Handouts
from
MHSA 2010/2011
Annual Plan Update
and Capital Facilities
Project Proposal
Public Hearings

MHSA
FY 10/11 Annual Update
DMH Info. Notice 10-01

Overview of Requirements for Plan Update
April 5, 2010

Overview of MHSA FY 10/11 Guidelines

- Purpose of DMH Information Notice No. 10-01:
  - Provides guidelines for Counties to submit for the Fiscal Year (FY) 2010/2011 annual update to their MHSA Three-Year Program and Expenditure Plans (Plan).
- What Can Be Approved through the Update:
  - Previously Approved Programs
  - New Programs
  - New Projects
  - Community Program Planning Limits

Overview of MHSA FY 10/11 Guidelines - *Continued*

- What can be approved, continued:
  - Administrative Costs
  - Local Prudent Reserve
  - Submission
- Definitions Revised for: "Work Plan", "Annual Update", "Update", "Program", "Project", "Work plan"

Previously Approved Programs

- CSS & WET
  - Same target populations with the same services/strategies/activities as approved in the County's most recently approved Plan or update.
  - Amount requested is within 15% of the amount previously approved for the program (15% plus or minus).
- Innovation
  - Same purpose and key learning goals using program and strategies consistent with the County's most recent approved Plan, annual update, or Plan update.

2010-2011 Annual Update

Previously Approved Programs *(continued)*

- Innovation, *continued:*
  - Amount requested is within 15% of the amount previously approved for the program (15% plus or minus)
- PEI (Programs)
  - Same key community mental health needs and priority populations with same activities that are consistent with the most recently approved annual update.
  - Amount requested is not greater than 15% or less than 35% of previously approved program.

New Programs

- CSS & WET
  - Existing programs with a change in target population, service description, services/strategies/activities, or funding levels from the currently approved program.
  - Existing programs proposing consolidation, expansion, and/or reduction beyond previously approved definition.
- Innovation
  - New programs or existing programs proposing to change the essential purpose and/or learning goals, or expand or reduce funding levels greater than 15% from currently approved Program.

New Programs - *continued*

- Innovation - *continued*
  - Consolidation of previously approved programs is considered a new program.
- PEI
  - Existing programs proposing to change key community mental health needs, priority populations
  - Funding levels greater than 15% or by less than 35% from currently approved program
  - Existing programs proposing consolidation, expansion, and/or reduction beyond previously approved definition.

New Projects

- Capital Facilities/Technology Needs (CFTN)
  - Projects are considered single, time-limited projects.
  - Requests for CFTN should follow the guidelines for a new project.
  - Expansion of an existing CFTN project beyond the originally approved scope is considered a new project.

Majority Requirement for Full Service Partnership (FSP)

- A County may choose to provide FSP services using funds other than MHSA, including but not limited to Medi-Cal, Medicare, and State General Fund
- If using funds other than MHSA, the County should provide an explanation and specify the amount and type of non-MHSA matching funds used to meet the marjority requirement.

Community Program Planning Funding Limits

- Funds shall not exceed 5% of any single component's Planning Estimate per FY
- CPP funds may be used to plan for any of the components;
- Exception: Counties who haven't submitted a PEI and/or INN Plan may exceed the 5% overall funding limit
  - (See DMH Info. Notices 08-27, 08-36, 09-02 for more information)

Administrative Costs

- Up to 15% of total cost of direct client services
- Costs exceeding 15% must be accompanied by a signed statement by the County Mental Health Director
- Administrative costs are divided into two categories:
  - Direct service costs, and
  - Indirect administrative costs

Administrative Costs – *Direct Services Costs*

- Costs associated with delivery of services tied to a specific program/project
- These direct costs should be included in the work plan budget for the program/project
- Examples: salaries and benefits of employees, operating expense, cost of materials, travel expense, cost of contract, etc.

Administrative Costs – *Indirect Costs*

- System-wide MHSA administrative costs are budgeted separately from direct costs.
- Costs exclude funds dedicated to the Operating Reserve or Local Prudent Reserve.
- Examples of these expenditures are salaries and benefits of employees in support units such as accounting and budgeting, or centralized personnel units. (The MHSA portion of the county-wide A-87 costs).

Local Prudent Reserve

- Due to current revenue projections for the MHSA fund, DMH has determined that the Local Prudent Reserve threshold has been met.
- The 50% requirement is being suspended in FY 10/11
- Assessing Local Prudent Reserve:
  - Counties may access these funds by submitting a MHSA request – this only applies to CSS and PEI
- Funding Local Prudent Reserve:
  - Counties choosing to continue funding Local Prudent Reserves should submit an Exhibit G.

Submission

- One hard copy and one electronic copy with a single document in PDF format to be submitted to both the MHSA Plan Review Section and MHSOAC.
- To ensure payment by July 1, 2010, for FY 10/11 funding requests, the MHSA Plan updated should be submitted by April 15, 2010.

