to CONREP discharge. The automated evaluation scheduling facilitates prioritization of evaluations to be conducted and references to previous evaluation results. Aggregate data regarding referrals, clinician activity, evaluation results, State Hospital population, CONREP population, and CDCR facilities are also provided.

Ombudsman's Services Data System (OSD) – This system was developed to provide a means of tracking calls received from Medi-Cal beneficiaries and/or their representatives who have questions, concerns, or complaints about their coverage. The system tracks beneficiary and representative information, and categories of issues such as accessibility, benefits/coverage, and quality of care. The system gives the Ombudsman the ability to keep notes on the nature of the call and any follow-up calls, and to record when the case was resolved and what kind of conclusion/resolution was reached.

Sexually Violent Predator (SVP) System – The SVP data system consists of several linked Microsoft Access databases containing information on potential SVP inmates referred from the CDCR and screened by DMH. The systems include inmate demographic/I.D. data, SVP record review and clinical evaluation data, DMH and "post-DMH" tracking information, research-

related data, SVP evaluation accounting information, and State Hospital SVP commitment data. Portions of this data are available to Atascadero State Hospital, Coalinga State Hospital, Board of Parole Hearings, and CDCR via DMH's ITWS.

Treatment Authorization Request - Level II (TAR Level II) - The TAR Level II tracks the provider appeal process. The system contains the date the appeal is received, sends letters requesting documentation and substantiation from the providers, tracks when information is received, notes whether the decision was upheld or reversed, and generates the appropriate information letter regarding the appeal to the provider.

OUTCOME REPORTING

The DMH is measuring performance with respect to the MHSA on multiple levels, including the individual client level, the mental health program/system accountability level, and the public/community-impact level.

At the individual client level, data across several domains is measured over time using three types of assessment forms. Each set of forms is tailored based on age groups: Child/Youth (ages 0-15), TAY (ages 16-25), Adults (ages 26-59), and Older Adults (ages 60+). The forms include the Partnership Assessment Form which gathers historical and baseline information about each client while a Key Event Tracking and Quarterly Assessment forms gather follow-up information within these same domains¹. The domains include: residential setting (including hospitalizations and incarcerations), education, employment, sources of financial support, legal issues/designations, emergency interventions, health status and substance abuse.

FSP Assessment data is reported using the DCR. This centralized, web-based application ensures interoperability between disparate county/provider systems that combines the traditional relational data model which maximizes performance and scalability with support for the Extensible Markup Language (XML) data type to ensure system flexibility to changes in business/data needs. By leveraging XML technology, DMH is able to exchange, manage, and integrate data from counties using their own data collection platforms. The DCR system serves as an early prototype that moves the state forward towards an EHR for public mental health and is aligned with the State's vision for a comprehensive, interoperable electronic mental health record system. Consistent with DMH's vision for a comprehensive and fully interoperable information system, DMH also expects to incorporate future survey forms within the DCR to provide continued support for survey administration methods.

Approximately 23,501 unduplicated individuals were reported as having participated in FSPs in SFY 2008-09. This included 4,917 Child/Youth (ages 0-15), 4,669 TAY (ages 16-25), 11,909 Adults (ages 26-59), and 2,006 Older Adults (ages 60+). The baseline information collected on individuals at entry into the FSP program reveal extremely high levels of unemployment (close to ninety-nine percent for adults), frequent mental health and physical health-related emergency interventions, high levels of homelessness, higher than normal involvement with the criminal justice system and higher than normal levels of substance abuse co-occurring with SMI and SED.

¹ View the assessments at http://www.dmh.ca.gov/POQI/full_service_forms_POQI.asp

Initial evaluation of the outcomes associated with these individuals indicates that their lives are improving in several key areas including: increased housing stability and a movement towards more positive living environments, reduced physical and mental health-related emergency interventions, reduced involvement with the criminal justice system and reduced reports of individuals who indicate they have no sources of financial support. For more information regarding the initial evaluation of FSP Outcomes please see our website.²

The data collected above can also be linked with data collected during the bi-annual Consumer Perception Survey sampling periods to capture clients' perceptions of the FSP services/care they receive using the nationally developed Youth Services Survey for Youth (YSS-Y), Youth Services Survey for Families (YSS-F) and Mental Health Statistics Improvement Program (MHSIP) consumer surveys. Data reported to the CSI System is also linked to provide demographic information, as well as service information (which includes evidence based practices and other service strategies that are more tailored toward a client's individual needs). Analyses of these factors is currently underway and will be reported during next year's application.

² View a Powerpoint Presentation of the Initial FSP Outcomes Evaluation at: http://www.dmh.ca.gov/POQI/docs/InitialFSP_Outcomes.pdf

Adult - Describe State's outreach to and services for individuals who are homeless

OUTREACH TO THE HOMELESS

Recent estimates indicate that there are approximately 50,000 people who are homeless, have an SMI, and are living on the streets of California. Of that number, approximately 20,000 are thought to be veterans. New programs that differ markedly from traditional mental health services have been developed to address the need of this population.

Over the past ten years, DMH has consistently supported housing programs which expand the availability of safe, affordable housing with services for individuals with SMI. This effort has involved significant collaboration and mutual education among agencies (both public and private), state departments, county departments, and many committed individuals along the way. These activities have been informed by the experience gained through the SHIA and AB 2034 Integrated Services Program, as described in previous SAMHSA reports.

Beginning in January, 2005, the MHSA provided a new funding source for services and supports that promote wellness, recovery and resiliency for adults and older adults with SMI and for children and youth with SED and their family members. Safe, affordable housing was recognized as a critical element for recovery, and during the past several years a range of housing services and supports have been included as the result of the implementation of MHSA programs throughout California.

In addition to housing services and supports that have been developed through MHSA county mental health plans, the following describes two statewide housing initiatives focused on expanding permanent supportive housing resources for persons with SMI.

Governor's Homeless Initiative (GHI)

The GHI created a housing finance model that ties together HCD capital funding (Proposition 46) and MHSA funds to encourage development of supportive housing projects that target chronically homeless individuals with SMI. This Initiative offers a non-traditional centralized loan and application approval process. Approximately \$3.15 million from MHSA funds in FY 2005-06 were targeted for this initiative, with \$2.75 million designated for rental subsidies and \$400,000 distributed to establish supportive housing development collaboration at the local level.

In support of developing capacity for this initiative, DMH conducted a series of regional housing trainings throughout the State with the goal of bringing together county mental health departments, county housing agencies, housing developers, and community-based service providers to share expertise and leverage resources to develop more housing opportunities for homeless people with SMI. With the goal of leveraging resources to meet the housing needs of individuals with SMI, county mental health department collaboration is a requirement for projects applying for funding under this program. One of the conditions for approval is the county mental health department commitment to fund the supportive services. To date, eleven permanent supportive housing projects have been approved under this program. Of the total 151 units developed under the GHI program, for FY 2009-10, 71 units have been designated

for individuals with mental illness who are homeless and another 48 units designated for the chronically homeless.

MHSA Housing Program

The MHSA Housing Program is jointly administered by DMH and CalHFA. This interagency collaboration continues to evolve using the mental health expertise of DMH and CalHFA's finance and housing development experience. Collaboratively, DMH and CalHFA administer the MHSA Housing Program which includes operating subsidies that support the development of permanent housing for persons with SMI.

This collaboration between DMH, CalHFA, county mental health departments, housing developers and/or agencies continues to be successful as demonstrated by the new 93 MHSA supportive housing projects developed throughout California thus far. The MHSA Housing Program is flexibly designed to meet the needs of larger urban counties as well as small or more rural counties. To date, over \$203 million of MHSA funds have been committed to new projects. This funding has leveraged over \$1.5 billion dollars of other local, federal and private housing dollars for a total of over \$1.7 billion dollars committed to developing low income and supportive housing.

DMH and CalHFA will continue to collaborate and provide a comprehensive training and technical assistance program aimed at helping county mental health departments with project development and the application process during the new FY (2010-2011). Planned training activities and services include assistance with project development, project financing, project operations, service planning, fair housing and tenant selection, property management, strategies for community acceptance and assistance with application submission. These technical assistance and training opportunities are identified as essential to building capacity as well as moving the public mental health system toward more integrated services and supports.

McKinney Projects for Assistance in Transition from Homelessness (PATH)

The DMH has been awarded federal homeless funds annually since 1985, initially through the Stewart B. McKinney Homeless Block Grant, and beginning in SFY 1991-92, through the McKinney PATH formula grant. The PATH grant funds community based outreach, mental health and substance abuse referral/treatment, case management and other support services, as well as a limited set of housing services for the homeless mentally ill. During SFY 2010-11, a total of 48 counties elected to participate in the PATH program. While local programs serve thousands of homeless persons with realignment funds and other local revenues, the PATH grant augments these programs by providing services to approximately 21,000 additional persons annually. Each county determines the use of PATH funds based on local priorities and needs. These targeted funds provide much needed services to an extremely vulnerable population throughout California.

In accordance with federal procedures, the DMH's PATH and housing staff have developed guidelines that define the counties' responsibilities to clients who are homeless and have a mental illness. The State provides oversight of the performance of all county programs through site

visits. In addition, all counties provide financial reporting of fund expenditures on a quarterly basis and also are required to submit an annual cost report. Program reporting by all counties is required annually. Counties receiving PATH funds must develop an annual service plan and budget for utilization of the funds. The service plan must describe each program setting and the services and activities to be provided. The estimated number of persons to be served must also be included in the plan. Each county that receives PATH funds has established one or more programs of outreach to, and/or services for, persons who are homeless and have a mental illness.

Allowable PATH services include:

- Primary Service Referrals
- Habilitation and Rehabilitation
- Alcohol/Drug Treatment
- Service Coordination
- Screening and Diagnostic Treatment
- Outreach
- Community Mental Health
- Staff Training
- Housing Services
- Supportive Services in Residential Settings

In addition to demographic information, the PATH-funded programs also report outcomes relative to achievement of their objectives. The most fundamental goal for PATH programs is outreach and engagement to persons who would otherwise not receive services due to the combined conditions of homelessness and SMI. In SFY 2008-09, approximately 12,044 individuals (number from preliminary report) in California received some combination of PATH supportive services.

In an effort to improve and expand services to the mentally ill homeless, PATH staff participates in federal, State, and local groups involved in the development of effective public policy related to the problem of homelessness. Other PATH staff responsibilities include providing information and education on the needs of persons who are homeless and have a mental illness, and serving as liaisons to State and local organizations. Serving veteran populations who are homeless and mentally ill is a new focus in SFY 2010-2011. 38 of the 47 participating counties applied for and received additional funds for veterans who are qualified to receive PATH services. The amount allocated to veterans is approximately \$800,000, which is ten percent of the grant's base allocation.

The SFY 2010-11 PATH allocation to California will be \$9,073,000. Of this amount, \$8,891,540 will be distributed among 48 counties to continue regular PATH programs. The balance of \$181,460 will be utilized for PATH administrative costs.

Adult - Describes how community-based services will be provided to individuals in rural areas

MENTAL HEALTH SERVICES FOR ADULTS RESIDING IN RURAL AREAS

Definition of “Rural Area”

While California is generally perceived nationally as an urban State, a significant proportion of the State is considered rural. Rather than rely upon the more general definitions of “rural” and “urban” utilized in the compilation of U.S. Census Bureau statistics, California health planning agencies have adopted a definition promulgated by the California Rural Health Policy Council (RHPC). The RHPC is charged by the State Legislature with the responsibility of oversight of rural health care matters.

The Council defines rural areas as follows: “Rural areas are Medical Service Study Areas as defined by the Office of Statewide Health Planning and Development (OSHPD) that have a population density of less than 250 persons per square mile and have no incorporated community with a population greater than 50,000 people.” The provision of publicly funded rural health care services, including those for mental health treatment for adults and older adults, are predicated upon this definition.

Mental Health Services for Adults and Older Adults

In providing mental health services to adults, California draws a distinction between the adult population age 18 to 64, and the population of adults age 65 and older. Specifically, California recognizes individuals under age 65 often have different mental health treatment needs than those who have reached retirement age.

This need becomes even greater with age. The MHSA indicates, “Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government.” Additionally, the Act finds that “adults lose their ability to work and be independent, many become homeless, and are subject to frequent hospitalizations or jail.”

The rural elderly encounter many of the same challenges as their urban counterparts in gaining access to services and maintaining their independence. These challenges are much more difficult to overcome because of the demographic and socio-economic challenges inherent in this population.

In general, the mental health treatment needs of adults living in rural counties appear to be similar to the needs of adults in urban areas. However, these needs, as well as the more unique needs of older adults, often go either untreated or under-treated due to barriers that are unique to rural areas.

Significant Barriers to Treatment in Rural Areas

The primary barriers identified by DMH include the following:

- **Transportation Problems**

Limited or no access to public or private transportation makes mental health treatment access virtually impossible for many rural residents. Severe geographic barriers, such as

mountainous terrain or vast distances from available services exacerbate this problem. Medical transportation services are excluded from Medi-Cal reimbursement, except in instances of transporting the beneficiary from a psychiatric inpatient hospital to another 24-hour care facility. Consequently, this creates yet another systemic barrier.

According to the report, “Best Practices in Service Delivery to the Rural Elderly,” forty percent of rural residents live in areas with no public transportation system, eighty percent of rural counties have no public bus service, and, although the automobile is their only mode of transportation, fifty-seven percent of rural residents do not own a car.

- **Lack of Qualified Mental Health Professionals**

In the February 2003, the California Workforce Initiative released its’ report, “The Mental Health Workforce: Who’s Meeting California’s Needs?” The report finds that nearly thirty percent of licensed mental health personnel are employed in the 10-county Bay Area and twenty-four percent are employed in Los Angeles County. Interestingly, those employed in the Central Valley and North County regions of the state jointly comprise only nine percent of the total workforce.

California’s rural mental health care suffers from severe staff and specialist shortages that limit access for many residents. The Workforce Initiative’s general workforce data shows that the demand for mental health professions will grow significantly over the next decade. From 2001 to 2010, their forecast indicates an overall demand for mental and behavioral health care workers with an expected growth from 63,000 to between 73,000 and 80,000 (between sixteen and thirty percent).

Additionally, the California Legislative Analyst’s Office (LAO) released a report entitled, “HMO’s and Rural California” in August 2002. Their analysis indicates that HMOs are withdrawing coverage from rural California because a combination of circumstances makes it difficult for them to profitably operate. The LAO found that circumstances included: a residential population that is relatively expensive to insure; the inherent difficulty of distributing the risks and costs of health coverage to a smaller population base; shortages of health care providers; expensive medical practices that increase costs; and concerns over reimbursement rates for care paid by health-care purchasers. As of May 2002, thirty-seven percent (11) of rural/small counties no longer have HMOs providing services on a countywide basis. Statistics indicate that since 1997, declining enrollment has affected an estimated 5 million residents. Two California counties experienced a seventy-eight percent drop and ninety-five percent drop in enrollment in that same time period. This trend continues to increase, indicating an increasing lack of mental health services that will heavily strain county mental health resources and that are approaching critical levels. If HMOs provided an incentive for qualified staff to work in these areas, the counties might be more successful with staff retention.

Even more acutely felt within the rural mental health treatment community, is the lack of culturally competent staff with special expertise in non-English languages, cultural differences, and age and gender issues. During the Community Program Planning component of the MHSA in Spring 2005, local mental health departments were asked to access their county’s underserved

and unserved communities, including the reduction/elimination of racial and ethnic disparities. Furthermore, DMH requested that counties provide county-specific information on staffing/provider data including gender and race/ethnicity. In January of 2010, DMH issued revised CCPRs. The counties were to submit their revised Plans to DMH by July 28, 2010.

- **Few Available Psychiatric Hospital Beds**

The lack of available hospital beds and related resources (e.g., skilled nursing/sub-acute) is problematic even in the primary health care field for California's rural areas. It is an especially drastic situation with respect to available sites for providing acute and sub-acute psychiatric treatment in most rural areas. Given the nature of mental illness, and the likelihood of the need for crisis intervention during the course of mental health treatment for many clients, this particular resource deficit is highly significant.

In June 2004, the Shasta County psychiatric health facility (PHF) closed its doors due to budget constraints. This has been a serious hardship for many of the rural counties in Northern California since the Shasta PHF was a hub for the region.

Current Efforts at Mitigating These Barriers

- **Working Groups**

There are a number of working groups, most notably the Small County Directors and Superior Region Committees of the CMHDA, that concertedly seek solutions to the above barriers in rural areas. CMHDA has more than one committee functioning under its guidance with specific focuses on rural mental health treatment concerns and issues. Finally, the RHPC identifies and plans for approaches to rural-based impediments to effective mental health services delivery.

- **Technology**

Telemedicine technology is a prime opportunity to explore the efficacy of collaborations between the mental health and physical health services systems. County mental health departments have always relied on collaborative efforts to avoid duplication and maximize cost effectiveness. This especially is true in rural areas, which have traditionally shared a small number of providers and hospitals. The establishment of telemedicine services is no exception.

One of these telemedicine networks is the Northern Sierra Rural Health Network (NSRHN), which provides services to 9 Northern Region counties. These counties are Modoc, Siskiyou, Shasta, Lassen, Plumas, Sierra, Nevada, and Trinity. NSRHN serves health care professionals, organizations, and agencies covering more than 27,000 square miles of Northeastern California.

Additionally, the UC Davis Center for Health and Technology (CHT) is home to a highly successful telemedicine program offering over 30 specialty consultations. Telepsychiatry

has been a part of this program since 1996. Over 1,200 telepsychiatry consultations have been conducted. By augmenting the existing telemental health care service, the collaborative efforts of the UCD Department of Psychiatry and Behavioral Sciences and the CHT enhances the delivery and access to telemental health care services to these rural communities by an interdisciplinary team.

- **Addressing California's Staffing Shortages**

Part of the intent of the MHSA is to establish a program to remedy the shortage of qualified individuals to provide services to address SMI. As part of the MHSA each county mental health program is required to submit a needs assessment identifying its shortages in each professional and other occupational category. The purpose of the assessment is to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide increased services to additional individuals and families. DMH is required to identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan (Five-Year Plan). DMH has continued to work with stakeholders in all policy and program formulations, to include the development of state and county responsibilities in the administration of workforce education and training funds, and the development of an initial budget and funding categories. DMH has recently completed the Five-Year Plan which was approved by the CMHPC in April 2008.

DMH has established a total funding level of \$210 million through June 2009 for local WET activities. Of this total, \$15 million has been allocated for planning and early implementation efforts.

Adult - Describes how community-based services are provided to older adults

SERVICES TO OLDER ADULTS

The 2000 Census showed that, in California, just over fourteen percent of the population were aged 60 or older. In general, California's older adult population, age 60 and over, is not only growing but is getting older. It is expected to reach its peak some time around 2030 as the oldest of the baby boomers reach 85, while the youngest reach 65.

The characteristics of the older adult population for the next 7 to 40 years are:

- By 2010, 1 in 5 Californians will be age 60 or over;
- The number of Californians age 60 and over is projected to grow 154 percent over the next 40 years;
- The influence of the 60 and over age group on California is expected to emerge most strongly over the next 17 years;
- Between 2000 and 2030, minorities over age 60 will increase by 350 percent;
- With 3.3 million residents age 65 and over, California is home to the largest elderly population in the country, ten percent more than Florida, which has the next greatest number. While the rest of the country is also aging, the rate in California is far outpacing the national average for a number of reasons, according to state demographers:
 - California already has a proportionately larger share of people in their 40s than other states, and those people will be at or near retirement age within the next 20 years; and
 - Californians also have a longer average life expectancy than residents of other states. According to the demographics unit of the DOF, there is migration into the state by retirement age people due to California's mild climate.
- Today, 1 in 77 Californians are more than 85 years old (the "oldest old"); that number will grow to 1 in 62 in 2010 and 1 in 34 by 2030; and
- The "oldest old" age group in California since 1950 had an average increase of less than 100,000 every 10 years. Starting in 2000, the rate of increase has been accelerating so that the average will be about 300,000 every ten years by 2030.

BARRIERS TO CARE & PREVALENCE OF MENTAL HEALTH DISORDERS IN OLDER ADULTS

Major barriers currently hinder the delivery of adequate mental health services to older adults, and these barriers will only become more pronounced as the number of older people dramatically increases in the coming decades. Almost 20 percent of those who are 55 years and older experience specific mental disorders that are not part of "normal" aging. The most common mental health disorders treated within California are schizophrenia and other psychotic disorders; mood disorders including depression and bipolar disease; anxiety disorders and adjustment disorders. Within California, older adults account for about 2 percent of dollars spent for all mental health services.

Barriers to care include fragmentation of services among public and private mental health service providers, physical health providers, and social services. A senior or family member often has multiple contacts with a variety of providers before accessing appropriate mental health services. Multiple public and private health insurance plans, disparate and unreliable funding streams, multiple entry points, multiple third part payers, and an incomplete patchwork of state and local

laws and policies that are frequently in conflict add to these barriers. Additionally, there are cultural and linguistic barriers that ethnic populations and their families encounter in seeking mental health services.

Dementia disorders are not included in the Medi-Cal medical necessity target population. However, DMH cooperates with DHCS in providing assessment of individuals with apparent cognitive deficits such as displayed by dementia disorders, including Alzheimer's Disease through use of the PASRR. Nationally, the prevalence of this diagnosis grows with age from over 1.4% for older adults under age 70 years to 25% for those over age 85 years.

Several years ago, CMHDA established an OASOC that provides a structural link between DMH efforts and local efforts in establishing effective OASOC for older adults. The DMH actively participates in these committee meetings and collaborates in policy formulation, the expansion of older adult programs, and the development of training, conferences, and services associated with older adult services. Additionally, as a result of feedback from statewide older adult services and from the demonstration projects, a transitional age subcommittee of the older adult committee was formed. The mission of this subcommittee is to explore the needs of individuals in the 55-59 year old age group who would benefit from the array of services typically offered in an OASOC Demonstration Project but who do not meet the OASOC age requirement.

Transitional Adult Subcommittee

The Transitional Adult Subcommittee is a subcommittee of the CMHDA ASOC and the CMHDA OASOC. The subcommittee membership consists of representatives from the following departments or agencies: County ASOC and OASOC coordinators and managers, mental health consumers, DMH, provider organizations, CMHDA, and the CMHPC. The subcommittee follows the work of the ASOC and OASOC frameworks and reports to those committees.

The subcommittee's mission is to ensure that there is a continuity of care for the adult transitioning from the adult system of care to the community or other phase of life or when transitioning to the older adult system of care. The subcommittee also recognizes the importance of understanding and respecting the cultural and gender issues of the adult consumer in transition. The subcommittee has identified the ages of 55-59 years old as the transitional age for adults entering into the older adult population, though the transition can begin, depending upon need, prior to age 55 and could also happen anytime past the age of 59 years old. Integrated planning should begin based on the functionality of the individual, and the likelihood that the person will need the intensive linkage to health and support services available under OASOC.

Definition of Transitional Adults

- Transitioning from the ASOC to the OASOC;
- Transitioning from the ASOC out into the community;
- Transitioning from the community to the ASOC/OASOC systems – brand new clients; and

- Aging ASOC clients who do not transition into a new program, but into a new phase of life.

Issues for Transitional Adults

Health

- Declining health and mental acuity; fear of dementia, heart attacks, increased pain, medical disabilities, etc.;
- There is a parallel process for physical health and mental health;
- When individuals age within a system, the adjustment to new staff such as doctor, nurse, case manager, clinician, or team (primary contacts with in the system) may be difficult;
- Depression and higher risk for suicide;
- Need for planning for increased older adult supportive mental health services in community / Elder Programs within Regional Support Teams;
- Improved service coordination and interface with medical providers (Doctor, Dentist, Podiatrist., etc.); and
- The need for geropharmacology and affordable treatment.

Abuse

- Substance use and abuse issues; increased need for medications along with side effects;
- Elder abuse; and
- Fiduciary abuse.

Spirituality and Feelings

- Search for meaning and purpose in one's life (past and future);
- Spiritual issues;
- Unresolved guilt and grief; and
- Unfinished Emotional Business.

Family

- Older adults who are also parents to grand-children, nephews and nieces etc.;
- Fear of becoming dependent on someone else;
- Relationship issues with children and spouse, including former partners;
- Fear of abandonment;
- Living alone – family concerns; and
- Dependent transitional adults who are at risk of losing their caretakers (their parents).

Aging Process

- Fear of dying;
- Anger/fear at being marginalized because of age;
- Fear of becoming ugly and/or unattractive in various ways;
- Ageism;
- Managing physiological/emotional changes of aging; and
- Career stresses and “Maintaining the Course.”

Social Security and Retirement

- Retirement and Social Security benefits needs to be addressed, especially in light of the changes which are going to occur to Social Security Benefits and Disability Benefits funds in the near future; and
- Fear of being useless (loss of job and earner role); what to do with that free time.

Financial and Housing

- Financial issues, especially as they relate to healthcare;
- Affordable housing is an important issue especially for persons in residential care settings;
 - Homes are licensed to care for persons either 18-59, or age 60 and over. While age waivers are allowable, persons may be required to move which can be disruptive and costly.
- Living Options – relocate or stay;
- Retirement Finances/Money Management/Advance Directives;
- Affordable Housing;
- Intentional Living Communities;
- Olmstead Planning
- Avoid pre-mature SNF placements;
- Loss of friends and relatives through death and disability;
- Realistic/Unrealistic Expectations;
- Crises – How to Cope;
- Guardianships; and
- Living Wills/Durable Powers of Attorney/Legal/Probate Issues.

Future Areas of Focus

- Need for system change;
- Need for training for ASOC on needs of older adults;
- Need for increased funding for services (e.g., housing);
- Need for coordinated services;
- Need for regulation of the insurance system for older adults accessing services;
- DMH;
- CMHPC;
- Telecare; and
- Mental Health Consumers.

MHSA

Older Adults are a focus of the MHSA. The Welfare and Institutions Code, Section 5813.5 specifies that MHSA services will be available to adults and seniors with severe mental illnesses who meet the eligibility criteria in the WIC Code Section 5600.3(b). Specifically, the focus is on older adults (60 years and older) with SMI – including older adults with CODs and/or other health conditions – who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, 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. Transition age older adults (as described above) may be included under the older adult population when appropriate.

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

**COMMUNITY RESOURCES FOR
ADULT PROGRAMS
STATE FISCAL YEAR 2010-2011**

	FY 2009-2010	FY 2010-2011
DMH - Local Assistance	\$6,003,000	\$1,720,000
DMH - Managed Care	\$84,956,000	\$93,741,000
DMH - CMHS Block Grant	\$37,582,000	\$37,582,000
DMH - PATH	\$8,348,000	\$8,348,000
DMH - Brain Impaired Adults	\$2,918,000	\$7,718,000
DMH - Short-Doyle/Medi-Cal Match	\$585,627,351	\$438,496,000
Total DMH	\$725,434,351	\$587,605,000
Realignment Funds	\$857,334,000	\$865,759,000
Total Community Programs	\$1,582,768,351	\$1,453,364,000

HUMAN RESOURCES DEVELOPMENT

There is a current crisis in the number of mental health professionals trained and able to provide appropriate services to the most severely disabled public mental health clients, with projections for significant increased needs as we move into the 21st century. These acute shortages include staff serving clients who are bilingual/bicultural and those who live in both inner cities and in rural areas. There are also critical shortages of child psychiatrists as well as professionals trained to serve the elderly and other special populations. In addition, California's state hospitals are experiencing acute shortages of psychiatric technicians, nurses, and other clinical staff.

The DMH, in collaboration with the Administration, CMHDA, CMHPC, and other concerned stakeholders, will be addressing the current and future staffing needs in the coming years. The CMHPC has identified the shortage of human resources at all levels as one of the most urgent issues facing the mental health system. In an effort to address the crisis facing the mental health system, the CMHPC convened the Human Resources Summit 2000. Through a collaborative process, key decision-makers determined nine major aspects of the staffing shortage including: expanding the capacity of postsecondary education; work readiness in the classroom; multi-lingual and multicultural pipeline strategies; school-to-career strategies; job retraining for mental health occupations in the public sector; direct consumer and family member employment; licensing boards and professional recruitment; rural strategies; and community redefinition, corporate partnerships, and collaboration.

