

January 23, 2006

Notes on San Francisco County Community Services and Support Plan

Reviewed by: Tricia Wynne, Hector Mendez, Mark LeBeau, Blanca De Leon and Rosie Lamb

Consumer and Family Involvement: The committee agreed that San Francisco, right from the inception, notes that consumers and family members will be full partners in this process. Consumer and family input was prominent throughout the plan. The County should be commended for using language that focused on the strengths of individual consumers, as opposed to helping individuals from a deficit and pathological perspective. The policy papers written by diverse populations regarding mental health services needs and submitted to the County were a great idea. However, the service information and needs of the populations were not adequately included in the plan. Specifically, the needs of the Native American population were ignored. The Committee suggests that these deficiencies should be corrected. The committee was pleased that, for the most part, the plan is inclusive of doing “with” many of the consumers and families rather than “for” consumers and families.

There is a discussion, a plan, and a clear commitment to hire many consumers and families.

Wellness/Recovery/Resilience: The Committee noted that San Francisco made an extraordinary effort in defining and attempting to move the County toward a system of wellness and recovery-resilience. The discussion of efforts toward transforming a complex county mental health system is central to the overall plan.

The proposed plan demonstrates willingness to make “dramatic changes.” The plan proposes to include consumers and families as members of Boards of Directors and Advisory Committees. The plan includes descriptions of efforts to open “employment opportunities for consumers and families” while assuring that clients will be part of the “decision making” process in the treatments they receive.

The County plan describes the broad themes and describes the necessary components for system transformation and presents in detail the challenges affecting many underserved or unserved populations. And, although the plan describes the number of consumers to be served, the proposed outcome indicators appear to be too general throughout the plan.

Education and Training and Workforce Development: The San Francisco plan refers to the need to implement trainings for consumers and families for the purpose of making sure they understand the nature of mental illness as well as improve their understanding of the system of care. The plan also documents the need to improve the proficiency of service providers with respect to their ability to *work with* diverse populations. The plan however describes no one time funding for “serious training” effort.

There should be plans to training on cultural competency. This is an investment in the community and an investment in county providers of services. In order to be effective, decision makers and staff must understand unique mental health needs and services and provide such programs.

The committee notes that comprehensive “retraining” of existing staff to insure a transformational outlook, focused on recovery and wellness is an essential piece of any successful plan. The Committee believes that consumer and family members should be hired to do this training. Counties should be investing in retraining their workforces; the State should be helping with this training program. The budget for training should be considered throughout the plan.

Shortcomings: The Mental Health Services Act includes a very specific requirement that all counties must develop a Wraparound Program for children and their families as an alternative to group home placement. This is a requirement of specific interest to the Oversight and Accountability Commission as it is an essential component of transforming children’s mental health services by reducing unnecessary reliance on institutional care and developing intensive community services and supports for seriously emotionally disturbed/mentally ill children, adolescents and their families. Specifically, the MHSA (Section 10, Part 3.7, section 5847(a) (2) states:

“Each county mental health program shall prepare and submit a three year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following ... (2) A program for services to children in accordance with Part 4 to include a program pursuant to Chapter 6 of Part 4 of Division 9 commencing with Section 18250, or provide substantial evidence that it is not feasible to establish a wraparound program in that county.”

Wraparound, as defined in W&I Code commencing with Section 18250(a), is intended “to provide children with service alternatives to group home care through the development of expanded family-based services programs.” Note that this statutory language states that wraparound service is an alternative to group home care – not simply a step-down program. SB 163 programs, codified in Section 18250-18257 of the W&I Code, are very intensive services for children or adolescents who would otherwise be placed in high-level group homes at Rate Classification Level (RCL) Level 10 through 14. SB 163 makes the funds that otherwise would have been used for group home placement available instead for intensive Wraparound service as an alternative to the group home placement. This level of funding is essential to assure that the level of staffing and intensity of service required to support children with this high level of need is provided, so that SB 163 Wraparound Programs are in fact a viable alternative to intensive group home programs. The California Department of Social Services (CDSS) document “Review of Wraparound Standards, Guidelines for Planning and Implementation” (attached) includes the staffing ratios expected in a SB 163 Wraparound program.