MHSA ALLOCATIONS FOR 2010/2011

- For Community Services and Supports: $17,715,700
- For Prevention and Early Intervention: $5,016,100
- For Innovation ("INN")
  $2,719,300

TIME FRAME FOR SUBMISSION

- January 12, 2010 - Guidelines Issued
- February 10, 2010 - CPAW Data Committee
- March 4, 2010 – Draft Plan Update to CPAW
- March 5, 2010 – 30 Day Public Review & Comment Period Begins
- April 5,6, or 7, 2010 – Public Hearing by Mental Health Commission
- April 15, 2010 – MHSA FY 2010/2011 Annual Plan Update due to DMH

Mental Health Services Act Community Supports and Services (CSS) Outcomes

FY 2008-2009

MHSA 2010/2011
Annual Update
April 5, 2010

Outline

- MHSA Outreach and Engagement
  - Overview
- MHSA Progress Report
  - Overview
  - FSP's; Housing; Systems Development Strategies
- FSP Outcomes
  - Enrollment
  - Demographics, Employment, Arrests, School Grades, School Attendance, Hospitalizations

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CSS

MHSA Outreach and Engagement FY 2008-2009

	O&E with Individuals	O&E with Groups
Outreach and Engagement with Potential Full Service Partners		
Program	**# of People Engaged**	**# of Community Forums/ Presentations**
Children FSP	511	61
TAY FSP	150	10
Adult FSP	37	8
TOTAL	**698 Unique People Engaged**	**79 Community Forums/ Presentations**
Housing		
Housing For:	**# of People Engaged**	**# of Community Forums/ Presentations**
Children	0	
TAY	228	
Adults	684	
TOTAL	**912 Unique People**	
System Development Strategies		
Program	**# of People Engaged**	**# of Community Forums/ Presentations**
OCE	518	24
Wellness Program	1588	49
Older Adult Program	111	116
TOTAL	**2217 People Engaged**	**189 Community Forums/ Presentations**

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MHSA Progress Report FY 2008-2009

	1st Quarter (07/01/2008 - 09/30/2008)	2nd Quarter (10/1/2008- 12/31/2008)	3rd Quarter (01/01/2009- 03/31/2009)	4th Quarter (04/01/2009- 06/30/2009)
Full Service Partnership Enrollment				
Program	**# of FSP's**	**# of FSP's**	**# of FSP's**	**# of FSP's**
Children's FSP	51	58	82	90
TAY FSP	43	51	60	60
Adult FSP	117	121	137	152
TOTAL FSP's	**211**	**230**	**279**	**302**
Housing for Full Service Partners				
Program	**# of FSP's**	**# of FSP's**	**# of FSP's**	**# of FSP's**
Children FSP	0	4	2	2
TAY FSP	22	35	33	37
Adults FSP	99	87	87	94
TOTAL FSP's	**121**	**126**	**122**	**133**
System Development Strategies				
Program	**# of Consumers**	**# of Consumers**	**# of Consumers**	**# of Consumers**
OCE	4	53	30	34
Wellness Program	417	434	791	535
Older Adult Program	17	30	49	53

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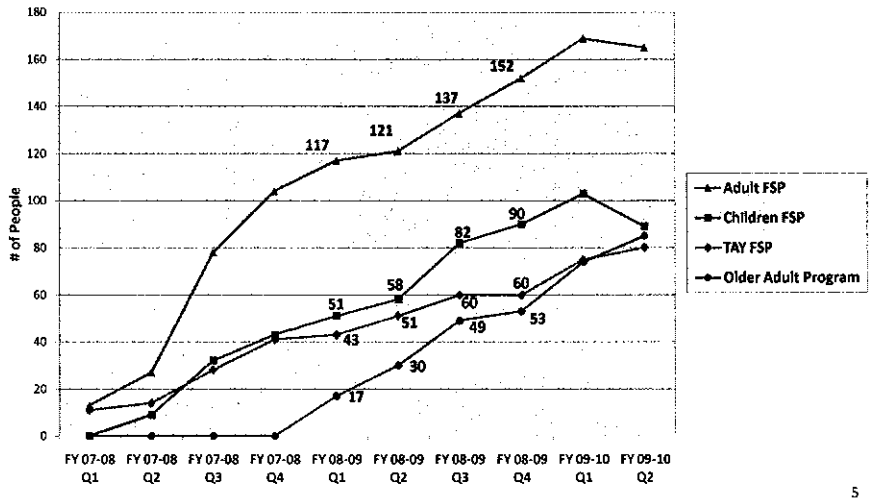
MHSA Progress Report