Human Resource Project

This project was developed to implement the action plan resulting from the March 2000 summit. The overall mission of the Human Resource Project is to increase the mental health workforce and to increase its cultural competence and diversity. Diversity is defined very broadly to include ethnicity, language, gender, age and clients and family members. As of June 30, 2010, the Human Resource project has accomplished the following:

- Collected data on vacancy rates among 22 occupations working within the public mental health system;
- Conducted a professional symposium with secondary education partners, and other stakeholders to develop strategies to increase mental health career opportunities in secondary educational programs;
- Published a guide entitled “A Guide for Developing Mental Health Components in High School Academies” to encourage the development of local partnerships among mental health employers and education programs;
- Convened a series of informational meetings and roundtable discussions with consumer and family member employment training programs;
- Convened a series of focus groups with multicultural social workers from various agencies, including mental health, social services, and alcohol and drug, to determine how to make mental health occupations and academic programs more attractive to bilingual and bicultural students, and produced a summary report of recommendations for schools of social work and the public mental health system;
- Developed a Curriculum (DACUM) that is a nationally recognized, standardized approach to job analysis that produces a complete job profile including prioritized tasks. DACUMs were developed for the following mental health professions and competencies: MFTs, psychiatric technicians, Integrated Dual Diagnosis, Peer Support Specialists, Child and Adolescent, Occupational Therapists, and TAY Services Providers;
- Published a Psychiatric Mental Health Nurse Practitioner (PMHNP) brochure targeted to various levels of the PMHNP career ladder;
- Convened a workgroup to address the shortage of nursing professionals and expand the utilization of psychiatric nurse practitioners in California;
- On behalf of DMH, staffed the SB 1748 Task Force and prepared a report for the State Legislature;
- Researched the capacity of the educational system to train professionals and paraprofessionals for work in the public mental health system;
- Convened a consumer and family member workgroup to make recommendations to the CMHPC and the DMH on consumer and family member employment programs and opportunities that are consistent with the recommended activities of the MHSA Education and Training Program components;
- Produced a report entitled, “Consumer and Family Member Employment in the Public Mental Health System.”
- Collaborated with Assembly Member Leland Yee’s Office to develop Assembly Concurrent Resolution 54, a measure that proclaims the 3rd week of May of every year as Mental Health Occupations Week and to develop AB 938, a bill that extends a loan repayment program administered by OSHPD to mental health professionals;

- Completed the initial phase of retired persons project that placed retirees in job/career roles in the California public mental health system;
- Developed a pilot project on the provision of geriatric specialty training in small counties for individuals providing services to older adults;
- Advocated for federal legislative staff to support current federal funding efforts to assist individuals who choose mental health occupational and educational pathways;
- Contracted with the California Association of Social Rehabilitation Agencies to conduct a time-limited Recovery Standards Task Force;
- Partnered with the California Foundation for Independent Living Centers to develop a resource document and disseminate strategies for engaging the cross disability community in public mental health workforce programs; and
- Worked with DMH in the completion of the MHSA Five-Year WET Development Plan (Five Year Plan) and reviewed and approved the final plan.

The Human Resource Project intends to provide at least the following products and advance the following activities in the coming FY:

- Provide technical assistance to local mental health departments on how to engage secondary educational programs as part of a long-term workforce development strategy;
- Continue to advise DMH on the development of evaluation requirements for objectives outlines in the Five-Year Plan that will hold programs accountable for increasing the diversity and cultural competency of the public mental health workforce;
- Contract with a consultant to conduct a series of statewide roundtables with ethnically diverse communities to obtain feedback on local and statewide WET initiatives;
- Continue the effort to better understand the unique needs of older adults within the public mental health system;
- Continue to promote the recruitment of retirees in California's public mental health system;
- Expand post-secondary educational opportunities for mental health occupations through encouraging distance education, career ladder programs, and promoting secondary and post-secondary educational programmatic coordination;
- Continue to develop DACUM projects in order to assess and document the skills and abilities of mental health workers at all levels of service in the public mental health workforce; and
- Advocate for federal financial support in the expansion of financial relief opportunities and programs in the state for mental health workers at all levels of service.

DMH completed and published the "MHSA Five Year WET Development Plan" with the cooperation and approval of the CMHPC in 2008. The department collects the county data to complete a comprehensive statewide occupational needs assessment as the counties submit their workforce and development plans. Currently, 48 counties have submitted and had their WET plans approved.

The MHSA envisions a system that promotes recovery/wellness for adults and older adults with SMI and resiliency for children and youth with SED and their families. In addition, mental health services should be effective in helping adults, children and families reach their goals

through the development of individualized service plans and delivery of evidence-based practices. The MHPSA WET component offers an opportunity to transform the system to reflect these values. The Department has fully vetted and has been actively involved in a public stakeholder process to solicit input on ideas for effective use of MHPSA WET funds.

MHPSA WORKFORCE EDUCATION AND TRAINING (WET)

In the WET component, the MHPSA specifies that each county MHP shall submit to the DMH a needs assessment identifying shortages in each professional and other occupational category, and a plan to increase the supply of professional and other staff that county MHPs anticipate they will require. DMH is required to identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan (Five-Year Plan). DMH has established a total funding level of \$210 million through April 2018 for local WET activities. Of this total, \$10 million has been allocated in approved planning requests to 49 counties and an overall total of \$159 million has been allocated to 48 counties. The Five-Year Plan was approved in 2008 by the CMHPC.

Statewide contracts with trainers and consultants are continuing through this FY. These are entities that have a proven track record of providing training and technical assistance as envisioned by the Act. These include:

- **Organizational Change Support**—CIMH continues its expanded statewide training and technical assistance mission of supporting county mental health programs. This expansion includes ongoing technical assistance for organizational development toward consumer and family member-driven, evidence-based service delivery as envisioned by the Act, and facilitates regional learning collaborative networks to plan and implement new practices.
- **Financial Incentive Program**—The California Social Work Educational Consortium (CalSWEC) expanded its existing stipend program to provide financial incentives for students in master's level social work programs committed to working in community public mental health. The 2007-08 Cohort had 185 graduates; 2008-09 had 183; and there are currently 183 students enrolled in the 2009-10 Cohort. Approximately \$5.8 million per year has been allocated for this effort.
- **Stipends**—DMH has entered into contracts with 7 universities to develop and model successful stipend programs for graduate students who are: clinical psychologists, psychiatric mental health nurse practitioners, and MFTs who commit to working in the public mental health system. These stipends programs have begun to do so by: 1) increasing the recruitment of individuals who can address the cultural diversity needs of public mental health recipients, 2) encouraging the enrollment and support of individuals with client and/or family member experience in the public mental health system and, 3) preparing professionals to deliver public mental health services that promote wellness, recovery and resilience. In FY 2008-09, 84 stipends were awarded to graduate students in marriage and family therapy, psychiatric mental health nurse practice, and clinical psychology. Seventy three percent of the stipend recipients represented a cultural

minority and fifty eight percent spoke a language other than English. In FY 2009-10, 163 stipends were awarded to graduate students in marriage and family therapy, psychiatric mental health nurse practice, and clinical psychology. Sixty four percent of the stipend recipients represented a cultural minority and sixty three percent spoke a language other than English.

- **Physician Assistant Training**—DMH has partnered with OSHPD to add a mental health track to the Residency Program for Physician Assistants as a strategy to address the shortage of individuals who can administer psychotropic medications. In FY 2008-09, five Physician Assistant programs that train a total of 383 second-year residents to specialize in public mental health were awarded for a total of \$500,000 (approximately \$100,000 per program). In FY 2009-10, three Physician Assistant Programs that train a total of 147 second-year residents to specialize in public mental health were awarded \$300,000 (approximately \$100,000 per program).
- **Mental Health Loan Assumption Program (MHLAP)**—DMH partnered with the OSHPD-HPEF to award a total of \$2.5 million to qualified mental health professionals throughout California. MHLAP was launched in February 2009 and the awardees were selected in May. The MHLAP provides loan assumption awards to pre-licensed as well as licensed individuals in all the mental health professions. In its initial cycle, 1,243 individuals applied for this program, requesting over \$15 million. Representatives from DMH, County Departments of Mental Health, experts in the mental health field and OSHPD-HPEF selected a total of 288 applicants from 44 counties. A total of \$2,286,699 was awarded.
- **Statewide Constituency Partnership**—The statewide constituency organizations of CNMHC, UACF, and NAMI-California have expanded their efforts to reach consumers and family members with self-help technical assistance and train-the-trainer curricula, such as Educate, Equip and Support – Building Hope, Peer-to-Peer, Family-to-Family, and Wellness Recovery Action Planning. These curricula will promote the meaningful inclusion and employment of consumers and family members at all levels of the public mental health system.
- **Statewide Technical Assistance Center** The Department has contracted with Working Well Together to assist county public mental health and community based organizations in successfully employing consumers and family members within their organizations; and providing the training and tools to create welcoming environments that value consumer and family member employees and their experience. Working Well Together is a collaborative comprised of four agencies: CIMH, UACF, NAMI and CNMHC.
- **Regional Partnerships** The Department is working with five counties that serve as the fiscal sponsors for area regional partnerships throughout California. The purpose of the regional partnerships is to:
 1. Partner with educational systems;
 2. Expand outreach to multicultural communities;

3. Increase diversity of the workforce;
 4. Reduce stigma;
 5. Promote web-based technologies; and
 6. Promote distance learning techniques.
- **Psychiatric Residency Programs** DMH has contracted with the Regents of the University of California, Davis to develop a specialty Med Psych residency program. DMH is also in the process of securing a contract with Kern County Mental Health who will work with UCLA-Kern to develop a Child and Adolescent Fellowship program, and The Regents of the University of California- San Francisco (Fresno Medical Education Program) to develop a child and adolescent psychiatry fellowship program.

Additional state administered programs and activities are in the development stage and DMH is facilitating a stakeholder process to ensure these planned programs and activities adhere to the intent of the Act. Proposed county guidelines for developing county administered programs and activities are currently in draft form, and are posted on the DMH web site for public input.

DEPARTMENT OF MENTAL HEALTH TRAINING

The DMH State Hospitals' Training Officers provide a wide range of training opportunities for State Hospital employees. The Headquarters Training Officer reviews, approves and tracks headquarters employee training requests. The Headquarters Training Office also acts as liaison with State Hospital Training Officers regarding issues that impact all DMH employees.

Current staff development efforts at the state hospitals are focused on:

- Conducting annual training needs assessments;
- Implementing an annual training plan; and
- Evaluating the success of the plan at the conclusion of the FY.

Training currently offered by the DMH State Hospitals and the Headquarters Training Office includes, but is not limited to, the following:

- Training required by the Government Code, Department of Personnel Administration policy, DMH policy, agreements between the State of California and employee union organizations, and, at the State Hospitals, the Joint Commission on Accreditation of Healthcare Organizations;
- In-house and contracted training courses identified through staff development needs assessment in subjects such as: mental health history and policy, writing skills, etc.;
- Training using the DMH computer network, which links DMH headquarters, State Hospitals, and field offices;
- PsychLINK professional clinical training sessions presented via DMH satellite. Continuing Education Credits are offered and other departments are invited to attend. The Hospital Training Offices are responsible for registering, grading, and faxing test results for staff to receive continuing education credits to maintain their licensure. Topics include "Compliance

with Antidepressant Therapy” and “Beyond Efficacy: Obesity and the Psychotic Patient.” These sessions are also videotaped and can be viewed at later dates; and

- State Hospitals presenting training programs with DMH staff and participants from county mental health programs on such topics as dual diagnosis, biopsychosocial treatment planning, and vocational rehabilitation programming.

The DMH Information Technology (IT) unit coordinates with the data center, outside vendors, and headquarters based computer training for DMH employees. Computer training provided by outside vendors includes Microsoft Windows 2000, Word, Excel, PowerPoint, Visio, and other appropriate courses. The Health and Human Services Data Center (HHSDC) offers one-to-three day courses in standard PC applications as well as longer and more specialized subjects. The IT unit also provides consultation to DMH staff in selecting the most appropriate computer training classes.

The DMH has contracted in the past, and will continue to contract with external providers and State organizations such as the CPS Human Resource Services, Health and Human Services Data Center, universities and community colleges for training. The scope of training topics includes managed care, dual diagnosis, children's SOC, performance outcomes, and independent living with a focus on employment.

The DMH has developed the capability for interactive videoconferences that links headquarters and all State Hospitals. In addition, some counties, other government agencies, and State universities have the same capability so the system can be used with local mental health programs as well. Teleconferences are presented to promote more efficient communication while saving travel costs and time. The videoconference unit also has a document camera and videocassette recorder so documents can be read simultaneously in several locations and conferences can be recorded. For the same cost savings reasons, DMH has installed a satellite dish at headquarters that allows the onsite downloading of important professional development programming from throughout the United States.

The DMH, the CMHDA, the CMHPC, and the California Association of Local Mental Health Boards stress the need for continued and expanded federal funding of Human Resources Development programs. These funds are essential to State and local efforts to train the State's mental health work force, especially in light of the unique multicultural and linguistic needs of California.

Adult - Provides for training of providers of emergency health services regarding mental health;

COMMUNITY AND EMERGENCY HEALTH SERVICES PROVIDER EDUCATION

DMH community and emergency health services provider education efforts include distribution of educational materials produced by NAMI California through a contract with DMH. In addition to a broad array of educational materials in print and electronic-media format on a wide range of mental health subjects, NAMI California has produced a number of videotapes designed to educate the public, particularly law enforcement and emergency health services providers, on the nature of mental illness and dealing with individuals in crisis. Additionally, NAMI California has developed a series of booklets that have been most helpful to families of newly diagnosed persons.

The NAMI California website provides family members and consumers with current information on SMI 24 hours a day, 7 days a week. The website address is <http://www.namicalifornia.org>. NAMI California continues to expand, update, and maintain the website, with a focus on adjusting the layout to make the information more accessible and “user friendly.” NAMI staff contact, verify and update listings for service providers that treat SMI and local affiliates and organizations that assist families and consumers. The webmaster posts program class schedules and selects news stories relating to mental illness and mental health, including articles regarding government policies and programs, advances in treatment and pharmaceutical company announcements regarding new drugs, side effects and research. The NAMI website highlights new offerings in their annual conference, which will be distributed via video presentations regionally for the first time. DMH has continued to fund this effort in SFY 2009-10 and anticipates continuing its funding in SFY 2010-11.

DMH Disaster Assistance Coordinator (DAC) maintains a liaison role with the California Department of Health Services and Emergency Medical Services Authority for emergency planning and assistance. As part of an inter-disciplinary training team, the DAC participates in an annual training course entitled “Disaster Bootcamp,” which is offered to emergency medical and health services personnel. This presentation includes an overview of the mental health issues relevant to natural disasters and terrorist events and responder coping and stress management. The DAC may be a licensed mental health clinician qualified to teach courses on mental health issues or an emergency services expert.

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

EXPENDITURE PLAN FOR FY 2011

DMH will allocate the FY 2011 CMHS Block Grant to county mental health departments for the SFY 2011-12. These funds will be used to promote the implementation of integrated systems of care and to fulfill the mission of the California mental health system. In addition, the DMH will allocate a portion of the block grant to support the CMHPC.

The DMH is the State's designated recipient of the Block Grant and allocation of funds to counties is based on either a legislated formula or on a competitive basis. The allocation affords counties the opportunity to develop innovative programs or augment existing programs within their systems of care for adults with SMI or children with SED. In order to receive the allocation, each county is required to submit an annual application or expenditure plan that includes a narrative detailing its intended use of the funds.

Block grant funding may also be awarded through a competitive process. The process is structured to encourage counties to adopt proven practices and to promote innovation by encouraging counties to explore new approaches.

The expenditure plan for FY 2011 Block Grant funds includes:

- \$45,088,922 funding base to 57 counties. This funding base includes an \$8,059,000 set-aside to support existing efforts to provide integrated treatment services for individuals with a dual diagnosis of SMI and a substance abuse disorder;
- \$3,987,515 to provide ongoing funding to support seven competitively awarded CSOC programs;
- \$2,000,000 to support two Integrated Services Agencies (ISAs);
- \$200,000 to support Human Resource Development (HRD);
- \$20,000 to support the efforts of COJAC; and
- \$2,699,812 for DMH Administrative and Support costs (includes funding for CMHPC).

The following chart summarizes the Department's proposed total CMHS Block Grant funds to be allocated for adult and children's mental health services for SFY 2011-12.

CMHS BLOCK GRANT SFY 2011/2012 PROPOSED EXPENDITURES

COUNTY	FUNDING BASE	DDX SET-ASIDE	HRD PROJ.	CHILDREN SOC	ISA FUNDING	CO-OCCURRING DISORDERS	ALLOCATION AMOUNT
ALAMEDA	\$ 548,109	\$ 152,415					\$700,524
ALPINE	\$ 11,008	\$					\$11,008
AMADOR	\$ 31,999	\$ 8,477					\$40,476
BUTTE	\$ 247,366	\$ 94,983					\$342,349
CALAVERAS	\$ 107,938	\$ 11,903					\$119,841
COLUSA	\$ 51,462	\$ 1,535					\$52,997
CONTRA COSTA	\$ 1,496,897	\$ 76,984					\$1,573,881
DEL NORTE	\$ 110,372	\$ 13,127					\$123,499
EL DORADO	\$ 99,162	\$ 38,077					\$137,239
FRESNO	\$ 1,090,943	\$ 418,899					\$1,509,842
GLENN	\$ 107,284	\$ 8,700					\$115,984
HUMBOLDT	\$ 261,285	\$ 45,532		\$ 183,692			\$490,509
IMPERIAL	\$ 294,003	\$ 64,292					\$358,295
INYO	\$ 158,132	\$ 985					\$159,117
KERN	\$ 887,622	\$ 231,820					\$1,119,442
KINGS	\$ 124,692	\$ 47,879					\$172,571
LAKE	\$ 167,271	\$ 28,454					\$195,725
LASSEN	\$ 86,203	\$ 13,429					\$99,632
LOS ANGELES	\$11,566,142	\$ 1,162,873		\$1,012,034	\$1,000,000	\$ 20,000	\$14,761,049
MADERA	\$ 164,970	\$ 45,596					\$210,566
MARIN	\$ 256,736	\$ 98,581	\$200,000				\$555,317
MARIPOSA	\$ 90,094	\$ 2,534					\$92,628
MENDOCINO	\$ 32,287	\$ 12,398					\$44,685
MERCED	\$ 402,470	\$ 114,295		\$ 351,535			\$868,300
MODOC	\$ 11,130	\$ -					\$11,130
MONO	\$ 11,019	\$ -					\$11,019
MONTEREY	\$ 407,205	\$ 93,279		\$ 740,475			\$1,240,959
NAPA	\$ 179,928	\$ 69,089					\$249,017
NEVADA	\$ 59,637	\$ 22,899					\$82,536
ORANGE	\$ 1,669,447	\$ 559,023					\$2,228,470
PLACER	\$ 197,527	\$ 46,365		\$ 444,188			\$688,080
PLUMAS	\$ 208,900	\$ 8,136					\$217,036
RIVERSIDE	\$ 2,086,711	\$ 360,159					\$2,446,870
SACRAMENTO	\$ 1,473,368	\$ 498,582					\$1,971,950
SAN BENITO	\$ 31,901	\$ 12,250					\$44,151
SAN BERNARDINO	\$ 2,528,246	\$ 610,357					\$3,138,603
SAN DIEGO	\$ 2,392,515	\$ 878,852					\$3,271,367
SAN FRANCISCO	\$ 2,034,829	\$ 685,821					\$2,720,650
SAN JOAQUIN	\$ 846,218	\$ 282,744					\$1,128,962
SAN LUIS OBISPO	\$ 127,421	\$ 57,159		\$ 254,061			\$438,641
SAN MATEO	\$ 689,902	\$ 164,338					\$854,240
SANTA BARBARA	\$ 167,202	\$ 33,828					\$201,030
SANTA CLARA	\$ 543,363	\$ 172,184					\$715,547
SANTA CRUZ	\$ 96,068	\$ 22,376					\$118,444
SHASTA	\$ 195,919	\$ 75,228					\$271,147
SIERRA	\$ 48,289	\$ 317					\$48,606
SISKIYOU	\$ 97,274	\$ 22,840					\$120,114
SOLANO	\$ 120,364	\$ 46,217					\$166,581
SONOMA	\$ 204,638	\$ 42,804					\$247,442
STANISLAUS	\$ 542,357	\$ 185,018		\$1,001,530	\$1,000,000		\$2,728,905
SUTTER/YUBA	\$ 269,468	\$ 69,385					\$338,853
TEHAMA	\$ 170,234	\$ 21,397					\$191,631
TRINITY	\$ 83,541	\$ 2,042					\$85,583
TULARE	\$ 667,105	\$ 201,143					\$868,248
TUOLUMNE	\$ 53,192	\$ 16,616					\$69,808
VENTURA	\$ 224,953	\$ 86,376					\$311,329
YOLO	\$ 195,604	\$ 18,408					\$214,012
COUNTY TOTAL	\$37,029,922	\$ 8,059,000	\$200,000	\$3,987,515	\$2,000,000	\$ 20,000	\$51,296,437
DMH ADMIN/SUPPORT	\$ 2,699,812						\$2,699,812
GRAND TOTAL							\$53,996,249

Table C. MHBG Funding for Transformation Activities

State: California

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual or estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY2011	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input checked="" type="checkbox"/>		11,409,795
GOAL 2: Mental Health Care is Consumer and Family Driven	<input checked="" type="checkbox"/>		13,442,353
GOAL 3: Disparities in Mental Health Services are Eliminated	<input checked="" type="checkbox"/>		6,681,979
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input checked="" type="checkbox"/>		14,331,067
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input checked="" type="checkbox"/>		3,508,797
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input checked="" type="checkbox"/>		1,655,501
Total MHBG Funds	N/A	0	51,029,490.00

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research ... Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

DMH strongly agrees with the principles of transformation and is working diligently to accomplish those transformational goals as found in the guidance instructions and as articulated in the President's New Freedom Commission on Mental Health. Transformational activities are being facilitated through the implementation of the MHSA, as described below and as referenced in various narrative sections of the application and with the Mental Health Block Grant (MHBG) funds.

MHBG TRANSFORMATIONAL EFFORTS

Although the MHBG is a small percentage of California's mental health budget, it is invaluable for the purpose of providing an important and flexible funding source to support a broad range of innovative activities specific to the needs of each county. Many counties are using the MHBG to fund community mental health services that are transformational, innovative, recovery based, culturally competent and community based. The MHBG funds are allocated to all of California's 58 counties through two methodologies.

1. The first method is a legislated formula that provides a stable, flexible and non-categorical funding base, which the counties can use to develop innovative programs or augment existing programs within their SOCs for adults with SMI or children with SED. In order to receive the formula allocation, each county is required to submit an annual application or expenditure plan that includes a narrative detailing its intended use of the funds. \$8,059,000 of the MHBG funds have been set-aside and distributed to the counties based on this formula to support existing efforts to provide integrated treatment services for individuals with a dual diagnosis of SMI and a substance abuse disorder; and
2. The second method of allocating the MHBG funds is a discretionary method that allows the Department, in consultation with the CHMDA, to fund specific projects that are innovative and based on best practices. In the past the funds have provided for numerous successful projects including the development of an OASOC, Dual Diagnosis Projects, Veterans with PTSD, Youth Development and Crime Prevention Projects, and Supportive Housing Projects. The MHBG discretionary funds are currently being used to support the following programs (all described within the application).
 - \$3,987,515 to provide ongoing funding to support seven competitively awarded CSOC programs;
 - \$2,000,000 to support two ISAs;
 - \$200,000 to support Human Resource Development; and
 - \$20,000 to support the efforts of the COJAC.

California had not collected information as requested in the block grant application instructions related to transformational activities; therefore it was necessary to request counties to provide information to the State as to the transformational efforts occurring in their county. It must be recognized that the concept of transformation includes a system whose core structure is culturally competent, integrated, recovery-based, and consumer driven, and that these endeavors are an integrated effort and often overlap.

Other Transformation Efforts

In addition to the MHBG funds, DMH is engaged in numerous endeavors that support transformation efforts in California. Leading that effort is the implementation of the MHSA that provides the funding to expand community mental health services. The activities supported by the MHSA are consistent with the goals identified by the President's New Freedom Commission on Mental Health and are intended to achieve the following:

- To define mental illness as a condition deserving priority attention, including PEI services through medical and supportive care;
- To reduce the long-term adverse impact resulting from untreated SMI;
- To expand successful, innovative service programs including culturally and linguistically competent approaches for underserved populations;
- To provide funds to adequately meet the need of all who can be identified and enrolled; and
- To ensure that funds are expended in the most effective manner and services are provided in accordance with recommended best practices with oversight to ensure accountability.

The transformational activities, including those of the MHSA, are described throughout the narrative and have been summarized below.

Goal 1 - Americans Understand that Mental Health is Essential to Overall Health.

The MHSA authorizes DMH to establish program requirements for PEI in California including reduction of stigma, discrimination, and suicide. In addition, the MHSA authorizes the MHSOAC to approve program expenditures for PEI. Because of this unique relationship, DMH and the MHSOAC worked closely to craft the program and funding requirements in collaboration with the CMHDA and the CMHPC. To date, 45 counties have submitted their plan for PEI services.

- DMH convened a Statewide Advisory Committee which completed a draft California Strategic Plan for Suicide Prevention. The Strategic Plan was completed in June 2008; and
- The MHSOAC approved expenditures of \$40 million per year for Student Mental Health Initiative, Stigma and Discrimination Reduction and Suicide Prevention statewide efforts. DMH will be the administrator for those programs. Counties are assigning some of their funds to the state to fund this effort.

Goal 2 - Mental Health Care Is Consumer and Family Driven.

The California mental health system is based on the development of an integrated system for children, adults, and older adults that are recovery-based, comprehensive, integrated, and driven by consumer and family needs. Characteristics of this effort include:

- Dedication to providing recovery-based comprehensive services;

- Team models that rely heavily on interagency collaboration and cooperation to meet clients' needs;
- Voluntary participation of clients in each service identified in a personal service plan; and
- Provision of services on a 24-hour basis to meet the needs of individuals, including housing, supported and competitive employment, socialization, education, rehabilitation, legal assistance, money management, mental health treatment, physical health care, and dental care.

Some programs provide information, counseling, respite, and other services for relatives of clients.

In addition, consumers and family members have multiple opportunities to influence care for themselves and their children. For example:

- Clients and family members serve on committees of the CMHDA;
- DMH supports the CNMHC, which funds consumer-driven services in such areas as self-help and mutual support groups, public education and policy, cultural competence and sensitivity, membership outreach and networking, and job development;
- DMH also support other family and consumer support agencies such as NAMI California and UACF; and
- The DMH Ombudsman Office creates a bridge between the mental health managed care system and Medi-Cal beneficiaries by providing information and assistance to help them navigate the system; a toll-free number is an important feature of this service.

The MHSA directs that the perspective, participation of ongoing involvement of consumers and family members is a significant factor in the planning, development, and implementation of the MHSA. The effective participation of clients and family members throughout the process is critical and utilizes an inclusive stakeholder process for design of the MHSA.

The MHSA specifies the major components around which DMH has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the components was staggered. All MHSA components are now being implemented. The state's stakeholder process involves the development of discussion documents, a series of general stakeholder meetings, statewide teleconferences and topic-specific workgroups to provide input on critical implementation policies and processes. In addition, the DMH continues to encourage stakeholders to provide input on MHSA-related issues and policies through the general MHSA email address, the toll-free MHSA phone line and the MHSA Website.