It should be noted that SB 163 was based on the premise that the state and county share of the nonfederal reimbursement for group home placement would instead be made available to support Wraparound as an alternative to group home placement in a manner that was cost neutral to the state and to the county, i.e., it would cost the state and the county no more to provide intensive Wraparound services than they otherwise would have spent for group home placement for the same child. Because almost all the children that are, or otherwise would be placed in a group home program, are eligible for MediCal and EPSDT, very few MHSAs other than the 5% EPSDT match are required to develop a SB 163 Wraparound program. The W&I Code commencing with section 18250, which is the code section for SB 163 programs, states, in part, “(b) It is the further intent of the legislature that the pilot project include the following elements: (1) making placement, minus the state share, if any, of any concurrent out-of-home placement costs, for children eligible under this chapter, for the purpose of allowing the county to develop family-based service alternatives.” Section 18254 (c) states “The department shall reimburse each county, for the purpose of providing intensive wraparound services, up to 100 percent of the state share of nonfederal funds, to be matched by each county’s share of cost as established by law, and to the extent permitted by federal law, up to 100 percent of the federal funds allocated for group home placements of eligible children, at the rate authorized pursuant to subdivision (a).” Accordingly, any new or expanded Wraparound program meeting the requirements of the MHSAs should include the state and county share of the group home rate for each wraparound slot to assure that the level of staffing and intensity of service required to support children with this high level of need is provided.

The Mental Health Services Act, anticipating that counties would need technical assistance to develop SB 163 Wraparound programs, includes a provision (Section 6, 18257(b) that funds from the Mental Health Services Fund shall be made available to the Department of Social Services for technical assistance to counties in establishing and administering these projects. This technical assistance is available, at no cost to the county, by contacting Cheryl Treadwell, Program Manager, CDSS, at (916) 651-6023.

One other shortcoming in the plan is that the County notes a growing population affected by Autism. The plan notes this but fails to make a commitment to working closely with the Golden Gate Regional Center for the Developmentally Disabled funded by California Department of Developmental Services. In fact, the input obtained from SF Disability Task Force is not included in the plan as to how San Franciscans with disabilities will be served.

Collaboration: San Francisco has a history of inclusion, and in this plan, the county worked closely with local institutions and community based organization (150) in addressing the critical needs of a challenging, multi-racial and multi-ethnic population, primarily those of Asian and Latino descents. The county’s effort is documented very effectively.

The proposed plan demonstrates a wide partners involvement in the process with excellent references to minutes and manners of collecting input. The plan describes who the partners are and how many of them are part of the Plan Task Force composed by 40 members only. The plan includes efforts to continue to serve a diverse population and presents excellent demographic research demonstrating who needs services and the type of service needed.

The committee had two concerns on the issue of collaboration. First, the County discussed the growing Arab and Russian population but did not necessarily work to engage them in the process. There was also concern that the Native American population was not as involved as it should be. The second concern was that the County discussed partners who had funding to do similar projects and the desire for leveraging funds. However, there was not a discussion of how these groups could become true partners, not just financial partners.

Finally, the Plan included excellent references to the inclusion and consideration of various techniques and strategies to obtain input from the community. The county utilized position papers, surveys, peer-to-peer interviews, penetration analysis, transcripts, and summaries of meetings. Consumers and Family input was found in most information gatherings. The plan showed a great deal of effort to carry out community education opportunities to share the purpose of the MHSA planning process prior to full implementation. In fact, the kick-off gathering in which key San Francisco leaders attended attracted more than 200 diverse groups.

The Committee believes that the Task Force and the Advisory Committees could be valuable resources, but it did not get a sense as to who were the consumer and family representatives who would be included. The document indicates that at least 25% of this group should be consumers and families. The County should clarify ethnicity, sexual preference, disability etc. in the composition of the Task Force.

Plan #1 Full Service Partnership for Youth: This plan would offer services to 27 to 34 children and youth with coordination of both clinical and wraparound services. It will be comprehensive, integrated, family-center and strength-based approach. Clearly, this program will serve children well. The committee continued to question where was the discussion of the wraparound program that counties are required to develop and expand?

In the system development piece, the county will begin to offer mental health services in pediatric settings for early identification of mental health problems. This approach certainly addresses the priorities of the MHSA—decreasing barriers to access, reducing stigma and providing early interventions. The county also will replicate an existing violence and trauma recovery community service that has been operating successfully in the Latino Community for the last several years. The County will continue to organize and expand clinical capacity for youth targeting in ethnic/cultural populations. The county will rely on community based, non-profit providers. Finally, the County will expand its successful High School Wellness Center program that is offered in 8 high

schools. The committee questioned what happens to teens who attend alternative high schools and charter schools.

Plan #2 Full Service Partnership for TAY: This program will target youth between the ages of 16 and 25 with serious emotional disorders and their families. The services will focus specifically on African Americans, Latinos and youth who identify as LGBTQ. The FSP will offer client-driven and family-centered care to approximately 31 TAY.

In the system development piece, the county will offer psychiatric services in primary clinic settings serving primarily youth and young adults. This early intervention piece also addresses the issues of access and stigma.

