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Evaluation of Tulare County MHSA Three Year Expenditure Plan

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A few preliminary comments: Overall, the county recognized that delivery of services begins with talking with the consumer in his or her preferred language. There was an impressive effort at outreach in the planning process. The county recognized the need for pay incentives for professional staff that are bilingual. The County made efforts to engage in intense outreach to the unserved and underserved consumers in the county. There were indications of collaboration throughout the process and throughout the plan.

The County spent time to identify the community needs and made efforts to address them. Additionally, the County proposed several innovative programs that show great promise—including addressing directly the almost insurmountable transportation issues in the county. Finally, the plan addressed the need to do far greater outreach than had been done in the past.

There was concern that this plan did not fully embrace the wellness and recovery models included in the MHSA. Although the plan is not “business as usual,” there did not seem to be a transformational approach to services, nor was there an integration of the “whatever it takes” that is necessary to fully serve the consumers and families. The Commission hopes that Tulare County will take a more direct approach to wellness and recovery models by next year.

The committee would have liked the plan to be more specific in terms of goals or milestones for assessing the adequacy of their plans to achieve results, whether it is consumer served, cultural competency, housing needs met, etc.

Consumer and Family Involvement: There is a concern that “grass roots” outreach is very vague. The plan emphasizes the need to work with the Latino population, which is a very large population in the County. However, there are other minority populations in Tulare County, specifically Native American and Asian/Pacific Islanders whose needs were not discussed or addressed anywhere in the plan. The committee would like the County to address these populations in the next plan.

The OAC believes that in a transformed mental health system, services will be client driven and family involved. Here, the county articulated the involvement of clients and

families, but there was not a lot of evidence of consumers and families driving this system change. First steps are being taken. In this plan, there no clear commitment to hire many consumers and families throughout each work plan that should be a priority.

Wellness/Recovery/Resilience: The County plan did not reflect an adoption of wellness and recovery models that are essential to a system transformation. There was no detailed analysis that really reflected the need for dramatic change in the delivery of mental health services. It is clear that this County has further to go than other counties who have already begun to deliver mental health services in a more strategic way. The attention given throughout the plan to the unserved and underserved did indicate that the County intends to do better; there was a sense that the County was willing to work with this population.

Education and Training and Workforce Development: The plan did discuss the partnerships that it is creating with colleges in the area in order to recruit a more diverse and better-trained workforce as the MHSA is implemented. Perhaps the county should consider a stipend for young people in college who would consider pursuing a degree in social work. The intensive training that is needed in this county on wellness and recovery, both county providers and contract providers, is apparent throughout the plan. The committee believes that training should be a priority with MHSA funds. Finally, the committee believes that other county partners, including law enforcement, should receive the same trainings that mental health providers receive.

The plan was vague in terms of employment opportunities for consumers and families. There was a reference that contract providers would be required to meet certain targets. It is recommended that career paths be developed for family members and clients throughout the plan.

There should be training opportunities on cultural competency beyond linguistics. 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.

Collaboration: This County appears to have a long list of collaborators or partners, but it is not clear what the relationships include. The committee would like to see a better documentation of what resources each partner brings to the table, how often partners meet, where the linkages exist and where they could be created, and what this newer more robust relationship will produce. There is a lot of work to do to get beyond business as usual. There are additional relationships that need to be developed with community organizations. This will add to an enriched, consumer-driven system.

The committee had two concerns on the issue of collaboration. First, as discussed above, the County did not address any minority group beyond the large Latino population. There must be efforts made to engage all groups into this process. There was also concern that the Native American, African American, and Asian/Pacific Islander

populations were not as involved as they should be. While the plan makes reference to CBO's, their service roles are not well described as to who, what and why they will be active members of the MHSA plan.

The commission recommends that the county evaluate the increased utilization of CBO's to better meet their outreach and engagement goals.

The OAC has a concern that in this plan, the County relies too much on existing relationships and should be pushing itself to create new relationships. Additionally, the County should push itself to get better educated on issues relating to cultural competency, especially in the LGBTQ communities.

Plan #1 Full Service Partnership for Children and TAY:

Tulare County does not have any programs that could be considered full service partnerships—nor does it have a wraparound program. The County has three years to come into compliance and the committee would like to see a SB 163 Wraparound Program established as soon as possible.

MHSA Requirement for Wraparound Services for Children, Youth & Families

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.”

According to Webster's New Collegiate Dictionary, “feasible” means “capable of being done or carried out.”

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 MHSA funds 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 available to the county the state share of nonfederal reimbursement for group home 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 MHSA 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.

The proposed plan includes a full service partnership for children and youth in a one-stop center. The priority population will be children and TAY with SMI and/or SED; children and youth at risk for out-of-home placements, leaving placement, current or previous involvement with the juvenile justice system, special education and alternative school students.

This one stop center is a good idea, but the FSP proposed is not based on a recovery model, nor does it embrace a “whatever it takes” philosophy which is essential in FSP. There is a vague description of what role partners play in this program. Additionally, there are no clear goals articulated for this program. There is concern that this one stop

center will result in services, which are compartmentalized, rather than holistic. In reading this work plan, there is no clear commitment to recovery and collaboration. Services are not wrapped around a consumer, instead, a consumer can choose between services offered.

The committee would like to see a better description of this program in the next plan submitted. It would like the services to be consumer centered and family involved. Better training of staff and partners is an important part of this plan.

Plan #2 Supportive Housing for TAY:

The County is commended for addressing the need for supportive housing. Housing is a key component of any full service partnership; this proposal is a good first start for TAY. The plan proposes supporting housing for 10 TAY with case management living on site. There is language in the plan by bridging housing with one-stop centers, the consumer will have wrap-around services (p142). This language really shows a lack of understanding as to what wrap services are. This statement misses the mark. Further, the statement on the next page that the consumer must abide by the rules of the program shows a very top-down approach to TAY services, and an approach that does not work with this population.

Once again, the committee was concerned that there was not a good discussion of the challenges with this population. The committee suggests that this could be addressed with training and retraining opportunities.

Plan #3 and #4 Full Service Partnership for Adults and Older Adults: Unidos Para La Salud/United for Health (North County Mobile Unit and a South County Mobile Unit) which will serve the underserved and unserved children, youth, TAY, adults and older adults in urban communities. Clearly, this plan addressed a need that the communities expressed, “bring services to my community.” This plan states that it is a full service partnership and uses FSP dollars, but it is not FSP. The committee believes that this scattershot approach is not as well planned as it should be. It attempts to do too much, without any ability to provide the type of services that this population needs.

The Older Adult population needs a different kind of service than can be offered in a mobile unit. This problem of isolation and distrust of the mental health providers will not encourage older adults to take advantage of this program. The plan does address the transportation issues that the community described as important, but this mobile unit will not address the myriad needs facing this population.

The committee would like to see the county revisit the concept of FSP (whatever it takes) and design a program with those essential elements in mind.

CONCLUSION

Question: The overarching question for the Oversight and Accountability Commission is: “How will the three-year CSS plan move your county system forward to meet the standard of comprehensive, timely, appropriate services in the Mental Health Services Act?” **The Commission asks that the county prepare to answer this question as the first year of CSS plans are implemented.**

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.

In the coming year, the Commission will seek information such as 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.