There are five fundamental concepts inherent in the MHSA that are both consistent with the goals of the President's New Freedom Commission, and required to be embedded and continuously addressed throughout the Program and Expenditure Plans submitted by counties.

Two of the five fundamental concepts consistent with Goal 2 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, decision-making, ownership, vision, and responsibility. The goal of community collaboration is to bring community members together in an atmosphere of support to systematically solve existing and emerging problems that could not easily be solved by one group alone.
- **Client/family driven mental health system for older adults, adults and TAY and family driven system of care for children and youth:** With adult clients and families of children and youth identifying their needs and preferences; DMH can develop services and supports that will be most effective for them. These needs and preferences also influence the policy and financing decisions that affect them. Adult services are client centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from uncoordinated services and fragmented systems.

Many adults with SMI and parents of children with SED have limited influence over the services they or their children receive. Increasing opportunities for clients and families to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self monitoring, and accountability. Increasing choice protects individuals and encourages quality.

Goal 3 - Disparities in Mental Health Services Are Eliminated.

Eliminating disparities in mental health services requires culturally competent mental health care and a qualified workforce. The DMH OMS has had an active CCAC to provide assistance and advice in developing culturally competent mental health services. To date, OMS has completed more than 30 statewide trainings and direct county consultations on cultural competence and mental health.

In addition, OMS has completed a service provider competency assessment scale and training program in collaboration with a local university and the CIMH. This provider assessment scale toolkit is designed to assess the cultural competence training needs of mental health service providers and provide a roadmap for multicultural training in four areas: multicultural knowledge, awareness of cultural barriers, sensitivity to multicultural consumers, and non-ethnic ability.

A Multicultural Mental Health Brochure Series along with an Interactive CD has been developed to educate mental health consumers, family members, service providers, and the general public. This can be found at the CIMH website (<http://www.cimh.org>).

Further, the DMH Human Resource Project is designed to increase the diversity of the workforce and ensure that it is competent in terms of issues around culture, gender, age, and religion. In 2004, the project developed Psychiatric/Mental Health Nurse Practitioner fact sheets targeted to various levels of the career ladder. Because there is a dramatic shortage of mental health workers qualified to provide integrated services for people with SMI and CODs, the Human Resource Project will produce the information necessary to develop a curriculum for training staff in COD treatment.

Barriers to mental health service delivery in rural areas are addressed by the Small and Rural Counties Committee of the CMHDA and by the State's Rural Health and Policy Council.

Goal 4 - Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

Another fundamental concept inherent in the MHSA and consistent with Goal 4 is the provision of integrated service experiences for clients and their families throughout their interactions with the mental health system. This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum coordinated, through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/TAY/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have COD, such as substance use problems and/or other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults, and safe family living for children and youth, can be reached for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state for years to come. The combination of these five fundamental concepts ensure that through MHSA-funded activities, counties work with their communities to create culturally competent, client/family driven mental health services and support plans which are wellness focused, support recovery and resilience, and offer integrated service experiences for clients and families.

In addition, services for children and youth, people with COD, and older adults are a priority in the California mental health service system. The CSOC Initiative will benefit from funds generated by the MHSA. Positive outcomes for children involved in CSOC services include reduction in psychiatric hospitalizations, justice system involvement, and out-of-home placement and improvement in school attendance. Additional services for children and youth include:

- The Early Mental Health Initiative (EMHI) for children in kindergarten through third grade who are experiencing mild to moderate school adjustment activities;
- A Youth Pilot Program within the HHS designed to demonstrate collaborative, integrated child and family delivery systems; this program builds on the success of the

CSOC and is supporting the development of institutional and administrative reforms that improve client outcomes; and

- Interagency case management councils that coordinate resources for children who are concurrently using the services of more than one agency.

Activities on behalf of individuals with CODs include the following:

- DMH annually sets aside \$8 million of its Block Grant funds to support county efforts to provide integrated treatment services for adults with CODs.

Integrated Dual Diagnosis Treatment (IDDT):

DMH sought and received one of SAMHSA's Evidence-Based Practices grants for \$975,000 to (1) provide training and technical assistance to implement the IDDT model in eight sites throughout California; (2) evaluate the implementation process and fidelity to the IDDT model, and (3) develop the infrastructure to foster statewide implementation of evidence-based practices. One of the sites under this grant, Ventura County Behavioral Health, was recently awarded the Science and Service Award by SAMHSA in recognition of exemplary implementation of evidence-based intervention to prevent and treat mental illness and substance abuse.

The implementation and evaluation was contracted to CIMH. Six of the eight sites sustained implementation of the model, one to a very high degree of fidelity and three others to an adequate level of fidelity. In two of the four counties, IDDT is being further disseminated.

Goal 5 - Excellent Mental Health Care Is Delivered and Research Is Accelerated.

In the past years DMH has continued MHSAs implementation activities in the following areas:

Community Services and Supports (CSS)

CSS refers to "System of Care Services" as required by the MHSAs in Welfare and Institutions Code Sections 5813.5 and 5878.1 to 5878.3. The change in terminology differentiates MHSAs CSS from existing and previously existing SOC programs funded at the federal, state and local levels. The MHSAs requires that "each County¹ shall prepare and submit a three-year plan which shall be updated at least annually and approved by the DMH after review and comment by the Mental Health Services Oversight and Accountability Commission." The MHSAs further requires that "the department shall establish requirements for the content of the plans." Annual updates to the County's Three-Year Program and Expenditure Plan will be required pursuant to MHSAs requirements. Pursuant to California Code of Regulations, Title 9, sections 3300, 3310, subdivision (d), and 3515, subdivision (a), the annual update shall be developed with the participation of stakeholders. A draft of the annual update or update shall be circulated for 30 days to stakeholders for review and comment.

¹ "County" means the County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving funds per WIC Sections 57.01 (Cal. Code Regs. Tit. 9, § 3200.090).

The DMH developed plan requirements for the Program and Expenditure Plan for CSS with stakeholder participation in early 2005 and released them in final on August 1, 2005. As of June 2009, sixty (60) County Plans have been received and sixty (60) plans have been approved for funding.

The total funding amount for CSS for FY 2010-11 is approximately \$783 million. The total funding amount for PEI for FY 2010-11 is approximately \$216 million. The total funding amount for Innovation for FY 2010-11 is approximately \$119 million.

These Program and Expenditure Plan requirements are intended to build upon and operationalize the concepts in the Vision Statement and Guiding Principles for DMH Implementation of the MHSA. These requirements look beyond “business as usual” and are intended to start building a system where access will be easier; services are more effective; out-of-home placements, institutional care, homelessness and incarcerations are reduced; and stigma toward those who are diagnosed with SMI or SED no longer exists. These requirements are intended to initiate significant changes including:

- Increases in the level of participation and involvement of clients and families in all aspects of the public mental health system;
- Increases in client and family operated services;
- Outreach to and expansion of services to client populations in order to eliminate disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates; and
- Increases in the array of community service options for individuals diagnosed with SMI and children/youth diagnosed with SED, and their families, that will allow them to avoid unnecessary institutionalization and out of-home placements.

Essential Elements for All Three-Year Program and Expenditure Plans

There are five fundamental concepts inherent in the MHSA that must be embedded and continuously addressed throughout the Program and Expenditure Plans submitted by Counties. These include:

1. **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;
2. **Cultural competence:** Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those

professionals, consumer providers, and family member providers to work effectively in cross-cultural situations.

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. Service providers understand and utilize the strengths of culture in service delivery. 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 services that provide the most effective outcomes and create 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.

- 3. Client/family driven mental health system for older adults, adults and TAY and family driven system of care for children and youth:** Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.

Many adults with SMI and parents of children with SED have limited influence over the services they or their children receive. Increasing opportunities for clients and families to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self monitoring, and accountability. Increasing choice protects individuals and encourages quality.

- 4. Wellness focus, which includes the concepts of recovery and resilience:** Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means 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 elimination of symptoms. Focusing on recovery in service planning encourages and supports hope;

Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community.

- 5. Integrated service experiences for clients and their families throughout their**

interactions with the mental health system: This means that services are “seamless” to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family’s needs using the full range of community-based treatment, case management, and interagency system components required by children/TAY/adults/older adults.

Integrated service experiences include attention to people of all ages who have a mental illness and who also have CODs, including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached and maintained for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state.

These five fundamental concepts combine to ensure that through MHSA-funded activities, counties work with their communities to create culturally competent, client/family driven mental health services and support plans which are wellness focused, which support recovery and resilience, and which offer integrated service experiences for clients and families.

Services for Adults and Older Adults

The W&I Code, Section 5813.5 specifies that MHSA services will be available to adults and seniors with severe mental illnesses who meet the eligibility criteria in the W&I Code Section 5600.3(b)—adults and older adults who have serious mental disorder and (c)—adults and older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence. Some TAY may also be served under these provisions.

The MHSA Program and Expenditure Plan Requirements are based on a logic model that links: (1) community issues resulting from untreated mental illness and a lack of services and supports, (2) mental health needs within the community, (3) the identification of specific populations to be served based upon the issues and needs identified, (4) the programs and services/strategies to be implemented, and (5) the desired outcomes to be achieved. In addition to a focus on community issues and outcomes. The MHSA also emphasizes the importance of measuring outcomes achieved by specific individuals and families, including but not limited to: hope, personal empowerment, respect, social connections, independent living for adults and safe living with families for children/youth, self-responsibility, self determination and self esteem for clients and families. An outcome measurement system (system and individual level) will be developed and implemented under the MHSA to ensure that counties are providing the highest level of quality care possible in the most efficient and effective ways. It is further envisioned that as a part of the ongoing QI process, data and feedback on the individual, community and system levels are used

to refine and improve services and supports. Plans for addressing individual quality of care issues are a part of this ongoing process. Significant effort is being focused on streamlining the state and local plan development and approval processes, integration of the components of the MHSA with each other and into the larger public mental health system and increased focus on indicators. The commitment to transformation of the entire local public mental health system through the use of the MHSA continues.

Specific Populations by Age Consistent with MHSA and DMH Priorities:

- **Children and youth** between the ages of 0 and 18, or Special Education Pupils up to age 21, who have SED and their families, who are not currently being served;
- **TAY** between the ages of 16 and 25, who are currently unserved or underserved who have SED and who are homeless or at imminent risk of being homeless, youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems and youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization;
- **Adults with SMI** – including adults with a co-occurring substance abuse disorder and/or health condition; and
- **Older adults 60 years and older with SMI** – including older adults with co-occurring substance abuse disorders and/or other health conditions – who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services.

There are three service categories to emphasize and track the essential elements of transformation.

- In FSPs, each individual participating must be offered a partnership with the county MHP to develop an individualized services and supports plan that is based on “whatever it takes” approach;
- Counties may use general system development funding to help transform their core programs and service delivery system to be more consistent with the 5 fundamental concepts of the MHSA as described earlier; and
- The last category is outreach and engagement, to highlight the commitment to reach out to unserved and underserved communities and individuals.

Goal 6 - Technology Is Used to Access Mental Health Care and Information.

The University of California has been allotted \$200 million through Proposition 1D which was approved by California voters in November 2006. These funds provide for related infrastructure to expand medical school enrollment and build and enhance telemedicine statewide.

California was awarded a \$22 million grant from the Federal Communications Commission to fund the expansion of broadband services to over 300 rural telemedicine sites in California, including 81 rural hospitals. In addition, up to \$8.6 million in financial commitments have been offered by the California Emerging Technology Fund and United Health Group Inc to help support the implementation of this project. The telehealth network will be used to improve access to care in underserved communities, as well as to provide a resource for emergency services and disaster preparedness.

Telemedicine technology is being pilot tested in more than half a dozen projects around the State. One such project is the Northern Sierra Rural Health Network's Regional Telemedicine System Project that links rural providers with specialists in urban areas and with each other to access telemedicine and telepsychiatry, decrease provider isolation, and provide increased opportunities for continuing education for rural providers. Telemedicine units have been installed in rural clinics, hospitals, public health departments, and other health care sites in eight counties. More than 850 clinical consultations and more than 210 Continuing Medical Education events have been conducted. Budgetary constraints continue to be a barrier to full implementation of telemedicine services. The MHSAs have set aside a portion of the new funding for CFTN activities.

The Network of Care for Mental Health is an Internet-based community resource for individuals, families and agencies concerned with mental and emotional wellness. This online community provides critical information, communication and advocacy tools with a single point of entry. It ensures there is "No Wrong Door" for those navigating the system of mental health services, those working to avoid the need for formal services, and those ready to transition out of the mental health system. This easy-to-use website also provides an extensive directory to put people in touch with the right services at the right time. It also offers vital information about diagnoses, insurance and advocacy, as well as daily news from around the world concerning mental health.

A portion of the MHSAs funds have been specifically set aside for CFTN in FY 2004-2005 through FY 2008-2009 to enable counties to support the goals of the MHSAs in a manner which is consistent with the County's Three-Year Program and Expenditure Plan. In subsequent FYs, counties may continue to use a portion of their MHSAs CSS funding for CFTN. In March, 2008, DMH released proposed guidelines for Counties to submit their CFTN Component of the MHSAs. The County must clearly show how the planned use of the Capital Facilities funds will produce long-term impacts with lasting benefits, and the development of a variety of community-based facilities which support integrated service experiences and an increase in peer support and consumer run facilities. Capital Facilities funding will be utilized to purchase, construct, and/or rehabilitate facilities that provide services and/or treatment for those with SMI, or to provide administrative support to MHSAs funded programs.

The MHSA also provides funding for county technology projects that will improve the access and delivery of mental health services to the public. DMH is responsible for ensuring that the MHSA funds are appropriated to county technology projects that are consistent with MHSA goals and objectives. In order to allocate funds appropriately, DMH created a process in which counties submit their technology funding requests for approval in accordance with established DMH guidelines. DMH then works directly with each county technology representative (usually the chief information officer) to develop a comprehensive understanding of the technology project and the anticipated results, and make any required modifications prior to approval. Once the approval is granted, funds are released to the county in support of the project. The DMH then continues to work in an oversight capacity with the county in order to ensure the project's success.

DMH evaluates and approves technology requests within the context of two goals:

- Modernize and transform clinical and administrative information systems to improve quality of care, operational efficiency and cost effectiveness; and
- Increase consumer and family empowerment by providing the tools for secure consumer and family access to health information within a wide variety of public and private settings.

The long-term technology goal of DMH is to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information. This infrastructure will allow different county systems to share information across a secure network environment both inside and outside their respective counties. Counties and their contract providers, hospital emergency departments, laboratories, pharmacies and consumers and their families could all securely access and exchange information through the infrastructure. This long-term goal will be achieved as each county assesses their current state of technology readiness and moves through a continuum of improvements over time.

To facilitate the long-term technology transformation, DMH developed minimum statewide standards for mental health EHR systems. The EHR system is the foundation for the Integrated Information Systems Infrastructure. It is a secure, real-time, point-of-care, client-centric, information resource for service providers. The ability to share timely, accurate and secure access to the client's health and healthcare information is possible through the use of uniform standards to transfer information from one source to another. To achieve statewide technology transformation, DMH will periodically specify increasingly complex minimum standards so that counties and their vendors will be able to adapt their systems while meeting their current business needs.

Outcomes Reporting

Counties report FSP outcomes and other MHSA services information. In addition, all counties with approved CSS plans have begun submitting Quarterly Reports of targeted and actual numbers of persons outreached and served through the MHSA FSP, outreach and engagement,

and system development funding sources. The DMH is streamlining data entry, consolidation and analytic processes for statewide aggregation and reporting of this information.

Because PM selection includes the consideration of technology options available to improve workflow processes, data quality and the feasibility of data collection, DMH information technology personnel, performance measurement personnel and numerous stakeholders statewide continue to collaborate towards enhancing information management infrastructures that support performance measurement and accountability reporting. To that end, the DMH is developing the DCR and other Web-based data entry processes which streamline the data submission and reporting process for FSP programs and other MHPA strategies.

In addition, the MHPA is involved the following transformation efforts that are critical to the success of community mental health services in California:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	392,748	392,748	386,741	386,741
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To increase access to services for adults and older adults with SMI.

Target: To maintain or increase the current access to services.

Population: Adults and Older Adults with SMI.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: We estimate that clients accessing services will hold steady.

Measure: Number of Adults and Older Adults with SMI served.

Sources of Information: California Department of Mental Health Client and Service Information (CSI) system.

Special Issues: While the California mental health system's goal is always to increase access to services, the funding sources for mental health services have not been stable in recent years. As funds have not kept pace with population growth, counties have had to reduce their mental health programs, forcing them to serve only the most seriously ill and reduce services to all clients.

Significance: The Mental Health Services Act (MHSA) funds have provided new, innovative and transformational mental health services. These funds have allowed counties to provide services when funds from other sources are decreasing. MHSA funds can supplement, but not supplant existing services. It is anticipated that over time the services and supports from the MHSA will impact the entire public mental health system.

Action Plan:

2010:

1. DMH will continue to implement the adult services and program described in the narrative portions of the current application ("Executive Summary" and "State priorities and plan to address unmet needs").
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue to implement the adult services and program described in the narrative portions of the current application ("Executive Summary" and "State

priorities and plan to address unmet needs”).

2. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.

3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

4. DMH will continue to monitor and evaluate and assess the progress of the counties transition to an electronic health record (EHR) system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	4.66	4.67	14.90	14.90
Numerator	19	19	--	--
Denominator	408	407	--	--

Table Descriptors:

Goal: The Department will strive to decrease the readmission rates.

Target: There is a target to keep the readmission rate below 15 percent.

Population: Adults and Older Adults with SMI.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The performance indicator is stated as the percent of persons discharged who are readmitted. However, when the numbers are small, a difference of one or two people can have a significant impact on the rate of readmission, thus our target must be fairly liberal to allow for possible large swings in rates of readmission.

Measure: Readmission to state hospital for Adults and Older Adults with SMI within 30 days.

Sources of Information: California Department of Mental Health Admission Discharge and Transfer (ADT) Hospital data system.

Special Issues: California has not set specific goals to date because the absolute and relative numbers of persons served in State Hospitals is very low. A recent NASMHPD report shows that California's State Hospital utilization for voluntary and civil commitments is among the lowest in the country. The number of hospital days per 100,000 children and youth is 444 while the national average is 1,590. This is the second lowest rate among 30 state reporting. The rate for adults in California is 918 while the national average is 5,360. This is the third lowest rate among 39 state reporting for adults. These very low admission rates make establishing a goal to which the state will be held difficult. The department will strive to decrease the readmission rates and to keep the readmission rate below 15 percent to allow for wide variation that may take place in individual years.

Significance:

Action Plan: 2010:
1. DMH will continue to implement the adult services and program described in the narrative portions of the current application.
2. With the MHSA, Community Services and Support Component, the County Mental Health Departments will continue to implement full service partnerships which will greatly assist in the individual with SMI to stay in county settings; this reducing the utilization of Psychiatric Inpatient Beds.

2011:
1. DMH will continue to implement the adult services and program described in the narrative portions of the current application.
2. With the MHSA, Community Services and Support Component, the County

Mental Health Departments will continue to implement full service partnerships which will greatly assist in the individual with SMI to stay in county settings; this reducing the utilization of Psychiatric Inpatient Beds.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	7.35	5.85	14.90	14.90
Numerator	30	24	--	--
Denominator	408	410	--	--

Table Descriptors:

Goal: The Department will strive to decrease the readmission rates.

Target: The goal is to keep the readmission rate below 15 percent.

Population: Adults and Older Adults with SMI.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The performance indicator is stated as the percent of persons discharged who are readmitted. However, when the numbers are small, a difference of one or two people can have a significant impact on the rate of readmission, thus our target must be fairly liberal to allow for possible large swings in rates of readmission.

Measure: Number of readmission to state hospital within 180 days

Sources of Information: California Department of Mental Health ADT Hospital data system

Special Issues: California has not set specific goals due to the absolute and relative numbers of persons served in State Hospitals is very low. California has one of the lowest rates of state hospital utilization for voluntary and civil commitments. DMH cannot establish a goal to which the state will be held based on so few people. DMH will strive to decrease the readmission rates and that there is a general goal to keep the readmission rate below 15 percent. This will allow for variation that might take place in individual years.

Significance:

Action Plan: 2010:
1. DMH will continue to implement the adult services and program described in the narrative portions of the current application.
2. With the MHSA, Community Services and Support Component, the County Mental Health Departments will continue to implement Full Service Partnerships which will greatly assist in the individual with SMI to stay in county settings; this reducing the utilization of Psychiatric Inpatient Beds.

2011:
1. DMH will continue to implement the adult services and program described in the narrative portions of the current application.
2. With the MHSA, Community Services and Support Component, the County Mental Health Departments will continue to implement Full Service Partnerships which will greatly assist in the individual with SMI to stay in county settings; this reducing the utilization of Psychiatric Inpatient Beds.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal:

Target:

Population: Adults and Older Adults with SMI.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: Combining the resources from the Data Infrastructure Grant (DIG) and the Mental Health Services Act (MHSA), the Department has modified its data systems to enable the reporting of Evidence-Based Practices (EBP). These changes were combined with other changes that were needed to the data system. They are being implemented for SFY 2006-2007. Since 58 county systems are being modified to report these new data elements, we expect some lag in reporting over the next fiscal year.

Significance:

Action Plan:

2010:

- DMH will continue to implement the adult services and programs described in the narrative portions of the current application relating to Evidence Based Practices.
- DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
- DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.

2011:

- DMH will continue to implement and monitor the adult services and programs described in the narrative portions of the current application relating to Evidence Based Practices.
- DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
- DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.08	.20	.20	.20
Numerator	245	428	--	--
Denominator	310,620	209,110	--	--

Table Descriptors:

Goal: Supportive housing for adults with SMI

Target: To maintain the percentage of adults with SMI receiving Supportive Housing at .2%

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Adults with SMI receiving Supportive Housing

Measure: Number of adults with SMI receiving Supportive Housing

Sources of Information: CSI System

Special Issues: CSI data received as of July 31, 2010. Not all counties' data are available at this time.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the adult services and program described in the narrative portions of Community Services Support and MHSA Housing sections of the application.
2. It is anticipated that an additional 11-15 County MHSA Housing applications will be approved.
3. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
4. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
5. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
6. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue implementation of adult services to increase services to adults and older adults with SMI receiving Supportive Housing.
2. It is anticipated that another 10-15 counties will submit MHSA Housing application for DMH review and approval.
3. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and

improved upon.

4. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

5. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.06	.11	.10	.10
Numerator	171	231	--	--
Denominator	310,620	209,110	--	--

Table Descriptors:

Goal: To increase the number of adults with SMI receiving supported employment.

Target: The target is to hold steady at approximately .10% of adults receiving supported employment.

Population: Adults with SMI.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Adults with SMI receiving supported employment.

Measure: Number of adults with SMI receiving supported employment.

Sources of Information: Client and Service Information (CSI) system.

Special Issues: CSI data received as of July 31, 2010. Not all counties' data are available at this time.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the adult services and program described in the narrative portions relating to adults with SMI receiving supported employment.
2. DMH will continue to provide detailed information on individuals enrolled in MHSA funded, Full Service Partnership programs.
3. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will continue to monitor and implement the adult services and program described in the narrative portions related to adults with SMI receiving supported employment.
2. DMH will continue to provide and monitor detailed information on individuals enrolled in MHSA funded Full Service Partnership programs.
3. It is anticipated that the numbers of adults with more than one reported change in living situation will continue its reduction.
4. DMH will continue to work with counties to improve data quality.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.45	1.14	1	1
Numerator	1,392	2,393	--	--
Denominator	310,620	209,110	--	--

Table Descriptors:

Goal: Assertive Community Treatment (ACT) for Adults with SMI

Target: The target is to hold steady at approximately 1% of adults receiving ACT services.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Adults with SMI receiving ACT services

Measure: Number of adults with SMI receiving ACT services

Sources of Information: Client and Service Information (CSI) System

Special Issues: CSI data received as of July 31, 2010. Not all counties' data are available at this time.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the adult services and programs described in the narrative portions of the current application relating to assertive community treatment.
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
3. DMH will continue to explore the development of a database to better inventory the various programs/models (including EBPs-Adults with SMI receiving Assertive Community Treatment) being implemented by the counties in operating the MHSA.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will continue implementation of adult services to increase services to adults and older adults with SMI who are receiving assertive community treatment.
2. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.
3. DMH will continue to explore the development of a database to better inventory the various programs/models (including EBPs-Adults with SMI receiving Assertive Community Treatment) being implemented by the counties in operating the MHSA.

4. DMH will continue to explore the development of a database to better inventory the various programs/models (including EBPs-Adults with SMI receiving Assertive Community Treatment) being implemented by the counties in operating the MHSA.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.05	.09	.10	.10
Numerator	151	190	--	--
Denominator	310,620	209,110	--	--

Table Descriptors:

Goal: Family Psychoeducation for adults with SMI.

Target: To maintain the percentage of adults with SMI receiving Family Psychoeducation at .10%.

Population: Adults with SMI.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Adults with SMI receiving Family Psychoeducation.

Measure: Number of adults with SMI receiving Family Psychoeducation.

Sources of Information: CSI System.

Special Issues: CSI data received as of July 31, 2010. Not all counties' data are available at this time.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the adult services and program described in the narrative portions of the current application relating to family psychoeducation services.
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting punctuality and improve data quality.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with counties and assist with their efforts to report related data elements in a timely manner to ensure the department's ability to set appropriate, measurable targets.
5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue implementation of adult services to increase services to adults and older adults with SMI who are receiving family psychoeducation services.
2. DMH will assess county reporting methodology to ensure the quality and timeliness of reported data. Training and technical assistance will be further assessed and improved upon.
3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program

areas are affected to the least possible level.

4. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.27	1.05	1	1
Numerator	838	2,188	--	--
Denominator	310,620	209,110	--	--

Table Descriptors:

Goal: To maintain the percentage of adults with SMI receiving Integrated Dual Diagnosis.

Target:

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Adults with SMI receiving Integrated Dual Diagnosis Treatment (IDDT).

Measure: Number of adults with SMI receiving Integrated Dual Diagnosis Treatment (IDDT).

Sources of Information: Client and Service Information (CSI) system.

Special Issues: CSI data received as of July 31, 2010. Not all counties' data are available at this time.

Significance:

Action Plan:

2010:

- DMH will continue to implement the adult services and programs described in the narrative portions of the current application relating to adults with SMI who exhibit co-occurring substance abuse and mental disorders and are receiving Integrated Dual Diagnosis Treatment (IDDT).
- DMH will continue to participate on the California Co-Occurring Joint Action Council (COJAC).
- With MHSA funds, the Department of Alcohol and Drug Program will continue to work collaboratively with DMH and the County Mental Health Departments in assuring individual with co-occurring disorders are served appropriately.
- DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
- Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
- DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

- DMH will continue implementation of adult services to increase services to adults and older adults with SMI who exhibit co-occurring substance abuse and mental disorders and are receiving Integrated Dual Diagnosis Treatment (IDDT).
- With MHSA funds, the Department of Alcohol and Drug Program will continue to work collaboratively with DMH and the County Mental Health Departments in

assuring individual with co-occurring disorders are served appropriately.

3. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.

4. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.

5. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	13.32	13.32	13	13
Numerator	6,157	6,157	--	--
Denominator	46,214	46,214	--	--

Table Descriptors:

Goal: Increase or maintain the percentage of adults with SMI who receive Illness Self-Management and Recovery for adults with SMI

Target:

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Adults with SMI receiving Illness Self-Management and Recovery

Measure: Number of adults with SMI receiving Illness Self-Management and Recovery

Sources of Information: CSI System

Special Issues: While all 58 counties have modified their systems to report these data elements, eleven counties, including Los Angeles, have not completed reporting for SFY 2007-08, and Los Angeles has not completed reporting for SFY 2006-07. The incomplete reporting hampers the department's ability to set appropriate targets. This is likely due to counties changing not only what they collect, but the systems they use to collect the data.