The County also addresses the need for safe and permanent housing. Housing will be a key component in this program. The County will develop a range of housing options for TAY. The focus will be on a continuum of residential options and will strive for stability. The County will leverage its MESA dollars with the Mayor's housing program.

Finally, the County will support youth-run/developed programs to promote peer support, youth empowerment, and youth engagement activities. The program will promote resiliency and recovery. The committee noted that providers must be culturally competent to meet TAY where they are.

This TAY program relies heavily on collaboration with partners both at the county level and other non-profit community based organizations. The County keeps family and consumer concerns at the forefront of its descriptions. It also provides a Mobile Crisis service that will provide crisis interventions seven days a week, up to 12 hours a day.

Plan #3 Full Service Partnership for Adults: An enrollee based program will be developed to serve adults who are experiencing most severely the effects of untreated (or under-treated) serious mental illness. The risk factors are: chronic homelessness; and/or getting incarcerated; and/or revolving through the doors of acute or institutional psychiatric care, or recurring emergency medical care. This FSP will provide "whatever-it-takes" wrap-around services to 27 – 34 of the most seriously mentally ill individuals with an aim towards wellness and recovery.

In the system development for adults, the County has identified supportive housing services as one of its topmost priorities. The county has budgeted \$131,000 per year to supportive housing for adults. This should provide supporting housing for 30 – 40 consumers. The Committee would like to know where housing will be placed.

The county will budget \$100,000 per year for vocational rehabilitation services for adults; this will match an additional \$300,000 in Dept. of Rehabilitation dollars. This will provide the full range of vocational rehabilitation services for 50 consumers a year.

The County will enhance a consumer-operated peer-support service within the system by funding a peer-run drop-in center, which will also staff a warm line. They will also fund

additional beds in a residential treatment program for consumers who are undergoing acute crisis.

The Committee believes that law enforcement is a first responder in so many cases. Law enforcement should be a stronger, more engaged partner in every aspect of the adult program. They should receive training right alongside county mental health staff.

Plan #4 Full Service Partnership for Older Adults: A FSP will be developed to serve older adults experiencing most severely the effects of untreated (or under-treated) serious mental illness. The older adults who will benefit from this program will be: experiencing homelessness, repeatedly coming to the attention of APS; revolving through the doors of acute or institutional psychiatric care; or at-risk of high-level out-of-home institutional care due to untreated mental illness. The program will serve 34 – 43 of the most vulnerable, mentally ill older adults.

The system development piece will include a senior recovery center with peer outreach and support. Collaboration will be leveraged with an already existing older adult service provider to add this service on top of the existing ones. The committee was concerned that suicide prevention was not mentioned in the older adult program.

There will be services for supportive housing. Money from the MHSA will be leveraged with money provided through the Mayor's housing program, which will provide ongoing supportive housing services for 60 – 70 older adult consumers. The County will also provide mental health services in primary care settings, thereby increasing access and reducing stigma.

CONCLUSION:

Question: The overarching question for the Oversight and Accountability Commission is: "How will the three-year Community Services and Supports plan move your county system toward the standards of service in the Mental Health Services Act?" The Commission asks that you answer this question in your plan.

At the same time, the Commission recognizes the need to build a more reliable baseline of information available to everyone, so that answers can be understood within a context. To do so, the Commission is seeking to develop a description of the mental health system in your county, and in all counties, including an explanation of the structure of the service delivery system, access policies for all children and adults, and range of services received by those not in a categorical funded program.

The Commission is working to develop a baseline to assess the gaps between existing standards of care in mental health and the comprehensive, integrated services envisioned by the Mental Health Services Act. Statewide and national reports tell us that services have been limited and effectively rationed because funding is not tied to caseloads. The Commission believes it will be advantageous to all of the individuals and the private and public organizations involved in change, and beneficial to the public, to have a realistic understanding of the challenges to transforming the mental health system.

The Commission would like to know the average caseloads for personal service coordinators and/or case managers and for psychiatrists for the largest percentage of people served. We would like to know what percentage of all mental health consumers are receiving or have access to comprehensive, appropriate, and integrated services, such as individual or group therapy, family counseling, routine medical and dental care, educational or vocational training, substance abuse treatment, supportive housing, and other recovery-oriented services.

To begin with, the Commission will compile available data from traditional sources, and utilize the information you have provided in the CSS plan. In this first year of implementation, we will be enlisting your assistance in measuring the magnitude of changes taking place now and the prospective changes for many years to come. The Commission also will be asking you to determine and report on what resources are lacking in your county. The CSS Committee recognizes the tremendous effort involved in the planning process and commends the county on its many successes.