Significance:

Action Plan: 2010:

1. DMH will continue implementation of adult services to increase or maintain Illness Self-Management and Recovery for adults with SMI.
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
3. DMH will continue working with other entities relating to community support and self-help networks.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

2011:

1. DMH will monitor and continue implementation of adult services to increase or maintain Illness Self-Management and Recovery for adults with SMI.
2. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.
3. DMH will continue working with other entities relating to community support

and self-help networks.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	70	70	67	67
Numerator	32,352	32,352	--	--
Denominator	46,214	46,214	--	--

Table Descriptors:

Goal: To increase or maintain the percentage of Adults with SMI receiving Medication Management

Target:

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Adults with SMI receiving Medication Management

Measure: Number of adults with SMI receiving Medication Management

Sources of Information: CSU System

Special Issues: While all 58 counties have modified their systems to report these data elements, eleven counties, including Los Angeles, have not completed reporting for SFY 2007-08, and Los Angeles has not completed reporting for SFY 2006-07. The incomplete reporting hampers the department's ability to set appropriate targets. This is likely due to counties changing not only what they collect, but the systems they use to collect the data.

Significance:

Action Plan: 2010:
 1. DMH will continue implementation of adult services to increase services to adults with SMI who are receiving Medication Management.
 2. With funding from the MHSA, DMH will continue to work in partnership with the California Department of Health Care Services (the state's single state agency on Medicaid) or on a project known as CalMEND (California Mental Health Care Management Program). CalMEND, was established in 2005 as a quality improvement project to promote wellness and recovery for individuals with mental illness. Three program objectives for CalMEND Medication Management are: (1) Decision Aid for Use of Antipsychotics (a practical tool to promote shared decision-making between prescriber and client and maximize effectiveness of medication selected) (2) Pharmacy Utilization Reports to Promote Quality Improvement (standardized reports to identify opportunities to improve the quality or prescribing practices) (3) Health Economic Analysis of Population of Individuals with Mental Illness (examination of patterns of health care utilization among individuals with and without serious mental illness).
 3. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
 4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will monitor and continue implementation of adult services to increase services to adults with SMI who are receiving Medication Management.
2. With funding from the MHSA, DMH will continue to work in partnership with the California Department of Health Care Services (the state's single state agency on Medicaid) or on a project known as CalMEND (California Mental Health Care Management Program). CalMEND, was established in 2005 as a quality improvement project to promote wellness and recovery for individuals with mental illness. Three program objectives for CalMEND Medication Management are: (1) Decision Aid for Use of Antipsychotics (a practical tool to promote shared decision-making between prescriber and client and maximize effectiveness of medication selected) (2) Pharmacy Utilization Reports to Promote Quality Improvement (standardized reports to identify opportunities to improve the quality or prescribing practices) (3) Health Economic Analysis of Population of Individuals with Mental Illness (examination of patterns of health care utilization among individuals with and without serious mental illness).
3. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	72.57	72.75	89	89
Numerator	33,669	29,367	--	--
Denominator	46,398	40,368	--	--

Table Descriptors:

- Goal:** To maintain or improve client’s perception of care.
- Target:** The target is to maintain the approximate 89% positive response rate.
- Population:** Adults and Older Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Consumer Perception of Care
- Measure:** Mental Health Services Improvement Program Survey for Adults and Older Adults.
- Sources of Information:** The estimates for the numerator and denominator for the current year are obtained by doubling the numbers from the Nov 2008 data collection period. The numbers do not include data from the May 2009 data collection period as this data is not yet available.
- Special Issues:** The MHSIP Outcomes subscale was previously used for calculating cliets' perceived satisfaction with services. It has been determined that MHSIP Satisfaction subscale is a more accurate measure of Client Perception of Care; thus, it will not be possible to compare the previous years' scores to the most current scores as the subscales are not comparable.
- Significance:** These data are used to report on client’s perception of care. The DMH encourages counties to use this data locally to improve programs to benefit clients and family members.
- Action Plan:**
- 2010:
1. DMH will continue to work with counties to maintain or improve clients' perception of care.
 2. The Mental Health Services Improvement Program Survey will continue to be administered to identify disparities between what staff intended and what clients perceived was happening to them.
 3. Assist clients in understanding what brought them into the hospital, the goals of current treatment, and the importance of aftercare.
 4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
- 2011:
1. DMH will continue to work with and monitor counties to maintain or improve client’s perception of care.
 2. The results of clinical and client surveys will be evaluated to determine what improvements, if any, need to be implemented.
 3. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: Not Applicable

Target: No target set.

Population: Adults and Older Adults with SMI.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure: Not Applicable

Sources of Information:

Special Issues: California does not routinely compare changes in employment status of consumers. Employment status is included as a static measure reported to DMH at admission, and discharge, and is updated annually for consumers who continue to receive services beyond a year. It is not well reported which makes times-series comparisons difficult. DMH can provide more detailed information for individuals enrolled in Mental Health Services Act funded, Full Service Partnership (FSP) programs. Of the 10,103 individuals (Ages 16-70 years) enrolled in an FSP as of January 2009, 6.4 percent were participating in employment activities at enrollment. Post enrollment, 7.1 percent were participating in employment activities. This is a very modest increase that should be considered in light of the very high unemployment rate of the general California population. It is important to note that this sample is not considered comparable to the FY 2010-11 Block Grant Application to demonstrate any changes in employment for this cohort.

Significance:

Action Plan:

2010:

1. DMH will continue to provide employment information on individuals enrolled in MHSA funded Full Partnership programs.
2. Through the MHSA, there is a concerted effort to increase the number of adults with SMI who have or had received services through the Public Mental Health System. The Working Well Together Project will continue to train clients.
3. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
4. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
5. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will continue to monitor employment information on individuals enrolled in MHPA funded Full Partnership programs.
2. Through the MHPA, there is a concerted effort to increase the number of adults with SMI who have or had received services through the Public Mental Health System. The Working Well Together Project will continue to train clients.
3. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.
4. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	93.44	94.22	90	90
Numerator	3,448	3,111	--	--
Denominator	3,690	3,302	--	--

Table Descriptors:

- Goal:** To reduce the number of adults and older adults who report criminal justice involvement.
- Target:** By June 30, 2010, the number of consumers indicating reduced/maintained criminal justice involvement will be maintained.
- Population:** Adults and Older Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Number of adults and older adults indicating reduced/maintained criminal justice involvement.
- Measure:** Total number of adults and older adults in the sample.
- Sources of Information:** Mental Health Services Improvement Program Survey for Adults and Older Adults.
- Special Issues:** The estimates for the numerator and the denominator for the current year are arrived at by doubling the numbers from the November 2008 data collection period. The numbers do not include data from the May 2009 survey period as the data are not yet available. The targets are conservative due to the State's current budget and economic downturn.
- Significance:**
- Action Plan:**
- 2010:
1. DMH will continue to implement the adult services and program described in the narrative portions of the current application.
 2. The Mental Health Services Improvement Program Survey will continue to be administered to identify adults and older adults with SMI who report criminal justice involvement.
 3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
 4. Through the MHSA Prevention and Early Intervention Program, many Mental Health Departments are working more directly with the juvenile justice systems.
 5. MHSA funds support a program through the State Administrative Office of the Courts to increase the number of Mental Health Courts.
 6. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
- 2011:
1. DMH will continue to implement the adult services and program described in the narrative portions of the current application.

2. The Mental Health Services Improvement Program Survey will continue to be administered to identify adults and older adults with SMI who report criminal justice involvement.
3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.
4. Through the MHSA Prevention and Early Intervention Program, many Mental Health Departments are working more directly with the juvenile justice systems.
5. MHSA funds support a program through the State Administrative Office of the Courts to increase the number of Mental Health Courts.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To increase the percentage of adults and older adults receiving public mental health services who report stable housing.

Target: No target set.

Population: Adults and Older Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure: Not Applicable

Sources of Information:

Special Issues: California does not routinely collect information about housing stability. This is included as a static measure reported as 'living arrangement' collected at admission, and discharge from public mental health services, and is updated annually for consumers who continue to receive services beyond a year. However, it is not well reported which makes times-series comparisons difficult. DMH can provide more detailed information for individuals enrolled in Mental Health Services Act funded, Full Service Partnership (FSP) programs. In examining these data, of the 7,901 adults and older adults 18 years or older who were enrolled in an FSP for at least one year, 5,391 (68.2%) reported more than one change in living situation in the 12 months prior to enrollment. At 12 months post enrollment, 2,985 (38%) reported more than one change in living situation. This represents a 30% reduction in the number of adults with more than one reported change in living situation during the 12 months after enrollment into an FSP. It is important to note that this sample is not considered comparable to the larger population of individuals receiving public mental health services due to the intensive nature of the services provided. However, DMH will provide comparison data for the FY 2010-11 Block Grant Application to demonstrate any changes in housing stability for this cohort.

Significance:

Action Plan: 2010:
1. DMH will continue to implement the adult services and program described in the narrative portions of Community Services Support and MHSA Housing sections of the application.
2. DMH will continue to provide detailed information on individuals enrolled in MHSA funded, Full Service Partnership programs.
3. It is anticipated that the number of adults with more than one reported change in living situation will continue to reduce during the 12 months after enrollment into an FSP.

4. DMH will continue to work with counties to improve data quality.
5. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
6. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
7. DMH will work closely with developing evaluation efforts that are currently underway through the MHSAs.

2011:

1. DMH will continue to implement the adult services and program described in the narrative portions of Community Services Support and MHSAs Housing sections of the application.
2. DMH will continue to provide and monitor detailed information on individuals enrolled in MHSAs funded Full Service Partnership programs.
3. It is anticipated that the numbers of adults with more than one reported change in living situation will continue its reduction.
4. DMH will continue to work with counties to improve data quality.
5. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.
6. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	73.26	73.65	72	72
Numerator	33,488	29,358	--	--
Denominator	45,712	39,860	--	--

Table Descriptors:

- Goal:** To maintain or increase adults and older adults perception of social supports and social connectedness.
- Target:** The target is to hold steady at 72% of adults and older adults reporting increased social supports and social connectedness.
- Population:** Adults and Older Adults with SMI.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percent of individuals that indicate increased social supports/social functioning based on subscale scores from the MSHIP Survey.
- Measure:** MHSIP Survey.
- Sources of Information:** The estimate for the numerator and denominator for the prior fiscal year was arrived at by doubling the numbers from the November 2008 survey period as the May 2009 survey data is not yet available.
- Special Issues:** These data may be impacted by fluctuations in funding which result in program expansions, reductions, new implementations and discontinuations. This constant ebb and flow in funding causes significant variation in program availability and service consistency which makes it difficult to establish meaningful targets. The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.
- Significance:**
- Action Plan:**
- 2010:
1. DMH will continue to administer the MHSIP survey and track changes in indicators over time.
 2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
 3. DMH will continue to develop targets for future fiscal years based on the survey indicators.
- 2011:
1. DMH will continue to administer and monitor the MHSIP survey and continue to track changes in indicators over time to further establish meaningful targets.
 2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
 3. DMH will continue to develop targets for future fiscal years based on the survey indicators.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	68.89	69.07	68	68
Numerator	32,245	28,048	--	--
Denominator	46,809	40,606	--	--

Table Descriptors:

Goal: To increased the number of adults and older adults who report improved levels of functioning.

Target: The target is to hold steady the approximate 68% of adults and older adults that reported improved functioning.

Population: Adults and Older Adults with SMI.

Criterion:
 1:Comprehensive Community-Based Mental Health Service Systems
 3:Children's Services
 4:Targeted Services to Rural and Homeless Populations

Indicator: The percent of individuals that indicate improved functioning based on subscale scores from the MSHIP Survey.

Measure: MHSIP Survey

Sources of Information: The estimates for the numerator and denominator for both prior fiscal years were arrived at by doubling the numbers from the November 2008 survey period as the data from May 2009 survey period is not yet available.

Special Issues: These data may be impacted by fluctuations in funding which result in program expansions, reductions, new implementations and discontinuations. This constant ebb and flow in funding causes significant variation in program availability and service consistency which makes it difficult to establish meaningful targets. The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.

Significance:

Action Plan:

2010:

1. DMH will continue to administer the MHSIP survey and track changes in indicators over time.
2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
3. DMH will continue to develop targets for future fiscal years based on the survey indicators.

2011:

1. DMH will continue to administer and monitor the MHSIP survey and continue to track changes in indicators over time to further establish meaningful targets.
2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
3. DMH will continue to develop targets for future fiscal years based on the survey indicators.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: California Health Interview Survey (CHIS)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To provide data for analysis at the county level regarding the prevalence of adults with SMI and other co-morbidity conditions.

Target: By June 30, 2010, the DMH will analyze the additional mental health data added to the California Health Interview Survey (CHIS) for adults and older adults. DMH will make data available on departmental websites and present findings to interested stakeholders.

Population: Adults and Older Adults

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Adults and Older Adults with SMI.

Measure: California Health Interview Survey (CHIS).

Sources of Information: California Health Interview Survey (CHIS).

Special Issues:

Significance: CHIS is the largest and most complete source of behavioral health data for California. DMH's continued participation and funding (MHSA) has provided the opportunity to include mental health questions to this biannual statewide survey conducted by UCLA.

Action Plan: 2010:

1. DMH will continue to fund mental health questions on the CHIS surveys.
2. DMH will look at options for providing and disseminating these findings to program and policy makers as well as mental health consumers and other interested stakeholders.
3. DMH will use these findings to plan programs and services.

2011:

1. DMH will continue to fund and monitor the mental health question on the CHIS surveys.
2. DMH will provide and disseminate information to mental health consumers.
3. DMH will continue to use these findings to plan programs and services.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: FSP Services for Older Adults in Rural Counties

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	109	178	10	10
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To create a comprehensive community mental health system that promotes recovery and wellness for older adults with serious mental illness (SMI).

Target: By June 30, 2010, the percentage of older adults in rural counties enrolled in Full Service Partnerships will be maintained at 10%.

Population: Older adults diagnosed with SMI.

Criterion: 4: Targeted Services to Rural and Homeless Populations

Indicator: Number of adults and older adults in rural counties enrolled in Full Service Partnership programs.

Measure: Number of adults and older adults enrolled in Full Service Partnership programs.

Sources of Information: Full Service Partnership Outcomes Assessment.

Special Issues: The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the adult services and program described in the narrative portions of the current application relating to FSP Services for Older Adults in Rural Counties.
2. By June 30, 2010, the percentage of adults and older adults enrolled in FSP will be maintained at 10%.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue implementation of adult services to maintain services to adults and older adults with SMI who reside in rural communities.
2. DMH will monitor enrollment of adult and older adults enrolled in FSP to maintain the 10% goal.
3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.
4. DMH will continue to monitor and evaluate and assess the progress of

counties transition to an electronic health record (EHR) system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Full Service Partnerships

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	8,836	13,570	70	70
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** To create a comprehensive community mental health system that promotes recovery and wellness for adults and older adults with serious mental illness (SMI).
- Target:** By June 30, 2010, the percentage of adults and older adults enrolled in Full Service Partnerships will be maintained at 70%.
- Population:** Adults and Older Adults with SMI.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Total number of adults and older adults enrolled in Full Service Partnerships.
- Measure:** Total number of individuals enrolled in Full Service Partnerships.
- Sources of Information:** Full Service Partnership Outcomes Assessment.
- Special Issues:** The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.
- Significance:**
- Action Plan:**
- 2010:
1. DMH will continue to implement the adult services and program described in the narrative portions of the current application relating to FSP Services for Adults and Older Adults with SMI.
 2. By June 30, 2010, the percentage of adults and older adults enrolled in FSP will be maintained at 70 %.
 3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
 4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
 5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.
- 2011:
1. DMH will continue to implement services to adults and older adults with SMI.
 2. DMH will monitor enrollment of adult and older adults enrolled in FSP to maintain the 70% goal.
 3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.
 4. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Strategies for Increasing the Diversity of the Workforce

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: Support activities of the California Mental Health Planning Council (CMHPC) to serve as a statewide catalyst to address the shortage of mental health staff.

Target: By June 30, 2010, complete a report that will describe successful strategies for engaging the broader cross-disability community in public mental health educational and workforce development programs. By June 30, 2011, conduct a Family Member/Parent Partner DACUM (Developing a Curriculum)

Population: Adults and older adults diagnosed with SMI

Criterion: 5:Management Systems

Indicator: 2010: A completed report submitted to the Department of Mental Health. 2011: A completed DACUM submitted to the Department of Mental Health

Measure: 2010: A completed report submitted to the Department of Mental Health. 2011: A completed DACUM submitted to the Department of Mental Health

Sources of Information: 2010: A survey of national and statewide strategies to create an inclusive and diverse workforce. Convening a series of regional roundtables workgroups to review findings and provide input. 2011: Work group convened to perform the DACUM process.

Special Issues:

Significance: California Mental Health Planning Council (CMHPC) is dedicated to promoting strategies that engage diverse communities in contributing to the work of the CMHPC and developing education and workforce pipelines that lead to increasing the diversity and inclusiveness of the workforce. The CMHPC believes that an inclusive and diverse workforce is a significant strategy for eliminating health and mental health disparities. Consequently, the CMHPC Human Resources Committee has developed a Diversity Project to:

- Identify workforce development strategies, especially those strategies that reach-out to the broader cross-disability community. The broader cross-disability community includes all individuals with a mental or physical condition that limits one or more major life activities, such as learning, walking, seeing, thinking, working, breathing etc.
- Receive input on the components of the Five-Year Plan

The mechanism selected for obtaining input and conducting outreach was the development of at least three regional roundtables (far north, central, and far south). Roundtable participants will be comprised of individuals and representatives from organizations that are selected by CMHPC. Participants will be asked to respond to the workforce strategies outlined in the DMH plan for

workforce development entitled, Mental Health Services Act Five-Year Plan. In addition, participants will be asked to provide information on innovative approaches to workforce development and deployment not described in the DMH plan that engage the broader disability community.

A report will be published detailing the findings of the roundtable participants that will be provided to the Department of Mental Health and shared with public mental health organizations throughout California.

2011:

The employment of family members and parent partners is vital to the transformation of the public mental health system. In order to increase the capacity of family member and parent partner participation in the public mental health system, county mental health departments have developed the peer support specialist, peer advocate position, parent partner, and family advocate positions. Understanding the duties, knowledge, skills, and abilities of this vital occupational niche is critical to developing additional training programs and being able to expand career mobility opportunities for individuals who are working within these positions. A family member and parent partner DACUM will allow for a more standardized review of the roles and responsibilities of family members and partner partners in the public mental health system. In addition, a DACUM will enable employers to determine the training that will best enhance the work of family members and parent partners, allowing organizations to develop career ladders that link to other professions. Lastly, the DACUM will assist in documenting the differentiation of duties, roles, and responsibilities of family member advocates and parent partner advocates, who are dealing exclusively with issues of aiding parents who have a child in need of or receiving public mental health services.

Action Plan:

2010:

1. DMH will support activities of the CMHPC to serve as a statewide catalyst to address the shortage of mental health staff.
2. DMH will work with CMHPC to complete a report that describes successful strategies for engaging the broader cross disability community in public mental health educational and workforce development programs.

2011:

1. DMH will continue to support activities of the CMHPC to serve as a statewide catalyst to address the shortage of mental health staff.
2. DMH will support CMHPC activities to conduct a Family Member/Parent Partner DACUM (Developing a Curriculum)

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

CHILDREN'S ORGANIZED COMMUNITY-BASED SYSTEM OF CARE

All 58 of California's counties currently offer community-based care systems, providing services to the many different service populations that are dependent upon the public mental health system for care. Although the State categorical funds for the Children's System of Care (CSOC) Initiative that had supported system enhancements for over 15 years were eliminated in SFY 2004-05 due to severe budgetary constraints, the context and values of children's services remain at the local levels. Within California the CSOC Initiative has focused upon:

- Target populations diagnosed as SED;
- Services that are culturally competent, child-centered and family-focused;
- Families as an integral part of service planning, delivery, evaluation and policy discussions; with age appropriate child and youth voice and choices; and,
- The belief that children and youth should, whenever possible, be served at home or in the most home-like setting available.

The many years of State-level funding for the CSOC model have provided counties with ongoing service practices and system expectations. To improve individual child and youth outcomes and agency resource management, services are most efficient when there is formal collaboration among such agencies. Typical partners at the local level include the following: child and family community based organizations, juvenile justice, education, social services, child welfare, mental health, and parent/family representatives. Through the use of Medi-Cal funding, in combination with local county funds and other agency resources earmarked for health services, California counties continue to provide an array of community-based services.

The DMH will continue to fund seven counties with dedicated SAMHSA funding for the development and implementation of specific CSOC program components contained within existing State statutes that define the CSOC Initiative. These seven counties are Humboldt, Los Angeles, Merced, Monterey, Placer, Sacramento and San Luis Obispo. Approximately 1000 children and youth with SED are proposed to be served in 2008-09 by these seven counties. Eligible participants are children/youth with SED who are involved with at least two systems and are placed or at risk of hospitalization, school failure, incarceration, and/or out of home placement.

In November 2004, California voters passed the MHSA to transform the mental health services in California. The MHSA provides the first opportunity in many years for increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, youth, TAY, adults, and older adults. The MHSA addresses a broad continuum of prevention, early intervention, treatment services, and the necessary infrastructure, technology and training elements required to effectively support this system.

MHSA addresses many of the overarching goals for transforming mental health care in America, as stated in the NFC report. It acknowledges that mental illnesses are extremely

common and mental health is essential to overall health and that failure to provide timely treatment can irreparably harm individuals and families. The MHSAs support early diagnosis and treatment and elimination of disparities in mental health services and outcomes. There are five core values in MHSAs that echo the CSOC values and the NFC goals:

- Community collaboration;
- Cultural competence;
- Client/family driven services;
- Focus on wellness, recovery and resiliency; and
- Integrated services.

TRANSFORMATIONAL ACTIVITIES

The MHSAs represent 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, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. To provide for an orderly implementation of MHSAs, DMH has planned for sequential phases of development for each of the components. Eventually all these components will be integrated into comprehensive plans with a continuum from PEI to comprehensive, intensive interventions for those in need.

The first component that was implemented was CSS. This component targeted children, youth, adults and older adults with SED and/or SMI. County proposals are evaluated for specific outcomes, such as the following:

- Meaningful use of time and capabilities, including things such as employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

Specific Populations by Age Consistent with MHSA and DMH Priorities:

- Children and youth between the ages of 0 and 18, or Special Education Pupils up to age 21, who have SED and their families, who are not currently being served.
- TAY between the ages of 16 and 25, who are currently unserved or underserved who have SED and who are homeless or at imminent risk of being homeless, youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems and youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization.
- Adults with SMI – including adults with a co-occurring substance abuse disorder and/or health condition who are either:
 - Older adults 60 years and older with SMI – including older adults with co-occurring substance abuse disorders and/or other health conditions – who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, 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. Transition age older adults (as described above) may be included under the older adult population when appropriate.

Each individual identified as part of the initial full service population must be offered a partnership with the county mental health program to develop an individualized services and supports plan. The services and supports plans must operationalize the five fundamental concepts identified at the beginning of this document. They must reflect community collaboration, they must be culturally competent, they must be client/family driven with a wellness/recovery/resiliency focus and they must provide an integrated service experience for the client/family.

MHSA FOR CHILDREN AND YOUTH

MHSA provides an exciting opportunity to expand and establish new programs for children and youth with SED. The original submission of the CSS plans from 56 counties identified 182 new or expanded programs that include children and youth. These are FSP programs that will provide individualized and flexible ‘whatever it takes’ services with 24/7 coverage. It is estimated 4,571 children, youth and their families will be served by the 182 programs. All these programs reflect local collaboration among various partners, which may include child welfare, education, probation, public health, law enforcement, faith based organizations, tribal organizations, employment, alcohol and drugs, juvenile court, and housing.

Of the 56 CSS plans submitted, 28 counties (50%) proposed to expand or establish youth or family-run programs for children and youth. These youth or family-run programs promote hope, empowerment and support for youth and families. Such expansion reflects California’s effort to meet the NFC report goal that ‘mental health care is consumer and family driven.’

STATE-LEVEL COORDINATION FOR EFFECTIVE CSOC

The DMH continues to support inter-agency collaborations that are reflective of local county efforts to integrate services for children. Continued state-level activities include:

- DMH provides funding through the MHSA for increased staffing at the DSS to provide training and technical assistance to support implementation and expansion of SB 163 Wraparound programs which provides service alternatives to children in, or at risk of, group home care. MHSA requires that counties implement the SB 163 Wraparound Program, or provide substantial evidence that it is not feasible to establish one in the county. To date, 39 of the 58 counties have implemented the SB 163 Wraparound Program in California and another 9 counties are in the process of implementing their programs.
- DMH representatives have participated in several workgroups convened by the State Attorney General's Office to address the multiple issues related to domestic violence.
- Continued participation in the SIT Team. SIT is a state level multi-agency team established to lead and guide systems improvements that benefit communities and the common population of children, youth and families served by the member agencies which include mental health, social services, education, employment, alcohol and drugs, health services, developmental services, and justice etc. DMH staff also participate in various SIT workgroups to work on issues such as alcohol and drugs screening, increased utilization of mental health services, and provision of cultural competent services in member agencies.
- Funded by MHSA, DMH is working closely with the State Department of Education (CDE) to increase statewide capacity and build local collaborations between education and mental health. Through an MOU with CDE, DMH contracted to successfully provide 11 regional training sessions for county offices of education and special education local plan areas during the past year.
- DMH is participating in interagency meetings to discuss Indian Child Welfare Agency concerns, especially when mental health issues related to children, youth and TAY are discussed. The focus recently has been on foster care policies related to tribal customs and culture and federal legislation impacting these policies.
- DMH is participating in the California Child Welfare Council (CWC). The CWC is a new State advisory body that considers recommendations to improve child and youth outcomes through increased collaboration and coordination among the programs, services and processes administered by the multiple agencies and courts that serve children and youth in California's child welfare system.
- DMH is participating in meetings regarding the DSS' Child Welfare Reform Program Improvement Plan (PIP). The PIP incorporates significant actions to ensure that California moves in the direction of conformity with federal requirements for the child welfare system.

- In addition, DMH continues to participate in a High Rate Underage Users Workgroup which brings together personnel from several school districts and state representatives from education, mental health, alcohol and drugs, and the attorney general's office. This workgroup addresses underage drinking and other barriers that affect academic performance.
- Continued support of the CMHS-funded "System of Care" and "Circle of Care" sites, to the extent resources allow. This includes working with the existing counties of Glenn, San Francisco, and Monterey as well as the Circle of Care sites in Humboldt County (United Indian Health Services) and in Alameda County (Native American Health Center).

SERVICE COORDINATION AND ACCOUNTABILITY TO THE CLIENT AND FAMILY

DMH has made a commitment to ensure that consumer and family involvement is an overriding value in planning, implementation, and oversight of mental health services. DMH has developed an oversight system that involves on-site review of each MHP with teams that include county peer reviewers, direct consumers, family members, and DMH staff. These teams identify problems that are resolved through a Plan of Correction that is submitted by the MHP to DMH for approval.

The MHSA also requires that clients and families have an active stakeholder role in planning, program implementation, service delivery and evaluations. Clients and family members are represented in the statewide and local stakeholder process for the various components of MHSA. To provide a voice for TAY, eight youth-friendly roundtables were held in five regions to solicit their input on MHSA. To support client and family involvement, DMH contracted with local parent and family groups to provide technical assistance to help families understand and become actively involved in the local MHSA planning process. In addition, the MHSA WET Component provides funding for technical assistance and training to increase capacity to promote consumer and family member employment in the public mental health system. These efforts relate to the NFC overarching goal that 'mental health is consumer and family driven.

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

CHILDREN'S SERVICES

California's 58 county departments of mental health, and the hundreds of community-based certified providers, continue to offer a wide range of service options. The menu of services includes the continuum of "rehabilitative" services, designed to engage children, youth and families in services and supports that return these consumers to positive developmental trajectories. California law requires that a minimum array of services be available for children with SED, to the extent resources are available. Included in the counties' menu of services are: pre-crisis and crisis services; assessment; medication education and management; individual, family and group therapies; day treatment programs; service coordination; 24-hour treatment services; and support services designed to alleviate symptoms and foster the development of age-appropriate, cognitive, emotional and behavioral skills necessary for success. Within the last several years there has been an increasing demand for school based mental health services, either at a school health care center, or services provided by the county mental health program or a community service provider on site; and mental health services and supports that are offered within a "wraparound service approach."

County departments of mental health continue to participate in the county's "court schools" or "juvenile justice programs" which provide combined educational and treatment services for adolescents with serious legal, educational and medical conditions such as drug/alcohol abuse with co-occurring mental/emotional disorders. County mental health staff provides services within juvenile halls, after school programs, and coordinated case management services through existing juvenile justice programs operating with state grant funds.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

The EPSDT program is a federally mandated benefit under Medi-Cal (California's Medicaid Program). EPSDT provides comprehensive health care for eligible persons under 21 years of age. This benefit includes screening services that provide initial, periodic or additional health assessments under the Child Health and Disability Prevention (CHDP) Program. EPSDT mental health services were expanded in 1995 by DHCS in accordance with federal regulations and statutes that require states to provide any medically necessary services, including mental health services, to correct or ameliorate the health or mental health condition of a full-scope Medi-Cal beneficiary under the age of 21. In SFY 2008-09, the counties, in their role as MHPs, provided SMHS to 192,825 clients. The projection for FY 2009-10 is 197,794 clients.

California provides Therapeutic Behavioral Services (TBS) as a result of a class action lawsuit in federal court in Los Angeles, *Emily Q. v. Bonta*. TBS is a Medicaid SMHS that provides additional short-term support to children/youth with SED who meet certain criteria and who are experiencing a stressful transition or life crisis to prevent high-level placement (Rate Classification Level 12 or above) or to enable a transition to a lower level of residential care. On April 23, 2009, the Court approved the *Emily Q.* Settlement Exit Strategy Plan, also known as the Exit Plan. The exit criteria are based on Point Nine of the *Emily Q.* TBS Nine-Point Plan. The steps outlined in the Exit Plan must be: do-able; not let the perfect be the enemy of the good; be within the Law and Court Order; increase utilization; decrease disproportionality

between the MHPs; show evidence of improvement, both quantitative and qualitative; be aligned with parties' interests; demonstrate simplicity; be sustainable; and result in faster service access.

HEALTHY FAMILIES PROGRAM (HFP)

The expansion and reauthorization of the State Children's Health Insurance Program (SCHIP) was signed into law by President Obama on February 4, 2009. In California, the SCHIP is known as Healthy Families (HFP). This law keeps nearly 900,000 California children in Healthy Families. It also gives thousands more children access to health care. It provides funds for 4 ½ years and gives financial stability for Healthy Families. Federal funds provide 2/3 of the funding needed for states to run their SCHIPs.

This program experienced a \$178 million reduction for FY 2009-10 and is expected to serve approximately 600,000 fewer children as a result of this reduction. The California First 5 Commission (Proposition 10) has transferred part of its funds to the Managed Risk Medical Insurance Board (MRMIB) that implements the HFP. These funds will support and additional 200,000 children (ages 0-5), producing a net loss of 400,000 children.

In California, the HFP provides low-cost health insurance with federal matching funds reimbursed under the SCHIP, Title XXI of the Social Security Act for children under the age of nineteen whose families do not have insurance, do not qualify for zero share-of-cost Medi-Cal and whose income is at or below 250% of the federal poverty level. Services are provided by health, dental and vision plans under contract with MRMIB, the state agency that administers HFP. MRMIB is responsible for most budgeting related to HFP; however, DMH is responsible for the mental health benefit for children with SED. HFP health plans are responsible for providing basic mental health benefits to HFP enrollees who do *not* meet the SED criteria and for the first thirty days of psychiatric inpatient services. The costs associated with these benefits are not included in the DMH estimate. Medically necessary mental health services for HFP enrollees with SED are typically provided by the county mental health plans.

On Feb. 4, 2009, the **Children's Health Insurance Program Reauthorization Act (CHIPRA)** was signed into law by President Obama. CHIPRA allows states to subsidize premiums for employer-provided group health coverage for eligible children, but it also imposes certain requirements on plan sponsors:

1. Plan sponsors must notify employees of a new special enrollment opportunity.
2. Plan sponsors must provide disclosure to their employees.
3. Plan sponsors must provide disclosure to state agencies.

CHIPRA applies to both fully insured and self-insured group health plans. The most pressing of these three obligations is the special enrollment changes, which are effective April 1, 2009.

HOUSING SERVICES

Each year in California, over 4,000 youth exit the foster care system when they turn 18. These "emancipated foster youth" commonly leave the foster care system without a place to live, a job,

a high school diploma or the consistent support of a caring adult. It is even more challenging for emancipated foster youth with SED to attain self sufficiency after age 18. Without assistance, former foster youth do not fare well, and experience rates of homelessness, unemployment and incarceration far above their peers.

The Transitional Housing Placement Plus Program (THP-Plus) is a California housing program that targets former foster youth and is administered by DSS. THP-Plus provides affordable housing and comprehensive supportive services to help former foster care and probation youth ages 18 up to 24, to make transitioning from out-of-home placements to independent living successful. In June 2006, the THP-Plus Statewide Implementation Project was launched to reduce homelessness among California's former foster youth by expanding access to the THP-Plus program. It is a partnership between the John Burton Foundation, the Corporation for Supportive Housing and CDSS. A goal of this project is to expand housing opportunities for former foster youth and to improve the public system responsible for assisting youth as they make the transition from the foster-care. A final evaluation of this project reported that in the area of systems change, there was substantial growth in the number of counties implementing the THP-Plus Program, from five counties in 2005-2006 to 52 counties in FY 2010/2011. There was also a notable increase in the number of youth served by THP-Plus, from 200 to 2,442 participants. In addition, California voters passed Proposition 1C in November 2006. Prop 1C would provide \$2.9 billion in funds to provide a variety of housing supports for battered women, senior citizens, low income families etc. Included in the fund is \$50 million for homeless youth.

Finally, as stated in the MHSA Section, to transform the mental health system in California and address homelessness among individuals with mental illness, the MHSA Housing Program was established under the CSS Component. The MHSA Housing Program is jointly administered by DMH and the CalHFA. This program has been developed through an interagency collaboration between the CalHFA and DMH, in consultation with County Mental Health Departments with the goal of utilizing their combined resources to address homelessness for individuals and their families. The resulting program blends the mental health services expertise of DMH and the County Mental Health Departments with the fiscal and housing development expertise of CalHFA. The MHSA Housing Program provides funding for both capital costs and operating subsidies to develop permanent supportive housing for persons with SMI who are homeless, or at risk of homelessness, and who are eligible for services under the MHSA. The application for these program funds must include a commitment for service funding from the County Mental Health Department. A total of \$400 million of MHSA funds has been set aside for initial funding of the program, and each County Mental Health Department in California received a portion of the funds that are available for both capital costs and capitalized operating subsidies. Local collaboration between County Mental Health Departments and housing developers and/or agencies is essential to the success of these projects and this program.

DMH is working with CDSS to make these two programs work together to better meet the needs of emancipated foster care youth with serious emotional disturbance. THP-Plus is a time-limited program while MHSA Housing Program has no time limit.

EDUCATIONAL SERVICES FOR CHILDREN

Individuals with Disabilities Education Act / Special Education Program

The federal Individuals with Disabilities Education Act (IDEA) {PL 108-446} states that children with disabilities receive a free, appropriate public education in the least restrictive environment. Special education pupils in any of the 13 disability categories may receive mental health services from county mental health departments. To be eligible to receive services, they must have a current individualized education plan (IEP) on file. The services must align with the child's needs as identified in the IEP and are designed so that children will benefit from their educational programs. They are free to all eligible students regardless of family income or resources. The mental health program within California serving special education pupils at the community level is known as the "AB 3632" program.

The California Legislature passed AB 3632 in 1984 which combines education, social services, and mental health resources in an interagency delivery model to provide appropriate services to eligible students for special education. Prior to this legislation the Local Education Agency (LEA) provided these services. The interagency program requires local mental health programs to provide mental health services to special education pupils who have been determined to need mental health treatment to benefit from their education. County mental health agencies may not limit or deny services to eligible pupils, and may not, by law, bill the pupils' family for these services. Currently the program serves approximately 21,000 special education pupils annually.

An IEP team determines the eligibility of the pupil and recommends appropriate services in the least restrictive environment. Current law requires that prior to referral to county mental health agencies, the LEA ensure that 1) appropriate educational assessments have determined that a child is special education eligible; 2) the school has provided or considered counseling and guidance services; and 3) such services are not adequate or appropriate to meet the pupils' needs. Once these requirements have been met, a referral may be made to the LMHD. In support of the Special Education Program, the CDE, along with DMH, conduct collaborative interagency compliance complaint investigations to determine if program implementation by the LEAs and LMHDs meets the requirements of State and federal law.

The Governor and Legislature continue to examine the structure and functioning of mental health services delivered under AB 3632 and various options are being reviewed for the delivery of services.

Reforms In Educational Rights For Foster Youth

In 2008, California held its second annual state-wide Foster Youth Education Summit. More than three hundred child welfare, educational, judicial, and policy-making professionals joined with foster youth, families and caregivers to build upon the innovative, ground-breaking work of addressing the critical issues in foster youth education that began as a result of the 2007 summit. This statewide summit is sponsored by the California Foster Youth Education Task

Force, a coalition of more than 35 organizations dedicated to improving educational outcomes for foster youth. Some recent progress includes:

- California Assembly Bill (AB) (Statute of 2003) became effective on January 1, 2004. This bill created new duties and rights related to the education of dependants and wards in foster care. Though not directly impacting county mental health departments, the bill should result in more stable placements, complete and timely transfers of educational records, and continuity of the educational placements. These changes allow county departments of mental health to deliver improved services through the avoidance or reduction in out-of-community placements that frequently have lead to significant service disruptions.
- The 2007 expansion of the Foster Youth Services Program administered by the CDE provides grants to counties for educational and support services and increases service from approximately 14,000 to 35,000 children. DMH staff provides technical assistance to encourage and support Foster Youth Services Program to participate in local MHSA stakeholder process.
- The 2008 “Building on our Successes” Summit highlighted innovative programs and practices that represent “pockets of excellence” for improved educational outcomes throughout the state. 49 counties and Canada were represented, each bringing a multidisciplinary team committed to learning about and adopting new approaches to support foster youth education success.

EARLY MENTAL HEALTH INITIATIVE

The EMHI has been part of DMH’s continuum of mental health services for children since 1991, when it was signed into law through the California School-Based Early Mental Health Intervention and Prevention Services for Children Act. EMHI was established to fund programs that serve selected students in kindergarten through third grade who are experiencing mild to moderate school adjustment difficulties. Funding is distributed through grants to elementary school districts, which hire qualified personnel to provide PEI services that will enhance students’ social and emotional development and increase their likelihood of future school success.

There are several key components of the EMHI:

- Provide school-based and low cost services to students in kindergarten through third grade experiencing mild to moderate school adjustment difficulties;
- Use a systematic selection process of students most likely to benefit from program participation;
- Provide services in a culturally competent manner;
- Provide services to appropriate students in the target population from low-income families;

- Provide services to appropriate students in the target population who are in out-of-home placement or are at-risk of out-of-home placement;
- Encourage the involvement of parents and teaching staff to build alliances to promote student's mental health and social and emotional development;
- Provide services in collaboration with a cooperating mental health entity such as a county mental health department or a private non-profit agency;
- Change the traditional roles of mental health professionals and use alternative personnel, such as child aides, to provide direct services to students;
- Provide ongoing supervision and training of child aides by credentialed school psychologists, social workers, or school counselors in collaboration with professional staff of the cooperating mental health entities;
- Provide ongoing monitoring and evaluation of program services; and
- Ensure implementation of programs that are based on adoption or modification, or both, of existing program models that have been shown to be effective and which are based on sound research.

During SFY 2008-09, EMHI provided \$15 million for programs throughout the state and served approximately 16,043 of the state's estimated 279,791 children in kindergarten through third grade at risk of school adjustment difficulties (out of a total of 1.9 million children in grades K-3 statewide). Services were provided at 411 school sites located in 77 elementary school districts within 24 counties. The areas served range from sparsely populated, isolated rural districts to highly populated and diverse urban districts.

Each year since 1988, data from pre- and post- instruments have been collected and analyzed from state-funded programs to determine program effectiveness. This data has consistently yielded statistically significant levels (.001) of improvement in school adjustment by the students who participated in the program. In addition, the DMH collects school district demographic information and qualitative data related to services twice a year.

CHILD WELFARE SERVICES

The DSS reexamination process of the entire child welfare system within California concluded in September of 2003 with the final "Redesign Plan", and has been coordinated with the federal requirements (DHHS) for program improvements based upon the Child and Family Services Reviews (CFSR) and California's own legislature's proposal regarding program improvements. The principles of the federal review framework contain many of the same elements as previous mental health initiatives, including:

- Family-centered practices;
- Community-based services;
- Individualized services for children and families; and
- Strengthening the capacity of parents to provide for their children's needs.

As part of the "roll-out" of the child welfare redesign, DMH continues to work with the CIMH to assist the counties in adopting evidenced based practices targeting children and youth served by the child welfare system. These technical assistance efforts have been a valuable means for

counties to integrate the latest federal and State service and funding initiatives into their CSOC systems.

In 2006, Governor Schwarzenegger signed into law AB 2216 (Chapter 384, Statutes of 2006), the “Child Welfare Leadership and Performance Accountability Act of 2006”, to establish, among other things, the California CWC. The CWC is a new State advisory body that will consider recommendations to improve child and youth outcomes through increased collaboration and coordination among the programs, services and processes administered by the multiple agencies and courts that serve children and youth in California’s child welfare system. DMH staff actively participates in the four CWC committees: Prevention/ Early Intervention Committee, Permanency Committee, Child Development/Successful Youth Transitions Committee, and Data Linkage and Information Sharing Committee.

In addition, DMH is working with DSS, along with other public and private organizations, in the California Permanency for Youth Project (CPYP). Funded by the Stuart Foundation, CPYP aims at increasing awareness among the child welfare agencies and other stakeholders of the importance and urgency of permanency among older children and youth; and to assist 14 specific counties and private agencies to develop innovative practices to achieve permanency.

DMH is also actively working with CDSS to expand the SB 163 Wraparound Program in California. MHSA requires that counties implement the SB 163 Wraparound Program or provide substantial evidence that it is not feasible to do so in the county. SB 163 allows counties to use the State foster care maintenance payment to provide wraparound services for children in, or at risk of, group home placement. Wraparound is a family-centered, strength-based, needs driven planning process for creating individualized services for children, youth and their families. The ‘whatever it takes’ approach promotes cross-system integration and incorporation of natural and informal, community resources. The focus in child-centered, family-driven approach is consistent with the NCF goal that ‘mental health care is consumer and family driven’. Youth involved in juvenile justice system who have significant behavioral or mental health needs have been a particular focus of Wraparound. Recent studies found that Wraparound have resulted in positive outcomes for youth in juvenile halls, shelters and group homes. Currently, 40 counties have an active SB 163 Wraparound Program.

CO-OCCURRING SUBSTANCE ABUSE AND MENTAL DISORDERS (DUAL DIAGNOSIS)

The increasing awareness and acknowledgement of persons exhibiting co-occurring substance abuse and mental disorders, or dual diagnosis, is an issue of national concern. It is estimated that approximately 60 percent of persons with a SMI also have a substance abuse problem, and that up to 90 percent or more of the highest cost users of mental health services, including forensics consumers, also abuse substances.

ADP and DMH have long recognized the critical need of working cooperatively to provide quality treatment services to individuals with CODs. Building on the efforts that have taken place since 1995, DMH and ADP, in collaboration with the County Alcohol and Drug Program

Administrators Association of California, the CMHDA, the Alcohol and Drug Program Institute, and the CIMH, convened the COJAC, which meets quarterly.

The Council's joint vision statement — "One Team with One Plan for One Person" — states that "Each individual receives a comprehensive assessment that results in the formation of an interdisciplinary and possibly interagency team that will develop one individualized treatment plan for that person within a reasonable period of time. This plan will specify all necessary services and supports to be delivered by the single interdisciplinary service team that has all the needed skill sets and the right members in place from each agency. The individual client will have a strong voice in shaping the plan in development and implementation. The plan is expected to evolve as needed as that person progresses."

The COJAC recognized that in order to achieve its objectives it was necessary to have additional staff support from the two state agencies sponsoring this effort. The passage of the MHSA provides the opportunity for DMH to make available increased funding, personnel and other resources to support county mental health programs, including COD services, and monitor progress toward statewide goals for children, TAY, adults, older adults and families.

The COD office within the ADP continues to receive funds from the MHSA to provide for the functions and tasks listed below. Other functions and tasks may be added as determined by the COJAC, the DMH, and the ADP.

- Collaborate with the COJAC, the DMH, and others in recommending policies, programs and projects addressing COD;
- Provide assistance to policy makers who are providing leadership to the COD State Action Plan for California;
- Assist counties and other providers who are addressing persons with COD or those at high risk of the disorder;
- Recommend workforce development training for counties and other providers addressing COD issues;
- Provide technical assistance by conducting COD related research, collecting and disseminating data; and
- Assist the DMH and the ADP to blend their respective services into local programs that will effectively serve persons with COD.

Additional efforts by the DMH in the area of CODs include the following:

- The DMH has permanently setting aside \$8,059,000 of its annual SAMHSA Block Grant for allocation to counties to support existing efforts in providing integrated treatment services for adults with CODs. Counties are required to submit to DMH expenditure plans describing their intended use of the additional funds for the DMH's review and approval.

Resource-Building Treatment Strategies

Youth with CODs need special resources to overcome each of their disorders. The following are resource-building treatment strategies developed by the CMHDA, CYSOC/ASOC, and TAY Subcommittee, published April 29, 2005:

- There should be no wrong door as an entryway to treatment. Whatever agency the youth uses to request help must ensure that the youth has access to services from partner agencies. These services may include mental health and substance-related treatment as well as housing, training, rehabilitation resources, and therapeutic courts. This is critical because when the youth needs help, it must happen in the moment or the opportunity may be lost. With the youth's permission, there should be collaboration and coordination of the youth's treatment plan. Substance abuse programs, from the continuum of abstinence to harm reduction, recognize that recovery is incremental and the road to recovery has its ups and downs. Providers should strive to reduce barriers to the provision of appropriate, coordinated, and integrated services for TAY youth, which include different funding streams, philosophical differences, lack of cooperation and collaboration, and the lack of cross training.
- Once the youth acknowledges the substance use problem, and agrees to receive support, all significant social supports of the TAY youth should be involved in the treatment planning process including the youth, his or her family, school, social services or probation, mental health, and AOD providers as well as other members of the youth's support network. Providers must acknowledge that the youth is the holder of the privilege, and thus he or she must agree to how the treatment is organized. In the event the youth does not acknowledge the need for services, all providers and members of the support system should continue to encourage the individual until engagement and maintenance in treatment occurs.
- Youth who are homeless or otherwise without stable living conditions will find it difficult to embrace recovery from substance use. Therefore, ensuring that basic needs are met is a critical step in providing care to these youth. This is especially true for TAY with a background in the foster care system whose priorities may be focused on obtaining the basic necessities of living.
- Because of TAY's age-appropriate need for independence, providers should work to balance client-driven treatment planning with a solid supportive structure to prevent the individual from becoming "lost" in the process of recovery.
- Foster youth are most vulnerable to treatment failure because they may not have the financial and emotional resources to support them in recovery. The youth who suffered trauma from growing up in a domestically violent or an abusive or negligent home is especially vulnerable. If appropriate, family support services can strengthen the youth and the entire family system. By building on the strengths of the youth, his or her family, and his or her support system, counselors can draw on the resources that each participating party brings to the intervention. Using a strength-based approach, the

treatment team can develop and implement a realistic, attainable plan for recovery that improves the functioning of each participant.

Treatment Strategies

- Place a strong emphasis on family involvement. Youth need to feel secure and feel the support of his or her immediate family members and broader social network. No matter what the circumstances of the relationships within the family are, the youth and the family should be engaged in securing solutions to a better relationship. For a variety of reasons, some youth have disengaged from their families and/or support groups and will not have functioning social networks. In these situations, efforts should be made to help the youth build natural supports as part of the treatment process.
- Develop an individualistic case plan. Each client has unique circumstances with individualized sets of goals and objectives. A “cookie cutter” or “one size fits all” approach will not be effective. As Dr. Pablo Stewart has noted, there are instances where the substance use is a manner of self-medicating for long standing untreated mental illnesses. It is for this reason that MH and AOD staff need to work closely together and use a universal chart where entries from both Departments are available to the other and to additional participants of the treatment team.
- Explore the strengths of the youth. Recovery based goals will be founded upon the youth’s vision of his or her future. The treatment planning team will need to focus the discussion in a hopeful and supportive manner.
- Providers need to consider that what is happening for the youth may in fact be a “system issue,” meaning that the youth may be acting out symptoms for other family members or for a significant other. By including the whole family group and/or the significant other, there is a greater likelihood that a true solution will be found. A youth’s crisis is an opportunity for the family constellation to enhance communication and improve functioning for the future.
- Woman and girls with CODs often come from a background of family violence, and the sequelae of trauma endured may be what is driving the mental illness or substance involvement.

JUVENILE JUSTICE AND MENTAL HEALTH

According to national estimates, as many as 70 percent of adolescents in juvenile justice systems struggle with mental health or CODs, 20 percent have a serious mental disorder, and at least 10 percent have a serious medical condition. Many have come through the foster care system, and as a population are among the most at-risk. Many young people in the juvenile justice system have serious mental health problems that need treatment; and many young people with such problems end up in juvenile justice facilities because they lack access to treatment in their communities.

California has consistently had the highest youth incarceration rate, more than double the national average rate of incarceration for youth confined in secure public facilities. In a reorganization of the California corrections agencies in 2005, the California Youth Authority became the DJJ within CDCR. CDCR is now under a court consent decree stemming from litigation over programs and conditions in these facilities. California faces many challenges in its role to improve and respond to the mental health needs of youth in the juvenile justice systems.

With the passage of the MHSA in November 2004, DMH was provided the first opportunity in many years to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, TAY, adults, older adults and families. Many counties are using this opportunity to further develop innovative mental health programs for youth in the juvenile justice system.

The CMHPC is organized into five standing committees. One of the committees is the SOC Committee which has four subcommittees, one being the CYSOC. In 2009, the committee completed a report on the benefits of juvenile justice mental health courts in meeting the needs of children and youth. The purpose of the report is to raise awareness about juvenile justice mental health courts and assist in advocating for the expansion of these courts throughout California. The CYSOC also focuses on what constitutes adequate continuum of care for youth, and ways to maintain those components when the emphasis is on keeping children in their homes and communities.

ACTIVITIES TO REDUCE HOSPITALIZATION FOR CHILDREN

Children and youth with SED typically have needs in many areas, including the home, school, and community. Their needs cannot be met solely by the mental health system. Rather, what is required is the joint involvement of other agencies and systems, including special education, child welfare, health, and juvenile justice. In order to promote inter-agency and inter-system collaboration within local CSOC, California requires individual counties to form interagency case management councils. These local councils work toward coordinating resources for specific target population children who are concurrently using the services of more than one agency.

The goal is to reduce long-term hospitalization and group home placement in favor of using the multi-disciplinary resources of the county, and to treat the child within the community, whenever possible. Members of local interagency case management councils include, but are not limited to, representatives from special education, juvenile probation, social services, and mental health agencies. Members have the requisite authority to commit resources from their agency toward an interagency service plan for the child and his/her family. More counties are recognizing the key role that mobile crisis units can play in stabilizing a child/youth within their communities, delaying or making unnecessary restrictive inpatient hospitalizations.

The MHSA emphasizes community based rehabilitative services over treatment in hospitals and other institutional settings. This community-based emphasis is due to the past efforts in California to find the least restrictive setting appropriate for meeting the needs of the child or

youth. As part of the MHSA planning process, many stakeholders are brought together in the local community to assist in the identification of unserved and underserved children and youth. The MHSA specifically notes that education, social services, and law enforcement must be part of this stakeholder process. With the participation of these groups, California hopes to continue in its efforts to reduce hospitalization to those situations where it is the best clinical option for the needs of the child or youth.

MHSA also requires that counties implement the SB 163 Wraparound Program that aims at reducing out of home placement by allowing counties to use the State foster care maintenance payment to provide wraparound services for children in, or at risk of, group home placement. Wraparound is a family-centered, strength-based, needs driven planning process for creating individualized services for children, youth and their families. The ‘whatever it takes’ approach promotes cross-system integration and incorporation of natural and informal, community resources. The focus in child-centered, family-driven approach is consistent with the NCF goal that ‘mental health care is consumer and family driven.’ Youth involved in juvenile justice system who have significant behavioral or mental health needs have been a particular focus of Wraparound. The recent MAJC paper as described in the ‘Juvenile Justice and Mental Health’ section above cited studies that wraparound has resulted in positive outcomes for youth in juvenile halls, shelters and group homes. Currently, 40 counties have an active SB 163 Wraparound Program.

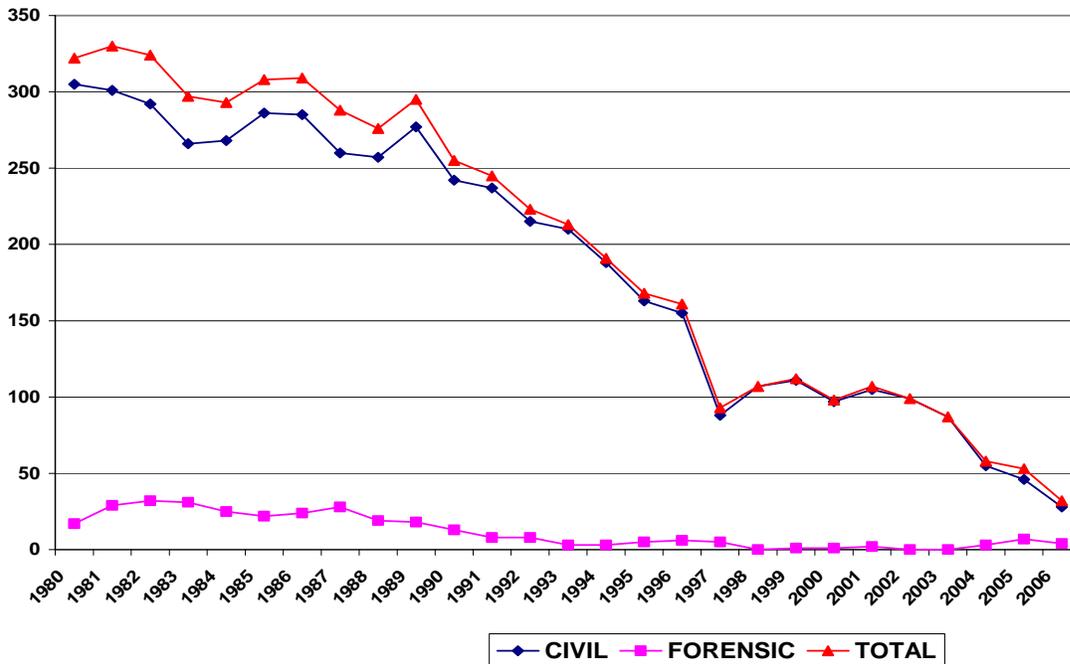
In 08-09, DMH will complete a PIP that will study Medi-Cal eligible children with high level mental health needs. The PIP will be completed as part of the External Quality Review process with the assistance of the California EQRO contractor, APS Healthcare, Inc.

REDUCED STATE HOSPITALIZATION

A significant component of the 1991realignment legislation was its impact on the State Hospitals. Prior to realignment, the State allocated to each county a historically fixed number of civil commitment State Hospital beds. The State Hospitals serving persons who are civilly committed are Metropolitan and Napa. The counties had little financial stake in, or programmatic control over, these beds. Realignment shifted bed funding to counties along with the discretion over where to spend those funds to serve the needs of persons with SMI. The result has been dramatic in its impact on these two State Hospitals.

Counties have developed community-based programs that provide alternative care to State Hospitalization. These programs are enriched by the continuum of services such as crisis intervention, outpatient services, day treatment and community outreach. This approach has reduced the number of children in State Hospitals. In FY 2008-09, 18 children and youth were in State Hospitals. Additionally, the Child and Adolescent Treatment Center at Metropolitan State Hospital has been closed. This contributes to the reduction of state hospitalization for this population. This gives California one of the lowest State Hospital utilization rates in the nation.

**State Hospital Population For
Persons Less Than 18 Years of Age
June 30th, 1980 - 2006**



In an effort to increase efficiency of available resources, schools have been certified as clinics to provide school-based mental health services through local mental health programs. In addition, some group homes have also been approved by the DSS to serve children with SED who, in the absence of these services, may have required hospitalization. These group homes are required to have annual certification from the LMHD that their MHP meets the statewide criteria. California continues to develop new programs and quality assurance mechanisms to avoid unnecessary hospitalization.

For all counties that have received CSOC allocations to develop and implement local systems of care for children with SED, service coordination is considered a key component. As such, service coordination protocols must be included for assessment, linkage, case planning, monitoring, and client advocacy to facilitate the provision of appropriate services for the child and family.

COMMUNITY TREATMENT FACILITIES

The CTF category of care has been under development since 1985 with the passage of SB 876. The intent of the CTFs was to create a complementary package of mental health treatment services delivered within a licensed community care facility serving children and youth with the program certified by the DMH. The CTF model sought to integrate within a single setting the services and supports of the foster care and mental health systems. The CTF model features joint monitoring and oversight from the DSS and DMH.

In 1988, additional amendments to the statutes added mental health oversight on the use of restraint, seclusion, and psychotropic medications in CTFs. Further amendments to the category were added in 1992 when the facility definition was restructured to become a secure treatment setting. During the years of discussion regarding the appropriate level of mental health treatment, CTFs evolved into a richly staffed, secure treatment environment that replicates many medically licensed health facilities, yet retains its “community-based” feel. Later deliberations led to the current regulatory scheme and the statutory 400-bed limit on the number of CTF beds to be implemented statewide. Three CTFs are currently licensed and operating. They include: Seneca in the City of San Francisco, Vista Del Mar in the Los Angeles region, and Star View in Torrance. Seneca for 22 beds, Vista Del Mar for 24 beds and Star View for 40 beds.

TRANSITIONAL SERVICES

The incorporation of recent findings regarding “success” for youth and the relationship to their educational achievements will drive more work in the area of ensuring that youth diagnosed with SED have sound educational placements and transition plans. CDE funded a study that examined policies and practices that negatively impact the academic success of youth living in foster care placements. This study proved to be the impetus for Assembly Bill 490. Existing California special education law requires that appropriate TAY services be provided to pupils with their needs listed on their IEPs. AB 490 helps ensure that there is additional focus at the local level for youth served within the foster care system.

DMH staff has been involved with ongoing workgroups at the State level that address the needs of youth transitioning between the child and adult systems. This has included DMH staff representation at the CMHDA TAY Subcommittee and involvement in the development of a TAY Resource Guide. The Resource Guide was published in April 2005 and widely distributed among county staff to assist youth in navigating the systems.

Transitional services have become a focus with the passage of the MHSA; the MHSA designates that the needs of TAY ages 16 to 25 be addressed in the county’s plan for CSS. Of all the original county plans submitted, a total of 244 programs would benefit TAY of which 53 of those programs focused exclusively on TAY. It is estimated that 3585 TAY would be served in a wide variety of services.

ELIMINATING MENTAL HEALTH DISPARITIES TO RACIAL, ETHNIC, AND CULTURAL POPULATIONS: MOVING TOWARD CULTURAL AND LINGUISTIC COMPETENCE SOLUTIONS

See Adult Section

EXTERNAL QUALITY REVIEW ORGANIZATION

See Adult Section

CHILD/YOUTH AND FAMILY PERFORMANCE OUTCOMES

California continues to align itself with transformational agendas reflected in the President's New Freedom Commission Report on mental illness, the Institute of Medicine's Six Aims for Improvement and the MHSA. To ensure measurement systems are consistent with these recovery/wellness-based philosophies for children and youth, California's participation in performance measurement designs at the national level is important in order to keep measurement strategies such as the Uniform Reporting System (supported in part through the DIG) and the NOMs, consistent with Federal reporting requirements.

During SFY 2009-10, DMH continued to use the Web-Based Data Reporting System (WBDRS) to collect data using a point-in-time method to target family members of child/youth consumers, as well as youth consumers themselves, who are receiving face-to-face mental health services. The DMH elected to suspend its twice per year CPS in order to conduct a pilot survey based upon a stateside random sampling methodology. The purpose of the pilot is to test the validity of the method to include a detailed analysis of the costs and administrative barriers. The results of the pilot are scheduled for release in February 2011.

In addition to the CPS, California's MHSA continues to support the transformation of California's mental health system by providing a more comprehensive approach to the development of community based mental health services and supports for the residents of California. With respect to performance outcomes, the Department has recently completed an initial analysis of FSP outcomes collected through the DCR System. This analysis indicates that the lives of individuals participating in FSP programs and services are improving in several key areas including increased housing stability and reduced criminal justice involvement. More information regarding this initial FSP Outcomes Analysis, the FSP assessment methodology and the DCR system is available on the DMH website.¹

The DMH CPS, which assesses perceptions of quality and outcomes of care, was conducted during a two-week period in November 2009 and May 2010.

In addition to the CPS, California's MHSA continues to support the transformation of California's mental health system by providing a more comprehensive approach to the development of community based mental health services and supports for the residents of California. With respect to performance outcomes, the Department has recently completed an initial analysis of FSP outcomes collected through the DCR System. This analysis indicates that the lives of individuals participating in FSP programs and services are improving in several key areas including increased housing stability and reduced criminal justice involvement. More information regarding this initial FSP Outcomes Analysis, the FSP assessment methodology and the DCR system is available on the DMH website.¹

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

INCIDENCE AND PREVALENCE OF SED

Definitions of serious emotional disturbance utilized in California are from the California Welfare and Institutions Code and the federal definition as established and disseminated pursuant to the Federal Public Health Services Act.

California Welfare and Institutions Code Definition

California's Welfare and Institutions Code, Section 5600.3 (a), defines children or adolescents with SED as follows:

“For the purposes of this part, ‘seriously emotionally disturbed children or adolescents’ means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.

Members of this target population shall meet one or more of the following criteria:

1. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school, functioning, family relationships, or ability to function in the community; and either of the following occur:
 - a) The child is at risk of removal from home or has already been removed from the home.
 - b) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
2. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
3. The child meets special education eligibility requirements according to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.”

Federal Definition of Target Population

The federal definition states that children with a SED are persons:

- A. From birth to age 18.
- B. Who currently or at any time during the past year:

1. Have had a diagnosable mental, behavioral or emotional disorder of significant duration to meet the diagnostic criteria specified within DSM-III-R, that
2. Resulted in functional impairment that substantially interferes with or limits the child's role or functioning in the family, school or community activities.

PREVALENCE METHODOLOGY

A number of needs assessment methodologies have been used in the past by the DMH. In the late 1980s, the DMH contracted for a needs assessment study with Dr. Ken Meinhardt and his collaborators. They used rates from the Epidemiological Catchment Area (ECA) Study and applied them based on the demographics of California's counties. This resulted in a rate for major mental disorders of 6.15 percent for adults. In 1993, the DMH again contracted with Dr. Meinhardt for a prevalence study based on the criteria for the target population that were specified in law. They were very restrictive and defined the target population based on diagnosis, functioning level, duration of disorder, and likelihood of being eligible for public assistance. This resulted in a rate of 1.6 percent, which was used for several years. However, since then, the DMH and county mental health programs have taken on increased responsibility to serve populations beyond the target population. For example, with the consolidation of Medi-Cal mental health specialty services, clients who meet medical necessity must be served. Also, California's welfare reform program (CalWORKs) has provided funding for mental health services needed to assist in employment.

Currently, the DMH uses prevalence data developed by Dr. Charles Holzer an epidemiologist from the University of Texas, Medical Branch. These data are based on the Collaborative Psychiatric Epidemiology Surveys (CPES) and show the number of youth who have SED disturbances (SED) and the number of adults who have SMI. Dr. Holzer has worked at the national and state levels on issues relating to epidemiology of mental illnesses for over 30 years. His methodology uses information from the Epidemiological Catchment Area (ECA) studies, the National Co-Morbidity Study (NCS), and rates of SED for youth published in the Federal Register based on a compilation of prevalence studies for youth ages 9 through 17 years. He applied these rates to all youth. The prevalence rates of SMI and SED were applied to each county based on the demographic characteristics that correlate with differential rates. Further information is available at the following site: <http://Charles.Holzer.com>

There are some limitations in using only the household population since some of the mental health client population is in skilled nursing facilities, residential treatment facilities, or board and care homes that are not considered households. However, the Census data are not available in sufficient detail to identify only those facilities. In addition, the Census data would not identify those persons who are placed out of county. There is a Census report that is available by county showing the total number or persons in "institutional and group quarters" by type of residence. This report can be referenced at the following website <http://www.dof.ca.gov/search/demograpquery.htm>.

CMHS contracted for a study of the prevalence of mental disorders among children and youth. The results of this study were published in the 1999 *Federal Register* and indicated prevalence rates of 9 to 13 percent for youth with a SED and substantial functional impairment, and 5 to 9

percent for SED and extreme functional impairment. The study recommends using the higher end of the ranges for areas with higher poverty rates. Data reported later use the midpoints (7% and 11%) of the ranges and show both prevalence rates although the higher rate is more consistent with the broader population that county mental health programs serve. These rates apply only to persons aged 9 through 17 years old. There are not sufficient studies on the population from infancy through 8 years old to reliably provide prevalence rates for the youngest population.

STATE POPULATION TO BE SERVED

The DOF estimates that in 2010 the population of persons over 18 years of age in California will be 29,146,279. Based on this population data, it is estimated that there are 757,803 adults and older adults in the State with SPMI, and 1,573,899 adults and older adults with SMI. For the same period and population data estimates, California will have 9,989,397 youth under age 18. Of those an estimated 699,258 with SED will be in need of mental health services. California, primarily through contracts with its 58 counties and two city mental health programs, expects to serve 453,334 adults and older adults and 217,610 children in SFY 2008-09. The following table shows the total state population, number of clients, and prevalence using the prevalence measures published in the 1999 Federal Register by age group for SFY 2007-08 and estimated data for SFY 2008-09:

**CALIFORNIA POPULATION ESTIMATES, CLIENTS SERVED
AND ESTIMATED PREVALENCE OF PERSONS WITH SPMI, SMI AND SED**

<u>FISCAL YEAR 2007-08</u>	<u>Total</u>	<u>0-8</u>	<u>9-17</u>	<u>18-64</u>	<u>65+</u>
State Population	37,810,582	4,832,236	5,175,265	23,705,767	4,097,313
Clients Served	670,944**	53,815	163,307	432,552	21,010
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,088,945	NA	362,269	616,350	106,530
Estimated Population with SMI/SED 11% SED and 5.4% SMI	2,075,801	NA	569,279	1,280,111	221,255

**Total includes clients of unknown age, and therefore does not equal the total among the age categories.

FISCAL YEAR 2008-09

State Population	38,246,598	4,881,060	5,122,836	24,044,666	4,198,036
Estimated Clients to be Served	670,944	50,383	167,227	432,404	20,930
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,092,909	NA	358,599	625,161	109,149
Estimated Population with SMI/SED 11% SED and 5.4% SMI	2,088,618	NA	563,512	1,298,412	226,694

It is estimated that the number of persons to be served in SFY 2009-10 is expected to remain approximately the same as the number of persons served in FY 2008-09 given normal county reporting. California is once again is facing a large budget deficit. The MHSA has been of help in past FYs. Its passage helped provide new and innovative mental health services in California counties. While it did not replace lost funds, it did augmented services that could be provided to mental health consumers. However with a severe statewide budget shortfall, the impact on county services is expected to be profound. Since MHSA funds cannot be used to offset reductions or supplant, we estimate that there will be no net gain over the next FY.

STATE-LEVEL REFINEMENTS OF PREVALENCE RATES AND SMI/SED DEFINITIONS

With the implementation of the MHSA there is increased pressure for California to refine the national prevalence rates. Counties have submitted a CSS plan which must be data-driven. It is fortunate that over the last year workgroups of county, provider, and client and family stakeholders have been meeting around issues that have emerged as the result of the need to redesign DMH's data system to capture data elements to meet new federal requirements. The DIG has served to promote the State's refinement of SMI/SED definitions and to develop State and county specific prevalence rates.

For several years, California has provided estimates of the SMI/SED population according to the method described above. While useful for the State as a whole, DMH was not able to respond to requests to provide prevalence rates of race/ethnicity by county. In 2003, DMH contracted with Dr. Charles Holzer to develop California specific prevalence rates. Dr. Holzer had done studies for several of the western States using a synthetic estimate model that applied prevalence rates developed from surveys conducted in the 1990's to the 2000 census data. He used this same model for California and provided prevalence rates by county and selected demographic characteristics. As updates are available, the data are posted on the DMH website.

The following table shows the California SMI/SED population using the Holzer method and updated with more recent Census data:

**COMPARISON OF STATE POPULATION, SMI/SED POPULATION,
AND CLIENTS BASED ON HOLZER METHODOLOGY
2000 CENSUS WITH 2007 UPDATE**

	Total	Youth	Adult	18-64	65+
Census					
TOTAL POPULATION - 2000					
Total Population	37,810,180	9,697,088	28,113,092	23,938,299	4,174,793
Household Population	36,889,731	9,632,453	27,257,279	23,264,418	3,992,860
Household Population Below 200% of Poverty	12,498,882	4,216,179	8,282,702	7,120,314	1,162,388
SMI/SED POPULATION					
Total Population	2,474,202	734,235	1,739,967	1,535,345	204,622
Household Population	2,323,921	724,052	1,599,868	1,438,873	160,995
Household Population Below 200% of Poverty	1,090,756	375,608	715,148	646,552	68,595
PERCENT SMI/SED POPULATION					
Total Population	6.5%	7.6%	6.2%	6.4%	4.9%
Household Population	6.3%	7.5%	5.9%	6.2%	4.0%
Household Population Below 200% of Poverty	8.7%	8.9%	8.6%	9.1%	5.9%
CLIENTS SERVED FY 2007-08					
Clients	670,944**	217,122	453,562	432,552	21,010

SMI/SED is the estimated number of adults who have a serious mental illness or youth who have a serious emotional disturbance.
**Total includes clients of unknown age, and therefore does not equal the total among the youth & adult age categories.

The above table shows the population and estimated prevalence for the total population, the household population, and the household population below 200 percent of the poverty level.

DMH's Statewide QI Committee has adopted the policy to focus on the population below 200 percent of the poverty level to be used in determining penetration rates. However, there are some limitations in using that population because it includes persons in households only. Many of the persons served by county mental health programs reside in board and care facilities, or residential programs that are not included as households.

Another critical aspect of using the prevalence data to calculate penetration rate is the fact that the prevalence rates focus on the SMI/SED population. While the DMH uses diagnosis only to estimate the number of persons who are SMI/SED, it is not satisfied with using diagnosis as the

single factor for determining SMI/SED. Both diagnosis and level of functioning are usually considered when determining if a person is SMI/SED. However, the reporting of functioning level has been incomplete. The DIG utilized the workgroup process to address, among other things, the quality of reporting and the data elements it is using to estimate the SMI/SED client population. The DIG recommendations resulted in changes to the DMH's CSI system which were implemented beginning July 2006. DMH has changed to a DSM IV TR five axis diagnosis. Since this includes Global Level of Functioning (GAF) scores, it is expected that this will give DMH a more accurate estimate of the number of clients who are SMI/SED.

The data provided by Dr. Holzer is based on the 2000 census. Updates have not been done for more current years because the household population below 200 percent of poverty is not a subgroup of the population that is updated annually. This is only collected on a sample basis at the time of the Census, which is every ten years. The population at lower income levels is growing at a higher rate than average, so the DMH is exploring alternative data sources or methodologies that could be used to update the prevalence data for persons below 200 percent of the poverty level annually.

The DMH believes that the estimates provided by Dr. Holzer showing prevalence rates by demographic characteristics and county are an improvement over using national rates. However, more work needs to be done to update the data, to include parts of the non-household population that would receive mental health services from county mental health, and to refine the data elements that are used to estimate the number of clients who are SMI/SED.

State-Level Performance Indicator Description

In May of 2004, prior to the passage of the MHSA, DMH presented county level prevalence data to all California counties. Since that time the data has been used extensively by counties as they develop their Service Plans for how they will use their MHSA funds.

Beginning in 2006, DMH, at the recommendation of CMHS, DMH began a partnership with CDPH to add to the mental health content of Centers for Disease Control's (CDC) Behavioral Risk Factors Surveillance Survey (BRFSS). In an Interagency Agreement with CDC, CMHS was able to fund the addition of the Public Health Questionnaire 8 (PHQ-8), which measures anxiety and depression, to the BRFSS. CMHS also gave states that applied an administrative supplement to cover their costs. This initial work has fostered an on-going relationship between DMH and CDPH. We are now active partners with other California state departments in the yearly survey development. In 2007 the Kessler 6 (K-6), which measures psychological distress, was added and in 2008, the PHQ-8 was added again. This allowed DMH to combine samples for a more powerful analysis of mental health issues in California.

In its continuing efforts to aid counties to refine estimates of their target service population, DMH also participates in an additional California specific survey, the California Health Interview Survey (CHIS). This survey is conducted by the University of California, Los Angeles Health Policy Institute. As a public health survey, the CHIS is done every two years and has always contained mental health content. However, beginning in 2005, DMH paid for the K-6 to be added. The sample size is over 50,000, which allows DMH to use it on a county level and

help refine previous prevalence estimates. In 2007, DMH modified the K-6 to include questions about the respondents' worst month, about access and utilization of mental health services, stigma, and adolescent access and utilization of mental health services. DMH is in the planning stages for the 2010 survey and anticipates a continuing partnership with CHIS which provides a comprehensive look at the health and mental health of California's population. DMH has received detailed data from the survey and plans to make it available to counties for their on-going MHSA planning process.

Child - Quantitative targets to be achieved in the implementation
of the system of care
described under Criterion 1

OVERVIEW OF CALIFORNIA'S DATA SYSTEMS

There are several automated systems at the State level that contain client, service and fiscal data from State Hospitals and county mental health programs. The data systems for State Hospitals have been developed around the ADT System, which is an on-line real time system for State Hospitals. The system includes basic demographic characteristics of all clients, dates in and out of the hospital, dates and types of legal class changes, and dates of ward changes. The function that tracks legal class and ward changes allows for billing and fiscal reporting since there is a daily rate established for each ward. Data from the ADT system are linked with the CRS to generate billing data. A number of other functions have been automated that tie to the ADT system, such as TACS, Pharmacy, Laboratory, and the POS. There are plans to continue data system development to support increased efficiency in State Hospital operations.

Wellness and Recovery Model Support System (WaRMSS)

WaRMSS is a comprehensive computer software program that records each patient's assessed needs as derived during initial treatment team planning sessions; patient-generated life goals; goals for each treatment session or class; available types and providers of treatment; a schedule and rosters of patients assigned to treatment sessions; degree of patient achievement of each treatment goal; changes in goals; and measures of progress in treatment. WaRMSS is deployed system-wide allowing DMH to monitor and summarize data concerning amounts and types of treatments provided and the effectiveness of these treatments. The system is consistent with the wellness and recovery models of mental health that place special emphasis on client-driven treatment goals and services and in which services are often provided in treatment malls with a campus atmosphere and flexibility in tailoring available treatment to individual needs.

Recovery-Model Outcome Reports (formerly "SHOES")

LTCS will combine data generated by the WaRMSS system with other centrally gathered data to write reports that were formerly conducted as part of the SHOES. The SHOES project was redesigned in the past year to be consistent with the Recovery Model of mental health treatment that DMH has adopted. LTCS will write monitoring and evaluation reports that expand upon the current "Questions and Answers About the Safety and Effectiveness of California State Hospital Services" report series begun in September 2004 to answer questions including:

- What proportion of patients met their goals for mental health recovery?
- What treatments were provided to patients who met and did not meet goals?
- What system results are achieved (reductions to length of stay and return rates)?

While the operational data systems for State Hospitals have been developed by and are maintained by DMH staff, county MHPs each develop their own systems and send extracts from their systems to DMH in specified formats. There are two primary data systems used for county mental health data. The CSI system is a statistical reporting and includes client and service information about all persons served in county MHPs. The Medi-Cal system is actually composed of several files that include all persons who are eligible for Medi-Cal, and the Medi-Cal claims that have been paid for SMHS.

Both of these systems are used extensively by DMH staff to calculate indicators for the Statewide Quality Improvement Committee, for program planning, monitoring, and to respond to requests from the legislature, state and federal agencies, county programs, consumers, family members, and other interested stakeholders.

In addition to client level data systems, there are two other systems that include county data. The CFRS is a year-end cost report of all costs expended by county mental health programs. Costs are reported in the same categories that are used for statistical reporting. The Provider and Legal Entity File identifies the actual provider site as well as the legal or corporate entity, or county, that “owns” the provider. The CSI system is based on provider reporting while the CFRS is based on legal entity reporting. Through the Provider and Legal Entity file, costs reported to the CFRS by legal entity can be linked to services reported in the CSI by provider. Through this linkage process it is possible to estimate the cost of services provided to specific groups of individuals, such as youth, or people with certain diagnoses. Preliminary efforts to link the data sets for several projects have proven to be challenging. There are frequently minor differences in spelling of names or transpositions of dates that cause records not to match when they should. DMH staff will continue to work in this area to improve the matching process so that the benefit of linking the data systems can be realized.

As the data systems are fully implemented and integrated, their use is increasing. With the increasing use of the data, the importance of complete and accurate data also increases. The DMH will be developing a data quality program focusing on CSI to ensure the accuracy of the data.

DMH’S APPLICATIONS DEVELOPMENT (AD) SECTION

DMH’s AD Section is divided into three units: Hospital Services, County Services and Headquarters Services. A brief description of the systems in each unit can be found under Criterion 2 for Adults and Older Adults.

State Hospital Services

This unit responds to the diverse business needs of the staff working in various capacities throughout the five State Hospitals. The systems they develop and maintain facilitate key hospital functions to assist in the care and treatment of approximately 5,000 patients. These systems are deemed mission critical by the DMH and interface with systems in other agencies. The following are Hospital Services systems that are either maintained or under development by the AD section:

Admission Discharge and Transfers (ADT) - The ADT System performs State Hospital census functions. Statistical information from this system is used for management reporting and research purposes. The system provides transactions to the DDS for billing purposes. ADT contains the patient file, which is the foundation for all patient care-related hospital systems, and vital criminal and clinical history data. The system has over 500 screens and 400 standard reports. When a patient is transferred from one hospital to another, patient data is available to the new hospital. This is essential for both the patient and staff at the hospitals.

Master Billing Project (MBP) - Provides a mechanism to capture Fee-For-Service (FFS) billing information within existing and future DMH HAS applications. An automated Patient Progress Note (PPN) will help facilitate the doctors completing the documentation that is required for billing. After validation of billing this information will be passed to the DDS CRS for billing.

Additionally, it will enhance the Master Formulary and create Drug Utilization Review tables for the PHO system and the POS (described below). This will allow for much needed order validation using the patient's diagnosis, medical condition, and medication regimen for indications and contraindications, appropriate dosing levels and duration of therapies as well as other valuable special conditions and precautions.

Pharmacy Hospital Operations (PHO) - The PHO system processes medication orders and recurring non-medication orders. It generates monthly Physician Orders for renewal and information that supports unit-dose order filling functions; this includes pick lists, Medication Administration Record forms and an electronic file for the Baxter automated unit-dose dispensing machine. All medication orders are checked for Drug-to-Drug Interactions, allergies, over maximum-dose, and approval for non-formulary items. When a patient is transferred, his/her medication orders are visible to the new hospital and can be utilized by the new physician as baseline current medications for the new episode. This greatly benefits the staff and minimizes patient risk. PHO also has over 500 screens.

Physicians' Orders System (POS) - POS automates physician order entry and transmission of physicians' orders to the service provider. This reduces order turnaround time and errors, and promotes more timely and effective patient treatment. This system uses extremely complex client/server architecture to provide the user with the easiest, friendliest interface possible.

Service Usage Report (SUR) - The SUR is used to collect data from the ADT system and maintain files of county usage of beds at the hospitals. The system runs twice a day and produces summaries of daily, monthly and fiscal YTD bed usage totals. This system supports the County Contract Monitoring (CCM) System, which reports over-contract use of State Hospital beds, and the Fiscal Automation System (FAS) reports, which the hospital accounting offices use to comply with certain CALSTARS cost reporting requirements.

Treatment Outcome System (TOS) - The State Hospital TOS schedules patients into treatment activities, records patient and staff attendance at those activities and produces reports for managers at the hospitals. TOS reports have been used to support departmental testimony at the yearly legislative budget hearings.

Trust Accounting Cashiering System (TACS) - The TACS accounts for patients' financial assets and associated transactions. The system records receipt from patients, their families, conservators, Social Security, etc., and disburses funds for patients' personal use and for reimbursing the cost of their care.

The Canteen subsystem allows the canteen operators to scan bar coded patient identification cards, determine patient account balances, apply purchases and other transactions saving operators' time.

County Services

This unit supports, enhances and develops automated systems to facilitate oversight and program decisions for the 58 counties providing services to mental health consumers. The systems also perform billing, payment and report processing for Medi-Cal services and federal reporting requirements. The unit's primary customers are the System of Care staff at DMH Headquarters and the county program and technical staff. In addition to DMH systems support, the units also develops county-level applications, file extractions, responds to technical questions, and fosters DMH and county program and technical relationships.

To further the modernization of the county systems, the unit is also developing a decision support system that includes data from all related county and State systems to provide management reporting on access, cost and outcomes of mental health services across the entire continuum of mental health care. The unit is using the newest Internet technologies to securely provide confidential mental health information to all its business partners.

The county technical staff is viewed as both customers and suppliers of these systems. All systems under construction are directed by the input of county technical staff, consumers and the county vendors. Although this is a more difficult approach than previously used, there is greater county buy-in and improved county reporting.

Client and Services Information System (CSI) – The CSI system collects, edits, and reports on client demographic and service encounter information on the entire California public mental health population of approximately 500,000 people receiving 7.5 million services per year. This system works via a web browser to provide data entry and correction screens, processes batch files and returns errors with error identity, and passes data to and from the counties via the Information Technology Web Server (ITWS). The CSI data will be integrated with other data sources to facilitate decision support.

Data Collection and Reporting System (DCR) – Currently, the DCR supports the collection of repeated-measures for the initial PMs for the MHSA FSP outcomes assessment. The DCR is aligned within the State's vision for a comprehensive, interoperable electronic mental health record system. By leveraging Extensible Markup Language (XML) technology, DMH will be able to exchange, manage, and integrate data, as well as distribute information system changes. This solution offers both a centralized, web-based application and methods that ensure interoperability between disparate county/provider systems.

Information Technology Web Server (ITWS) – Allows for the counties to pass data files for SD/MC, the Medi-Cal Eligibility Data System (MEDS), PODS, CSI, etc. electronically to DMH as well as receive them from DMH. This greatly decreases the time required for handling and errors in the initial processing steps.

Inpatient Consolidation System (IPC) - Allows counties to view and report the inpatient claims data files provided by the fiscal intermediary (EDS) under Managed Care Phase I. Counties use this information to verify realignment offsets by DMH and reconcile paid claims with their associated TARs. DMH Managed Care and Accounting use this system to resolve county inpatient claim issues and calculate the realignment offset.

Medi-Cal Eligibility Data System (MEDS) – This file is provided to DMH monthly by the DHCS. The DMH in turn provides county mental health programs with these files to conduct analyses of their risk under capitation or block grant contracts; plan allocation of their resources; identify clients who are eligible for Medi-Cal; and identify their third party insurance coverage, if any. This system also provides counties with non-resident beneficiary information upon submission of a MEDS ID. Currently, staff are analyzing a county request to perform real-time queries of the MEDS information from their county-based integrated systems.

New Institutions for Mental Disease (NIM) - The DHS is required to provide the federal CMS information on Medi-Cal beneficiaries in IMDs. This requirement is to ensure compliance with Medicaid requirements involving FFP and Fee-For-Service/Medi-Cal (FFS/MC) ancillary services. In order to facilitate this requirement, this system collects the IMD information from the counties.

Omnibus Budget Reconciliation Act (OBRA) System – This system is federally mandated to refer, track and maintain the data to determine the placement and treatment for seriously mentally ill residents in SNFs (i.e. whether they require nursing care, mental treatment, both or neither). The PASRR Section receives Level I screening documents from the facilities and determines which ones warrant the more thorough Level II evaluation. Based on the evaluation, an appropriate letter is sent to the resident, facility, physician and field office informing them of the treatment recommendations.

Provider System (PRV) – This is an on-line application for inquiry and update of provider and legal entity data, including Medi-Cal certification information; furnishing provider validation information to the CSI system; and generating reports and files required by external entities such as EDS, DHS and all county mental health plans.

Short-Doyle/Medi-Cal System (SD/MC) - This system processes claims submitted by the counties, and initiates corrections and applicable approval processes. The volume of claims processed by SD/MC exceeds \$1.5 billion annually.

SD/MC Explanation of Balances (EOB) – This is an application to view the EOB files, which contain detailed adjudicated claims information. This application was developed and is widely used by numerous counties.

Web-Based Data Reporting System (WBDRS) – The WBDRS is an integrated technology solution which was designed to improve data quality and ease the reporting of performance measurement data by counties to DMH. This system allows for direct, on-line data entry, scanning and local data verification, and batched data upload. The submitted data are used to evaluate the quality and increase the effectiveness of mental health services for California's clients and their families.

DMH Headquarters Services

This unit supports multiple divisions at Headquarters through the development of stand alone and server-based applications to facilitate tracking efforts and increase efficiency of day-to-day operations. Below are a few of the systems supported by the AD section:

Conditional Release Program (CONREP) - The CONREP system records patient data, provider contract information, and services received. This information is used to reimburse service providers, monitor service units and dollars, track patients and treatment compliance, and evaluate the effectiveness of the program that provides community-based services for the judicially committed. An interface with the Department of Justice (DOJ) provides access to criminal history data. Statistical reports are used to notify the Legislature of program status, as well as for program monitoring and fiscal planning.

Jamison/Farabee Program - The Jamison/Farabee system was developed to track court-ordered quarterly medication reviews of patients who have been diagnosed as “Gravely Disabled.” The database contains both patient and quarterly review data. The monthly statistics report summarizes the monthly review data by Review Type and Review Status. Monthly compliance checks, certified competent to consent and Rx Review counts are also included in the report. The Print Reviews report is a report of patient reviews that were completed within a date range. The report includes Reviewer Name, Review Date and Patient Name, Patient ID, Unit # and Patient’s Physician. The Non-Participant report is a list of all patients who have been terminated from the Jamison/Farabee review process.

Mentally Disordered Offender System (MDO) - The law requires that a prisoner who meets six specific MDO criteria shall be ordered by the Board of Parole Hearings to be treated by the DMH as a condition of parole. The MDO system provides a comprehensive method of tracking MDO patients from CDCR referral to CONREP discharge. The automated evaluation scheduling facilitates prioritization of evaluations to be conducted and references to previous evaluation results. Aggregate data regarding referrals, clinician activity, evaluation results, State Hospital population, CONREP population, and CDCR facilities are also provided.

Ombudsman’s Services Data System (OSD) – This system was developed to provide a means of tracking calls received from Medi-Cal beneficiaries and/or their representatives who have questions, concerns, or complaints about their coverage. The system tracks beneficiary and representative information, and categories of issues such as accessibility, benefits/coverage, and quality of care. The system gives the Ombudsman the ability to keep notes on the nature of the call and any follow-up calls, and to record when the case was resolved and what kind of conclusion/resolution was reached.

Sexually Violent Predator (SVP) System – The SVP data system consists of several linked Microsoft Access databases containing information on potential SVP inmates referred from the CDCR and screened by DMH. The systems include inmate demographic/I.D. data, SVP record review and clinical evaluation data, DMH and "post-DMH" tracking information, research-related data, SVP evaluation accounting information, and State Hospital SVP commitment data. Portions of this data are available to Atascadero State Hospital, Coalinga State Hospital, Board of Parole Hearings, and CDCR via DMH’s ITWS.

Treatment Authorization Request - Level II (TAR Level II) - The TAR Level II tracks the provider appeal process. The system contains the date the appeal is received, sends letters requesting documentation and substantiation from the providers, tracks when information is received, notes whether the decision was upheld or reversed, and generates the appropriate information letter regarding the appeal to the provider.

Outcome Reporting

The DMH is measuring performance with respect to the MHSA on multiple levels, including the individual client level, the mental health program/system accountability level, and the public/community-impact level.

At the individual client level, data across several domains is measured over time using three types of assessment forms. Each set of forms is tailored based on age groups: Child/Youth (ages 0-15), TAY (ages 16-25), Adults (ages 26-59), and Older Adults (ages 60+). The forms include the Partnership Assessment Form which gathers historical and baseline information about each client while a Key Event Tracking and Quarterly Assessment forms gather follow-up information within these same domains¹. The domains include: residential setting (including hospitalizations and incarcerations), education, employment, sources of financial support, legal issues/designations, emergency interventions, health status and substance abuse.

Almost 14,000 individuals were reported as having participated in Full Service Partnerships in Quarter 3 (January, February and March) of SFY 2007-08. This included approximately 2,282 Child/Youth (ages 0-15), 2,946 TAY (ages 16-25), 6,984 Adults (ages 26-59), and 1,526 Older Adults (ages 60+). The baseline information collected on individuals at entry into the Full Service Partnership program reveal extremely high levels of unemployment (close to 99% for adults), frequent mental health and physical health-related emergency interventions, high levels of homelessness, higher than normal involvement with the criminal justice system and higher than normal levels of substance abuse co-occurring with serious mental illness and serious emotional disturbances. While it is still too early to determine the impacts participation in the FSP program will have for these individuals, services are geared towards addressing the needs of individuals across multiple domains including employment, education, housing, etc. The DMH will include ongoing analyses of the outcomes data starting with next year's application.

The data collected above is then linked with data collected during the bi-annual Consumer Perception Survey sampling periods to capture clients' perceptions of the FSP services/care they receive using the nationally developed YSS-Y, YSS-F and MHSIP consumer surveys. Data reported to the CSI System is also linked provides demographic information, as well as service information (which includes evidence based practices and other service strategies that are more tailored toward a client's individual needs). The ability to integrate these three sources of data will provide a more comprehensive view of the impact of these transformative services than was previously possible.

¹ View the assessments at http://www.dmh.ca.gov/POQI/full_service_forms_POQI.asp

Full Service Partnerships Assessment data is reported using the Data Collection and Reporting System (DCR). This centralized, web-based application ensures interoperability between disparate county/provider systems that combines the traditional relational data model which maximizes performance and scalability with support for the XML data type to ensure system flexibility to changes in business/data needs. By leveraging Extensible Markup Language (XML) technology, DMH is able to exchange, manage, and integrate data from counties using their own data collection platforms. The DCR system serves as an early prototype that moves the state forward towards an EHR for public mental health and is aligned with the State's vision for a comprehensive, interoperable electronic mental health record system. Consistent with DMH's vision for a comprehensive and fully interoperable information system, DMH also expects to incorporate future survey forms within the DCR to provide continued support for survey administration methods.

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and
Health and mental health services.

Criterion 1 & 3 combined (See Criterion 1)

Child - Establishes defined geographic area for the provision of the services of such system.

Criterion 1 & 3 combined (See Criterion 1)

Child - Describe State's outreach to and services for individuals who are homeless

CHILDREN AND YOUTH WHO ARE HOMELESS AND HAVE BEEN DIAGNOSED WITH A MENTAL ILLNESS

Impacts to county level services and funding for foster youth exiting the system and youth served by the juvenile justice systems have created challenges for this population. With many county and state level initiatives facing severe budgetary crisis or termination, county program administrators and DMH continue to work on maintaining safety networks for homeless youth.

County programs, through the use of their interagency case management committees, maintain active supervision of youth known to the system, and in the process of exiting specific county services. To the extent that resources are available, and that the youth willing to participate, these case management teams make referrals to housing, employment and education institutions. There are many other youth in the larger counties that fall outside of the traditional case management committees' scope of work and oftentimes the interests of these youth are represented by the public health officers, law enforcement and local youth hotlines.

With the direct delivery of services coordinated at the county level in California, local communities are being stretched to maintain necessary services. The long standing practice of using mixed funding streams to maintain programs that address the needs of transitional youth is very essential this budget years as funding reductions in Medi-Cal, TANF, WIC, Food Stamps/GA, SSI, County Primary Care Health funds, Section 8 Housing, college financial aid and other county funds are expected.

The MHSA is providing an exciting opportunity to allow counties to address the issues of homelessness in children and youth. Homeless individuals needing mental health services are a primary group focused upon in the development of the MHSA. Many youth become homeless due to the lack of adequate transition systems as they approach young adulthood; TAY, who are ages 16 to 25 are one of the discrete age groups addressed in the county's MHSA plan for CSS.

Of all the original CSS plans submitted by 56 counties, 39 counties are proposing housing support and assistance for TAY. Fifteen of these counties are rural counties and a total of 152 TAYs are proposed to be served statewide in the FSP. In SFY 2008-09 the TAY population accounted for 20% (4,616) of the individuals served in FSPs.

FSP reflects the 'whatever it takes' approach and counties have the funding flexibility to offer a wide variety of individualized, intensive, cultural-competent, and client-driven mental health services and supports to clients. The menu of services being proposed by these counties for TAY include services such as housing, employment, training, transportation, integrated AOD and healthcare services, peer support, warm line, and peer support programs etc. Of all these programs, housing program is the number one focus in many counties and is included in 70% of all statewide programs exclusively for TAY.

In addition, to transform the mental health system in California and address homelessness among individuals with mental illness, the MHSA Housing Program was established under the CSS Component. Seventy-five million dollars will be allocated each year to finance the capital costs associated with the development, acquisition, construction and/or rehabilitation of

permanent supportive housing for individuals with mental illness and their families. An additional \$40 million per year is also available to provide operating subsidies to make the capital projects successful. In the first round of funding, \$400 million will be available for counties which represents approximately three and half years of funding. TAY leaving foster care or juvenile hall would benefit from the MHSA Housing Program.

The THP-Plus, administered by the DSS, also offers housing assistance for former foster youth. THP-Plus provides affordable housing and comprehensive supportive services to help former foster care and probation youth ages 18-24 transitioning from out-of-home placements to independent living. In June 2006, the THP-Plus Statewide Implementation Project was launched to reduce homelessness among California's former foster youth by expanding access to the THP-Plus program. It is a partnership between the John Burton Foundation, the Corporation for Supportive Housing and DSS. The goal of this project is to increase statewide capacity from serving 135 youth to 1000 youth by October 2008. This goal was met and for FY 2008-09, 1395 youth will be served. At this service level, approximately 1 in 4 youth in need will be able to access the THP-Plus program.

The SHIA, which is discussed under Criterion 1 for Adults, was passed into law in SFY 1998-99, and was subsequently allocated a total of \$48.2 million in General Funds for the development of supportive housing projects for individuals with disabilities. Under the SHIA program, DMH sponsored the development for seven supportive housing projects that specifically focus on TAY/young adults with disabilities.

These SHIA projects for TAY employ a range of models, from congregate living situations to young people having their own studio apartments. In spite of these differences, all of the projects offer permanent housing with a variety of supportive services on-site and in the community. Examples of two projects funded in San Francisco County are the Ellis Street Project and Gatinells's Supportive Housing. The Ellis Street Project, which is managed by Larkin Street Youth Services, houses formerly homeless young adults. Some of the tenants are run-aways and have lived on the streets, and others have exited the foster care system. This project also has six units of housing for individuals with HIV/AIDS. Gatinell's Supportive Housing targets young women with disabilities who have aged out of, or are emancipated from, foster care. This congregate living project is located in a large three-level home and each tenant has her own room. Clients may receive rental assistance and a range of supportive services, including strong linkages to culturally appropriate educational and health services in the community.

All of these projects have added much to our understanding of both the service and housing needs of young adults with SED/SMI.

Housing Challenges for TAY

TAY moving into the world of independence have many challenges to endure, but none may be as great as securing adequate, affordable, stable and safe housing. The lack of affordable housing, coupled with extreme poverty, is the underlying cause of homelessness in the United States. Consider the following facts gathered by the Child Welfare League of America.

Homeless youth become homeless for a variety of reasons, as do homeless adults and families. But some of the common avenues into homelessness for youth include:

- Separating from her or his already homeless family;
- Leaving home to escape physical or sexual abuse;
- Being thrown out of home by parents/guardians;
- Emancipating from the foster care system;
- Leaving an intolerable placement in an institution after having been placed there from her or his family;
- Immigrating unaccompanied to the United States;
- Unsuccessful experience in public school, which can lead to withdrawal from both home and academic life;
- Difficulty coping with the symptoms of mental illness;
- A TAY who has not developed sound financial skills, but lacks access to a payee, may be left homeless when impulsive decisions are made; and
- Often a combination of above factors may develop.

The reason that typical youth do not emancipate fully until 28 is that they are dependent on the relationships and support that families provide. Youth need to know that they can leave home, but that the emotional and financial support is still available in times of need. If a youth has been disappointed in relationships or if housing interruptions occur, and the youth needs to forge ahead in life alone, the chances for becoming homeless dramatically increase. When a youth is in a congregate living situation, negative events can happen when roommates transition too quickly, or when the youth finds him or herself bouncing from residence to residence without consolidating gains. Adults who want to assist a youth in securing a living situation may be wise to promote environments where youth can live together with a mature youth in a leadership role to provide oversight. In summary, the significant barriers to a youth finding a successful rental situation include:

- There will be an economic barrier. The youth will not have the work history or the income to qualify for fair rate market housing stock. They will not pass the credit check;
- They will not have the references from successful past rental experiences;
- The youth will not have clear information about what “sheltered” or “subsidized” housing programs are available. Once they discover a resource, they will need assistance to comply with all requirements;
- Once they are successfully housed, they will need assistance and support to stay in the house;
- If the youth is accepted into a subsidized housing program, they will need intensive support so they do not become overly reliant on the resource and continue to work towards increasing independence;
- Individuals or agencies supporting youth don’t always have knowledge about each other’s programs. They do not always collaborate;
- The youth with a disability of mental illness will have all the above stated challenges with the additional burden of dealing with the disability that may have contributed to the condition of homelessness in the first place;

- There are few Board and Care Facilities that accept youth, and often the facility will also accept older adults who may not be compatible with the youth lifestyle and needs;
- On an emotional and financial level, if the youth perceives that he or she has a severed relationship with the adults in his or her life; it will be far more difficult to feel secure in living in an independent setting;
- Congregate living situations, though the most desirable housing setting for the youth, may not be available in the community where the youth actually wants to live; and
- Youth without financial or emotional support of family will find entering into the independent world far more difficult than youth who have this safety net to fall back on. Youth transitioning out of the foster care system are most vulnerable to setbacks in finding a successful place to live.

Recommendations for County Administrators Regarding TAY Housing Resources

TAY who are homeless or at risk of homelessness need special resources to assist them in overcoming the above barriers to finding adequate housing. The following are resource-building treatment strategies developed by the CMHDA, CYSOC/ASOC, and TAY Subcommittee:

- TAY with mental illnesses needs intensive case management beyond high school graduation. Since this is 90% reimbursable under EPSDT Medi-Cal, providing case management is a good investment that can make a tremendous difference. The County Administrator must realize that even if the diagnosis is less serious than for other adults, as long as medical necessity exists for Medi-Cal, it is advantageous to both the youth and the department to provide specific mental health supports for this population. By giving the TAY population support in the early years of emancipation, the youth is more likely to be successful in his or her living situation.
- As county mental health departments identify housing resources for their clients, they must carve out stock that will be used for youth who will need subsidized assistance. Housing options must be thought of in the context of what is developmentally appropriate for this age. As discussed above, congregate supervised living arrangements that allow for sufficient privacy reflect most clearly the needs of the TAY population. The less a TAY congregate living situation looks like a residential treatment facility, the more likely the TAY will see it as a place they want to be.
- Every county should have a housing collaboration that meets regularly to review the resources and attend to the needs of homeless youth, those aging out of foster care, and TAY with mental illness for referral into the “sheltered” or “subsidized” housing stock.
- TAY should not be placed in board and care facilities with older adults. TAY needs to have an environment of hope and recovery and a home environment that is developmentally and culturally appropriate. If the home is licensed as a Board and Care, there should be a transitional theme that encourages youth to expand boundaries in a safe context.
- In supported housing programs, the ideal TAY climate can be fostered. There should be social support from peers and the service coordination necessary to assist with life’s

important decisions. The youth needs to be simultaneously involved in an educational or vocational program that will promote further independence. In such a setting, the symptoms of mental illness can be stabilized and TAY have the opportunity to self-monitor symptoms and balance activities in the outer world using the valuable experience of learning to live with a disability successfully.

- When TAY are still in a CSOC Program, it will take intensive collaboration with agencies involved as well as interested family members to create a service plan that will address the many needs that will develop after the “Freedom Birthday” of age 18. Only after a strengths-based assessment is completed, will the client and a clinician have established a trusting relationship in order to actually generate a client-driven culturally competent service plan.
- County Administrators need to be aware of family systems theory so that in the development and organization of programs, there is sensitivity to family members. Youth do not emotionally grow and thrive outside the context of the family system. The natural resources that the family and community can provide cannot be duplicated by an agency.

Child - Describes how community-based services will be provided to individuals in rural areas

MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH RESIDING IN RURAL AREAS

Definition of “Rural Area”

The State of California offers a variety of mental health treatment options and services to children, youth and their families through its counties. All urban and rural counties utilize EPSDT, Realignment, and MHSA funding to provide mental health services to California children, youth and their families. DMH values, philosophy and goals are embedded in rural county service provision. To the extent resources allow, California rural counties provide mental health services to children, youth and families that are collaborative, culturally competent, youth/family driven, and focused on wellness, recovery and resiliency.

Rural counties provide at least the minimum array of services for children and youth meeting the target population criteria. The following are modes of service provided:

- Pre-crisis and crisis services;
- Assessment;
- Medication education and management;
- Service coordination;
- 24-hour treatment services; and
- Rehabilitation and support services.

Most California rural counties provide MHSA funded FSP programs that provide individualized and flexible ‘whatever it takes’ services with 24/7 coverage. These programs serve many rural county children, youth and families in programs that reflect local collaboration among various partners, including child welfare, education, juvenile probation, public health, law enforcement, faith based organizations, tribal organizations, employment, alcohol and drug programs, juvenile court, and housing. Rural counties have taken additional measures to ensure quality mental health service provision by incorporating methods like telepsychiatry and strategic facility locations to improve access to services. However, rural counties have had to face unique obstacles in the provision of mental health services. Challenges in hiring staff with cultural and linguistic characteristics that mirror their communities, and serving large geographical areas with poor public transportation services have been major barriers to access.

DMH, in conjunction with the CMHDA and the CIMH, work with small and rural counties to implement fiscal and programmatic strategies consistent with challenges unique to these counties. Fiscal issues are a particular problem this year, and are projected to become a much larger issue in FY 2009-2010. As resources allow, CIMH continues with regional trainings in the areas of 1) evidence-based mental health treatment in the juvenile justice system; 2) multidimensional treatment foster care; and 3) evidence-based approaches to family therapy.

Evolving practice models in counties will help to assure quality services and cost effective approaches.

Significant Barriers to Treatment in Rural Areas

See Adult Section

Current Efforts at Mitigating These Barriers

See Adult Section

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

**COMMUNITY RESOURCES FOR
CHILDREN'S PROGRAMS
FISCAL YEAR 2010-2011**

	FY 2009-2010	FY 2010-2011
DMH – State Hospitals	\$0	\$0
DMH – Local Assistance	\$1,500,000	\$1,500,000
DMH – Managed Care	\$28,319,000	\$31,247,000
DMH – CMHS Block Grant	\$14,761,000	\$14,761,000
DMH – EMHI (AB 1650)	\$0	\$0
DMH – Healthy Families	\$26,437,000	\$33,053,000
DMH – EPSDT/TBS	\$1,023,517,000	\$1,189,983,000
DMH – Short-Doyle/Medi-Cal Match	\$213,077,000	\$159,545,000
Total DMH	\$1,307,611,000	\$1,430,089,000
Realignment Funds Base	\$179,333,000	\$181,095,000
Total Community Programs	\$1,486,944,000	\$1,611,184,000

HUMAN RESOURCES DEVELOPMENT

See Adult Section

MHSA WORKFORCE EDUCATION AND TRAINING

See Adult Section

DEPARTMENT OF MENTAL HEALTH TRAINING

See Adult Section

Child - Provides for training of providers of emergency health services regarding mental health;

See Adult Plan

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

EXPENDITURE PLAN FOR FY 2011

DMH will allocate the FY 2011 CMHS Block Grant to county mental health departments for the SFY 2011-12. These funds will be used to promote the implementation of integrated systems of care and to fulfill the mission of the California mental health system. In addition, the DMH will allocate a portion of the block grant to support the CMHPC.

The DMH is the State's designated recipient of the Block Grant and allocation of funds to counties is based on either a legislated formula or on a competitive basis. The allocation affords counties the opportunity to develop innovative programs or augment existing programs within their systems of care for adults with SMI or children with SED. In order to receive the allocation, each county is required to submit an annual application or expenditure plan that includes a narrative detailing its intended use of the funds.

Block grant funding may also be awarded through a competitive process. The process is structured to encourage counties to adopt proven practices and to promote innovation by encouraging counties to explore new approaches.

The expenditure plan for FY 2011 Block Grant funds includes:

- \$45,088,922 funding base to 57 counties. This funding base includes an \$8,059,000 set-aside to support existing efforts to provide integrated treatment services for individuals with a dual diagnosis of SMI and a substance abuse disorder;
- \$3,987,515 to provide ongoing funding to support seven competitively awarded CSOC programs;
- \$2,000,000 to support two Integrated Services Agencies (ISAs);
- \$200,000 to support Human Resource Development (HRD);
- \$20,000 to support the efforts of COJAC; and
- \$2,699,812 for DMH Administrative and Support costs (includes funding for CMHPC).

The following chart summarizes the Department's proposed total CMHS Block Grant funds to be allocated for adult and children's mental health services for SFY 2011-12.

CMHS BLOCK GRANT SFY 2011/2012 PROPOSED EXPENDITURES

COUNTY	FUNDING BASE	DDX SET-ASIDE	HRD PROJ.	CHILDREN SOC	ISA FUNDING	CO-OCCURRING DISORDERS	ALLOCATION AMOUNT
ALAMEDA	\$ 548,109	\$ 152,415					\$700,524
ALPINE	\$ 11,008	\$					\$11,008
AMADOR	\$ 31,999	\$ 8,477					\$40,476
BUTTE	\$ 247,366	\$ 94,983					\$342,349
CALAVERAS	\$ 107,938	\$ 11,903					\$119,841
COLUSA	\$ 51,462	\$ 1,535					\$52,997
CONTRA COSTA	\$ 1,496,897	\$ 76,984					\$1,573,881
DEL NORTE	\$ 110,372	\$ 13,127					\$123,499
EL DORADO	\$ 99,162	\$ 38,077					\$137,239
FRESNO	\$ 1,090,943	\$ 418,899					\$1,509,842
GLENN	\$ 107,284	\$ 8,700					\$115,984
HUMBOLDT	\$ 261,285	\$ 45,532		\$ 183,692			\$490,509
IMPERIAL	\$ 294,003	\$ 64,292					\$358,295
INYO	\$ 158,132	\$ 985					\$159,117
KERN	\$ 887,622	\$ 231,820					\$1,119,442
KINGS	\$ 124,692	\$ 47,879					\$172,571
LAKE	\$ 167,271	\$ 28,454					\$195,725
LASSEN	\$ 86,203	\$ 13,429					\$99,632
LOS ANGELES	\$11,566,142	\$ 1,162,873		\$1,012,034	\$1,000,000	\$ 20,000	\$14,761,049
MADERA	\$ 164,970	\$ 45,596					\$210,566
MARIN	\$ 256,736	\$ 98,581	\$200,000				\$555,317
MARIPOSA	\$ 90,094	\$ 2,534					\$92,628
MENDOCINO	\$ 32,287	\$ 12,398					\$44,685
MERCED	\$ 402,470	\$ 114,295		\$ 351,535			\$868,300
MODOC	\$ 11,130	\$ -					\$11,130
MONO	\$ 11,019	\$ -					\$11,019
MONTEREY	\$ 407,205	\$ 93,279		\$ 740,475			\$1,240,959
NAPA	\$ 179,928	\$ 69,089					\$249,017
NEVADA	\$ 59,637	\$ 22,899					\$82,536
ORANGE	\$ 1,669,447	\$ 559,023					\$2,228,470
PLACER	\$ 197,527	\$ 46,365		\$ 444,188			\$688,080
PLUMAS	\$ 208,900	\$ 8,136					\$217,036
RIVERSIDE	\$ 2,086,711	\$ 360,159					\$2,446,870
SACRAMENTO	\$ 1,473,368	\$ 498,582					\$1,971,950
SAN BENITO	\$ 31,901	\$ 12,250					\$44,151
SAN BERNARDINO	\$ 2,528,246	\$ 610,357					\$3,138,603
SAN DIEGO	\$ 2,392,515	\$ 878,852					\$3,271,367
SAN FRANCISCO	\$ 2,034,829	\$ 685,821					\$2,720,650
SAN JOAQUIN	\$ 846,218	\$ 282,744					\$1,128,962
SAN LUIS OBISPO	\$ 127,421	\$ 57,159		\$ 254,061			\$438,641
SAN MATEO	\$ 689,902	\$ 164,338					\$854,240
SANTA BARBARA	\$ 167,202	\$ 33,828					\$201,030
SANTA CLARA	\$ 543,363	\$ 172,184					\$715,547
SANTA CRUZ	\$ 96,068	\$ 22,376					\$118,444
SHASTA	\$ 195,919	\$ 75,228					\$271,147
SIERRA	\$ 48,289	\$ 317					\$48,606
SISKIYOU	\$ 97,274	\$ 22,840					\$120,114
SOLANO	\$ 120,364	\$ 46,217					\$166,581
SONOMA	\$ 204,638	\$ 42,804					\$247,442
STANISLAUS	\$ 542,357	\$ 185,018		\$1,001,530	\$1,000,000		\$2,728,905
SUTTER/YUBA	\$ 269,468	\$ 69,385					\$338,853
TEHAMA	\$ 170,234	\$ 21,397					\$191,631
TRINITY	\$ 83,541	\$ 2,042					\$85,583
TULARE	\$ 667,105	\$ 201,143					\$868,248
TUOLUMNE	\$ 53,192	\$ 16,616					\$69,808
VENTURA	\$ 224,953	\$ 86,376					\$311,329
YOLO	\$ 195,604	\$ 18,408					\$214,012
COUNTY TOTAL	\$37,029,922	\$ 8,059,000	\$200,000	\$3,987,515	\$2,000,000	\$ 20,000	\$51,296,437
DMH ADMIN/SUPPORT	\$ 2,699,812						\$2,699,812
GRAND TOTAL							\$53,996,249

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	192,825	197,794	170,687	170,687
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To increase access to services for children with SED

Target: The target is to hold at the current rate of access

Population: Children with SED

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator:

Measure:

Sources of Information: Client and Services Information System

Special Issues: While the California mental health system's goal is always to increase access to services, the funding sources for mental health services have not been stable in recent years. As funds have not kept pace with population growth, counties have had to reduce their mental health programs, forcing them to serve only the most seriously ill, and reduce services to all clients.

Significance: The Mental Health Services Act (MHSA) funds have provided new, innovative and transformational mental health services. These funds have allowed counties to provide services when funds from other sources are decreasing. MHSA funds can supplement, but not supplant existing services. It is anticipated that over time the services and supports from the MHSA will impact the entire public mental health system.

Action Plan:

2010:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application ("Executive Summary" and "State priorities and plan to address unmet needs").
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application ("Executive Summary" and "State

priorities and plan to address unmet needs”).

2. DMH will continue implementation of children services to increase services to adults and older adults with SMI.

3. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.

4. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

5. DMH will continue to monitor and evaluate and assess the progress of the counties transition to an electronic health record (EHR) system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	0	0	15	15
Numerator	0	0	--	--
Denominator	18	20	--	--

Table Descriptors:

Goal: The Department will strive to decrease the readmission rates.

Target: There had been a target to keep the readmission rate below 15 percent.

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The performance indicator is stated as the percent of persons discharged who are readmitted. The denominator being the number of children in the State Hospital and the numerator being the number of children readmitted. As the number of civil commitments in California's state hospital continues to decline, the number of discharges and readmission also declines. With such small numbers differences of one or two people can change the rate substantially.

Measure: Number of readmission to state hospital within 30 days.

Sources of Information: California Department of Mental Health ADT Hospital data system

Special Issues: CA has been reluctant to set specific goals to date because the absolute and relative number of persons served in State Hospitals is very low. A recent NASMHPD report shows that California's State Hospital utilization for voluntary and civil commitments is among the lowest in the country. The number of hospital days per 100,000 children and youth is 444 while the national average is 1,590. This is the second lowest rate among 30 states reporting. Metropolitan Hospital, in Norwalk, California, which had been the only remaining CA State Hospital providing long term mental health services for children with SED closed its Child and Adolescent Treatment center in December 2007. In recent years, Metropolitan Hospitals had been treating a decreasing population of institutionalized children and youth between the ages of 11 and 17. The remaining children and youth have all been placed in secure and safe settings for treatment within the community.

Significance:

Action Plan: 2010:
1. DMH will continue to implement the children services and programs described in the narrative portions of the current application.
2. With the MHS, Community Services and Support Component, the County Mental Health Departments will continue to implement full service partnerships which will greatly assist in the individual with SMI to stay in county settings; this reducing the utilization of Psychiatric Inpatient Beds.

2011:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application.
2. With the MHSA, Community Services and Support Component, the County Mental Health Departments will continue to implement full service partnerships which will greatly assist in the individual with SMI to stay in county settings; this reducing the utilization of Psychiatric Inpatient Beds.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	6.45	6.45	15	15
Numerator	2	2	--	--
Denominator	31	31	--	--

Table Descriptors:

Goal: The Department will strive to decrease the readmission rates.

Target: There had been a target to keep the readmission rate below 15 percent.

Population: Children with SED.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The performance indicator is stated as the percent of persons discharged who are readmitted. The denominator being the number of children in the State Hospital and the numerator being the number of children readmitted. As the number of civil commitments in California's state hospital continues to decline, the number of discharges and readmissions also declines. With such small numbers differences of one or two people can change the rate substantially.

Measure: Number of readmission to state hospital within 180 days.

Sources of Information: CA Department of Mental Health ADT Hospital data system.

Special Issues: CA has been reluctant to set specific goals to date because the absolute and relative number of persons served in State Hospitals is very low. A recent NASMHPD report shows that California's State Hospital utilization for voluntary and civil commitments is among the lowest in the country. The number of hospital days per 100,000 children and youth is 444 while the national average is 1,590. This is the second lowest rate among 30 states reporting. Metropolitan Hospitals, in Norwalk, California, which had been the only remaining CA State Hospital providing long term mental health services for children with SED closed its Child and Adolescent Treatment center in December 2007. In recent years, Metropolitan Hospitals had been treating a decreasing population of institutionalized children and youth between the ages of 11 and 17. The remaining children and youth have all been placed in secure and safe settings for treatment within the community.

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2. With the MHSA, Community Services and Support Component, the County Mental Health Departments will continue to implement full service partnerships which will greatly assist in the individual with SMI to stay in county settings; this reducing the utilization of Psychiatric Inpatient Beds.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal:

Target:

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: Combining the resources from the Data Infrastructure Grant (DIG) and the Mental Health Services Act (MHSA), the Department has modified its data systems to enable the reporting of Evidence-Based Practices (EBP). These changes were combined with other changes that were needed to the data system. They were implemented for SFY 2006-2007. Since 58 county systems have been modified to report these new data elements, we have had a lag in reporting. Not all counties have returned to regular reporting.

Significance: The Department’s reporting guidelines and standards were disseminated during SFY 2005-2006. DMH has been aggressively training counties by Web conference and regional in-person trainings. In addition, all trainings were recorded and posted on the Internet and could be reviewed at any time. These trainings were intended to guide and direct counties on making system modifications. While on-going technical assistance has been available, a number of counties are changing not only what they collect, but the system they use to collect it. As a result, there continues to be a significant lag in the required county reporting.

Training and technical assistance has been a significant component of the second DIG grant and will be for the third DIG grant. To ensure accurate data collection and reporting, for SFY 2007-08, the Department has and will continue to provide technical assistance to counties as they implement the changes and monitor reporting to identify any reporting problems. The Department expects to report EBP data for SFY 2007-08.

Action Plan:

2010:

1. DMH will continue to implement the children services and programs described in the narrative portions of the current application relating to Evidence Based Practices.
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.

3. DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.

2011:

1. DMH will continue to implement and monitor the children services and programs described in the narrative portions of the current application relating to Evidence Based Practices.

2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.

3. DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	29.68	29.68	28	28
Numerator	1,010	1,010	--	--
Denominator	3,403	3,403	--	--

Table Descriptors:

Goal: To maintain the number of children with SED receiving Therapeutic Foster Care.

Target:

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Children with SED receiving Therapeutic Foster Care.

Measure: CSI System

Sources of Information:

Special Issues: While all 58 counties have modified their systems to report these data elements, eleven counties, including Los Angeles, have not completed reporting for SFY 2007-08, and Los Angeles has not completed reporting for SFY 2006-07. The incomplete reporting hampers the department's ability to set appropriate targets. This is likely due to counties changing not only what they collect, but the systems they use to collect the data.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application relating to Therapeutic Foster Care.
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. The MHSA has made funds available to continue to purchase new systems in order to transition to an electronic health record (EHR) system. It is likely that the movement towards EHRs will improve data quality and decrease the ongoing challenges of reporting lag.

2011:

1. DMH will continue implementation of children services to increase services to Children with SMI who are receiving Therapeutic Foster Care.
2. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and

improved upon.

3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

4. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	48.55	48.55	40	40
Numerator	1,652	1,652	--	--
Denominator	3,403	3,403	--	--

Table Descriptors:

Goal: To maintain the number of children with SED receiving Multi-systemic Therapy.

Target:

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Children with SED receiving Multi-systemic Therapy

Measure: Number of children with SED receiving Multi-systemic Therapy

Sources of Information: Client and Service Information (CSI) system.

Special Issues: While all 58 counties have modified their systems to report these data elements, elevel counties, including Los Angeles, have not completed reporting for SFY2007-08, and Los Angeles has not completed reporting for SFY 2006-07. The incomplete reporting hampers the department's ability to set appropriate targets. This is likely due to counties changing not only what they collect, but the systems they use to collect the data.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application relating to Multi-Systemic Therapy.
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.
3. DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.
4. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
5. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will continue implementation of children services to increase services to Children with SMI who are receiving Multi-Systemic Therapy.
2. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.

3. DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.
4. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	21.77	21.77	30	30
Numerator	741	741	--	--
Denominator	3,403	3,403	--	--

Table Descriptors:

Goal: Functional Family Therapy for Children with SED

Target:

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Children with SED receiving Functional Family Therapy

Measure: number of children with SED receiving Functional Family Therapy

Sources of Information: Client and Service Information (CSI) System

Special Issues: While all 58 counties have modified their systems to report these data elements, eleven counties, including Los Angeles, have not completed reporting for SFY 2007-08, and Los Angeles has not completed reporting for SFY 2006-07. The incomplete reporting hampers the department's ability to set appropriate targets. This is likely due to counties changing not only what they collect, but the systems they use to collect the data.

Significance:

Action Plan: 2010:

1. DMH will continue to implement the children services and programs described in the narrative portions of the current application relating to family functional therapy.
2. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting punctuality and improve data quality.
3. DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.
4. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
5. DMH will work closely with counties and assist with their efforts to report related data elements in a timely manner to ensure the department's ability to set appropriate, measurable targets.
6. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue implementation of children services to increase services to

adults and older adults with SMI who are receiving family functional therapy.

2. DMH will assess county reporting methodology to ensure the quality and timeliness of reported data. Training and technical assistance will be further assessed and improved upon.

3. DMH will continue to explore the development of a database to better inventory the various programs/models (including Evidence Based Practices) being implemented by the counties in operating the MHSA.

4. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

5. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	64.15	69.70	89	89
Numerator	17,775	21,953	--	--
Denominator	27,707	31,495	--	--

Table Descriptors:

- Goal:** To maintain or improve client’s perception of care.
- Target:** The target is to maintain the approximate 89% positive response rate.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percentage of family members of children indicating satisfaction with public mental health services.
- Measure:** Youth Services Survey for Families
- Sources of Information:** The estimates for the numerator and denominator for the current year are obtained by doubling the numbers from the November 2008 data collection period. The numbers do not include data from the May 2009 data collection period.
- Special Issues:** The YSS-F Outcomes subscale was previously used for calculating clients' perceived satisfaction with services. It has been determined that the YSS-F Satisfaction subscale is a more accurate measure of Client Perception of Care; thus, it will not be possible to compare the previous years' scores to the most current scores as the subscales are not comparable. The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.
- Significance:** These data are used to report on client’s perception of care. The DMH encourages counties to use this data locally to improve programs to benefit clients and family members.
- Action Plan:** 2010:
 1. DMH will continue to work with counties to maintain or improve client’s perception of care.
 2. The Youth Services Survey for Families will continue to be administered to identify disparities between what staff intended and what clients perceived was happening to them.
 3. Assist clients in understanding what brought them into the hospital, the goals of current treatment, and the importance of aftercare.
 4. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
 5. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
 6. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue to work with and monitor counties to maintain or improve client's perception of care.
2. The results of The Youth Services Survey for Families will be evaluated to determine what improvements, if any, need to be implemented.
3. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.
4. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.
5. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	91.02	N/A	90	90
Numerator	3,384	N/A	--	--
Denominator	3,718	N/A	--	--

Table Descriptors:

- Goal:** To maintain or improve the clients' perception of improved school attendance.
- Target:** The target is to maintain the approximate 90% positive response rate.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Number of families of children indicating maintained or increased school attendance.
- Measure:** Youth Services Survey for Families (YSS-F)
- Sources of Information:** The estimate for FY 2009 was arrived at by doubling the results from the November 2008 survey period as the data for the May 2009 survey period is not yet available.
- Special Issues:** The school attendance question was not introduced until may 2007, so FY 2007 was estimated by doubling the results from the May 2007 survey. The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.
- Significance:**
- Action Plan:**
- 2010:
1. DMH will continue to administer the Youth Services Survey for Families.
 2. Continue to monitor school attendance for this survey.
 3. DMH target is to maintain the approximate 90% positive response rate.
 4. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
- 2011:
1. DMH will continue to administer and monitor the Youth Services Survey for Families.
 2. DMH will continue its conservative based target to maintain the approximate 90% positive response rate.
 3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	0	55.92	85	85
Numerator	N/A	425	--	--
Denominator	N/A	760	--	--

Table Descriptors:

Goal: To reduce the percentage of children who have encounters with police.

Target: The target is to hold at the current rate of decreased encounters with police.

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Decreased percentage of children reporting encounters with the police.

Measure: Youth Services Survey for Families

Sources of Information: The estimate for FY 2008/09 is arrived at by doubling the numbers from the November 2008 survey period as the data for the May 2009 is not yet available.

Special Issues: Due to the subjective nature of the question, it is possible that the number of individuals reporting reduced encounters with the police artificially high. The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application.
2. The baseline has been established based on data collected from FY 2007-08. This baseline data will be used to monitor increases in school attendance in the upcoming FY 2008-09 and FY 2009-10.
3. The Youth Services Survey for Families will continue to be administered to identify children with SED who report criminal justice involvement.
4. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
5. Through the MHSA Prevention and Early Intervention Program, many Mental Health Departments are working more directly with the juvenile justice systems.
6. MHSA funds support a program through the State Administrative Office of the Courts to increase the number of Mental Health Courts.
7. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application.
2. The Youth Services Survey for Families will continue to be administered to identify children with SED who report criminal justice involvement.
3. The adverse consequences of the economic situation will be further evaluated

and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

4. Through the MHSA Prevention and Early Intervention Program, many Mental Health Departments are working more directly with the juvenile justice systems.

5. MHSA funds support a program through the State Administrative Office of the Courts to increase the number of Mental Health Courts.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To increase the percentage of children receiving public mental health services who report stable housing.

Target: No target set

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure: Not Applicable

Sources of Information:

Special Issues: California does not routinely collect information about housing stability. This is included as a static measure reported as 'living arrangement' collected at admission, and discharge from public mental health services, and is updated annually for consumers who continue to receive services beyond a year. However, it is not well reported which makes times-series comparisons difficult. DMH can provide more detailed information for individuals enrolled in Mental Health Services Act funded, Full Service Partnership (FSP) programs. In examining these data, of the 2,725 children under age 18 who were enrolled in an FSP for at least one year, 975 (35.8%) reported more than one change in living situation in the 12 months prior to enrollment. At 12 months post enrollment, 205 (7.5%) children reported more than one change in living situation. This represents an 79% reduction in the number of children with more than one reported change in living situation during the 12 months after enrollment into an FSP. It is important to note that this sample is not considered comparable to the larger population of individual receiving public mental health services due to the intensive nature of the services provided. However, DMH will provide comparison data for the FY 2010-11 Block Grant Application to demonstrate any changes in housing stability for this cohort.

Significance:

Action Plan: 2010:
 1. DMH will continue to implement the children services and programs described in the narrative portions of Community Services Support and MHSA Housing sections of the application.
 2. DMH will continue to provide detailed information on individuals enrolled in MHSA funded, Full Partnership programs.
 3. DMH will continue to provide detailed information on individuals enrolled in MHSA funded, Full Service Partnership programs.
 4. It is anticipated that the number of children with more than one reported

change in living situation will continue to reduce during the 12 months after enrollment into an FSP.

5. DMH will continue to monitor county reporting and provide training and technical assistance to increase reporting and improve data quality.

6. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.

7. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will continue to implement the children services and programs described in the narrative portions of Community Services Support and MHSA Housing sections of the application.

2. DMH will continue to provide and monitor detailed information on individuals enrolled in MHSA funded Full Partnership programs.

3. DMH will assess county reporting methodology to ensure the quality of reported data. Training and technical assistance will be further assessed and improved upon.

4. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

5. DMH will continue to monitor and evaluate and assess the of the counties transition to an electronic health record (EHR) system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	87.22	89.17	87	87
Numerator	26,958	27,826	--	--
Denominator	30,907	31,204	--	--

Table Descriptors:

Goal: To maintain or increase children's perception of social supports and social connectedness.

Target: The target is to hold steady at 87% of family members of children reporting increased social supports and social connectedness.

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The percent of individuals that indicate increased social supports/social functioning based on subscale scores from the MSHIP Survey.

Measure: Youth Service Survey for Families

Sources of Information: The estimate for the numerator and denominator for the FY 08/09 was arrived at by doubling the numbers from the November 2008 survey period, as the data for the May 2009 survey period is not yet available.

Special Issues: The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.

Significance:

Action Plan:

2010:

1. DMH will continue to administer the Youth Service Survey for Families and track changes in indicators over time.
2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
3. DMH will continue to develop targets for future fiscal years based on the survey indicators.

2011:

1. DMH will continue to administer and monitor the Youth Service Survey for Families and continue to track changes in indicators over time to further establish meaningful targets.
2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
3. DMH will continue to develop targets for future fiscal years based on the survey indicators.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	66.71	72.80	68	68
Numerator	20,554	22,962	--	--
Denominator	30,810	31,542	--	--

Table Descriptors:

- Goal:** To increased the number of children who are reported as having improved levels of functioning.
- Target:** The target is to hold steady at 68% of families of children reporting improved level of functioning.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations
- Indicator:** The percent of individuals that indicate increased social supports/social functioning based on subscale scores from the MSHIP Survey.
- Measure:** Youth Services Survey for Families Survey
- Sources of Information:** The estimates for the numerator and denominator for both prior fiscal years were arrived at by doubling the numbers from the prior survey period.
- Special Issues:** The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.
- Significance:**
- Action Plan:**
- 2010:
1. DMH will continue to administer the Youth Service Survey and track changes in indicators over time.
 2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
 3. DMH will continue to develop targets for future fiscal years based on the survey indicators.
- 2011:
1. DMH will continue to administer and monitor the Youth Service Survey for Families and continue to track changes in indicators over time to further establish meaningful targets.
 2. DMH will explore additional means for reporting and utilizing data for the MHSIP.
 3. DMH will continue to develop targets for future fiscal years based on the survey indicators.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: California Health Interview Survey (CHIS)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** At the county level, to provide data on children who are SED and analyze co-morbid conditions.
- Target:** By June 30, 2010, the DMH will analyze the additional mental health data added to the California Health Interview Survey (CHIC) for Children and Transitional Age Youth (TAY). The DMH will make data available on departmental websites and present findings to interested stakeholders.
- Population:** Children and Transition age youth
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Children and youth with SED
- Measure:** California Health Interview Survey (CHIS).
- Sources of Information:** California Health Interview Survey (CHIS).
- Special Issues:**
- Significance:** CHIS is the largest and most complete source of behavioral health data for California. DMH's continued participation has provided the opportunity.
- Action Plan:**
- 2010:
1. DMH will continue to fund the CHIS surveys.
 2. DMH will look at options for providing and disseminating these findings to program and policy makers as well as mental health consumers and other interested stakeholders.
 3. DMH will use these findings to plan programs and services.
- 2011:
1. DMH will continue to fund and monitor the CHIS surveys.
 2. DMH will provide and disseminate information to mental health consumers.
 3. DMH will continue to use these findings to plan programs and services.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Full Service Partnership (FSPs) Programs for Transitional Age Youth (TAY) with SED

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	3,398	4,542	23	23
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To create a comprehensive mental health system that promotes resiliency for transition age youth with SED/SMI, and their families.

Target: The target is to maintain the percentage of transition age youth with SMI/SED served in Full Service Partnership at approximately 23%.

Population: Transitional Age Youth between the ages of 16 and 25 with SED/SMI.

Criterion: 3:Children's Services

Indicator: Full Service Partnership Enrollment

Measure: Number of TAY enrolled in Full Service Partnership Programs.

Sources of Information: Exhibit 6 Quarterly Reporting

Special Issues: The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.

Significance:

Action Plan:

2010:

1. DMH will continue to implement services and programs to create a comprehensive mental health system that promotes resiliency for children, youth and TAY with SED.
2. DMH will work to maintain the percentage of children, youth and TAY enrolled in FSPs at 23%.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.

2011:

1. DMH will continue to implement and monitor services and programs to create a comprehensive mental health system that promotes resiliency for children, youth and TAY with SED.
2. DMH will continue to work and monitor the percentage of children, youth and TAY with SED who are served in FSPs at 23%.
3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Full Service Partnership (FSPs) Programs for children with SED.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	23,275	35,341	23	23
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To create a comprehensive mental health system that promotes resiliency for children, youth and transition-age youth (TAY) with serious emotional disturbance (SED) and their families.

Target: The target is to maintain the percentage of transition age youth with SMI/SED served in Full Service Partnerships at approximately 23%.

Population: Children/Youth (Ages 0-15) with SED.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Full Service Partnership (FSP) Enrollment

Measure: Number of children enrolled in FSP programs

Sources of Information: Exhibit 6 Quarterly Reporting

Special Issues: The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.

Significance:

Action Plan:

2010:

1. DMH will continue to implement children services and programs described in the narrative portions of the current application relating to FSP Services for Older Adults in Rural Counties.
2. By June 30, 2010, the percentage of Children enrolled in FSP will be maintained at 23 %.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue implementation of Children services to increase services to Children with SED who are receiving assertive community treatment.
2. DMH will monitor enrollment of children enrolled in FSP to maintain the 23% goal.
3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.
4. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Full Service Partnership (FSPs) Programs for homeless children, youth and TAY with SED in rural counties.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	24	31	9	9
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: To create a comprehensive community mental health system that promotes resiliency for children, youth and transition-age youth (TAY) with SED/SMI, and their families.

Target: The target is to maintain the percentage of children, youth and TAY living in rural counties enrolled in Full Service Partnerships at 9%.

Population: TAY (Ages 16-25) with SED/SMI.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Increased enrollment of children and TAY in rural counties enrolled in Full Service Partnership Enrollment.

Measure: Number of childre, youth and TAY enrolled in Full Service Partnerships.

Sources of Information: Full Service Partnership Outcomes.

Special Issues: The targets for FY 2010 and 2011 are conservative based on the State's current budget and economic downturn.

Significance:

Action Plan:

2010:

1. DMH will continue to implement the children services and program described in the narrative portions of the current application relating to FSP Services for Children in Rural Counties.
2. By June 30, 2010, the percentage of children in rural counties enrolled in FSP will be maintained at 9 %.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue to implement and monitor the children services and program described in the narrative portions of the current application relating to FSP Services for Children in Rural Counties.
2. DMH will monitor enrollment of Children with SED living in rural areas in FSP programs.
3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program

areas are affected to the least possible level.

4. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Strategies for Increasing the Diversity of the Workforce

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

Goal: Support activities of the California Mental Health Planning Council (CMHPC) to serve as a statewide catalyst to address the shortage of mental health staff.

Target: By June 30, 2010, complete a report that will describe successful strategies for engaging the broader cross-disability community in public mental health educational and workforce development programs. By June 30, 2011, conduct a Family Member/ Parent Partner DACUM (Developing a Curriculum) .

Population: Children diagnosed with SED

Criterion: 5:Management Systems

Indicator: 2010: A completed report submitted to the Department of Mental Health 2011: A completed DACUM submitted to the Department of Mental Health

Measure: 2010: A completed report submitted to the Department of Mental Health 2011: A completed DACUM submitted to the Department of Mental Health

Sources of Information: 2010: A survey of national and statewide strategies to increase workforce diversity. Convening a series of regional roundtables workgroups to review findings and provide input. 2011: Work group convened to perform the DACUM process

Special Issues:

Significance: 2010: California Mental Health Planning Council (CMHPC) is dedicated to promoting strategies that engage diverse communities in contributing to the work of the CMHPC and developing education and workforce pipelines that lead to increasing the diversity and inclusiveness of the workforce. The CMHPC believes that an inclusive and diverse workforce is a significant strategy for eliminating health and mental health disparities. Consequently, the CMHPC Human Resources Committee has developed a Diversity Project to:
 Identify workforce development strategies, especially those strategies that reach-out to the broader cross-disability community. The broader disability community includes all individuals with a mental or physical condition that limits one or more major life activities, such as learning, walking, seeing, thinking, working, breathing etc.
 Receive input on the components of the Five-Year Plan
 The mechanism selected for obtaining input and conducting outreach was the development of at least three regional roundtables (far north, central, and far south). Roundtable participants will be comprised of individuals and representatives from organizations that are selected by CMHPC. Participants will be asked to respond to the workforce strategies outlined in the DMH plan for workforce development entitled, Mental Health Services Act Five-Year Plan. In

addition, participants will be asked to provide information on innovative approaches to workforce development and deployment not described in the DMH plan that engage the broader disability community. A report will be published detailing the findings of the roundtable participants that will be provided to the Department of Mental Health and shared with public mental health organizations throughout California.

2011: The employment of family members and parent partners is vital to the transformation of the public mental health system. In order to increase the capacity of family member and parent partner participation in the public mental health system, county mental health departments have developed the peer support specialist, peer advocate position, parent partner, and family advocate positions. Understanding the duties, knowledge, skills, and abilities of this vital occupational niche is critical to developing additional training programs and being able to expand career mobility opportunities for individuals who are working within these positions. A family member and parent partner DACUM will allow for a more standardized review of the roles and responsibilities of family members and partner partners in the public mental health system. In addition, a DACUM will enable employers to determine the training that will best enhance the work of family members and parent partners, allowing organizations to develop career ladders that link to other professions. Lastly, the DACUM will assist in documenting the differentiation of duties, roles, and responsibilities of family member advocates and parent partner advocates, who are dealing exclusively with issues of aiding parents who have a child in need of or receiving public mental health services.

Action Plan:

2010:

1. DMH will continue to work with the CMHPC to promote strategies that encourage the contribution of diverse communities for increasing the diversity of the workforce.
2. Complete a report by June 30, 2010 that describes successful strategies for the increase of diversity in the public mental health workforce.
3. Given the current economic situation, special emphasis will be focused on services and program areas impacted by budget cuts, staffing reductions and other adverse impacts of the state of affairs.
4. DMH will work closely with developing evaluation efforts that are currently underway through the MHSA.
5. DMH will monitor and evaluate the counties transition to an electronic health record (EHR) system.

2011:

1. DMH will continue working with the CMHPC to develop and implement strategies that encourage the contribution of diverse communities for increasing the diversity of the workforce.
2. By June 30, 2011, conduct a Family Member/ Parent Partner DACUM (Developing a Curriculum)
3. The adverse consequences of the economic situation will be further evaluated and reparative action will be taken to ensure impacted services and program areas are affected to the least possible level.
4. DMH will continue to monitor and evaluate and assess the progress of counties transition to an electronic health record (EHR) system.

Upload Planning Council Letter for the Plan



August 25, 2010

CHAIRPERSON

Gail Nickerson

EXECUTIVE OFFICER

Ann Arneill-Py, PhD

Stephen W. Mayberg, PhD, Director
Department of Mental Health
1600 9th Street
Sacramento, CA 95814

Dear Dr. Mayberg:

The California Mental Health Planning Council has received the 2011 Community Mental Health Services Block Grant Application. This is the application for the second year of a two-year application. As such, it has only minor revisions and is substantively the same as the year-one version of the application.

The Planning Council has already conducted a comprehensive review of the year-one version of this application. We are satisfied that this version of the plan does not require additional review. We look forward to the new process and format that will be in effect for the 2012 year.

Sincerely,

A handwritten signature in cursive script that reads "Gail Nickerson".

Gail Nickerson
Chairperson

1600 9th Street
Sacramento, CA 95814
916.651-3839
fax 916.651-3922



John Wickham

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.