FSP & Older Adult Enrollment Trends



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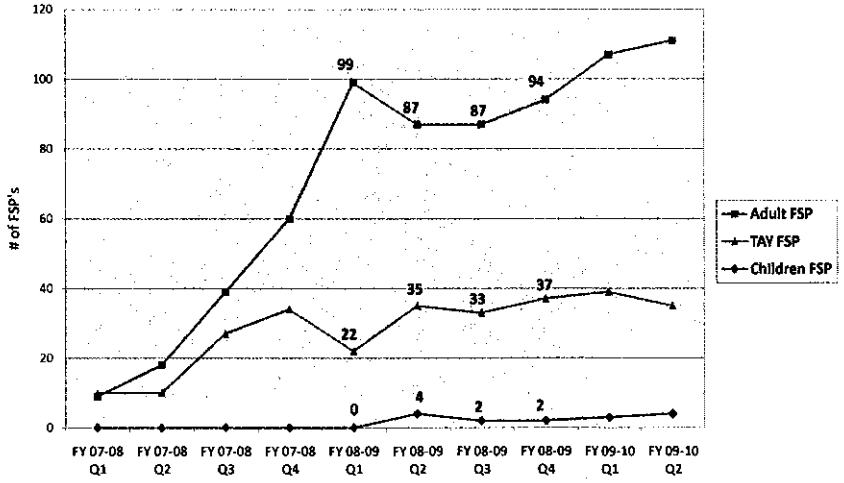
MHSA Progress Report

Housing for Full Service Partners



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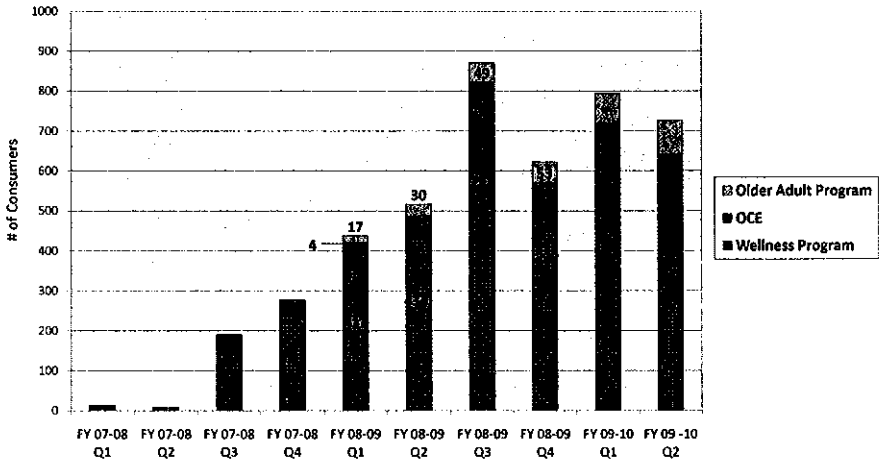
MHSA Progress Report

Systems Development Strategies



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Full Service Partnership Outcomes FY 2008-2009

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FSP Outcomes Continued

Program Capacity End of FY 2008-2009

Program	# of FSP's Enrolled	Program Capacity	% of Capacity
Children	90	100	90%
TAY	60	90	67%
Adult	152	150	101%

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FSP Outcomes Continued

FSP Demographics FY 2008-2009

	Children FSP's	TAY FSP's	Adult FSP's
Average Age	12 years old	21 years old	45 years old
Gender	*57% Male* 42% Female	*57% Male* 43% Female	47% Male *52% Female*
Race/Ethnicity	*Hispanic (65%)* Caucasian (18%) African-American (10%) Other (7%)	*African-American (51%)* Caucasian (27%) Hispanic (11%) Other (11%)	*African-American (41%)* Caucasian (30%) Hispanic (12%) Other (17%)
Preferred Language	*English (69%)* Spanish (31%)	*English (96%)* Other (4%)	*English (88%)* Other (12%)

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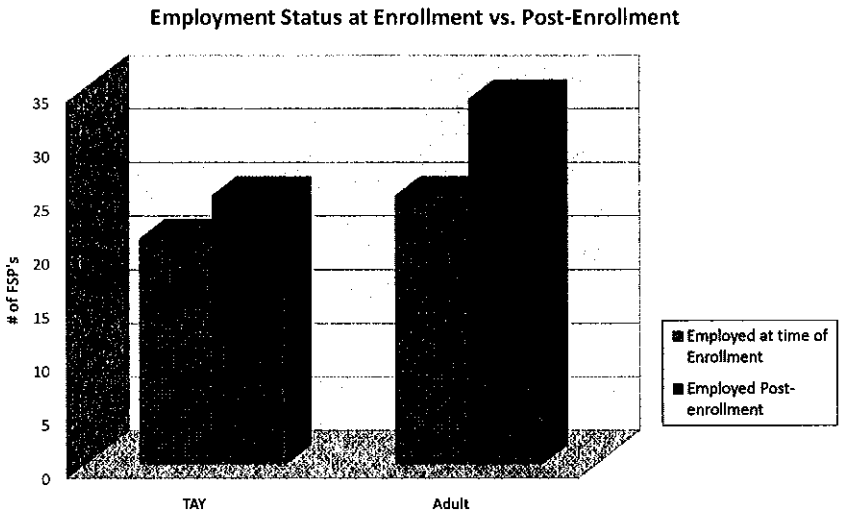
FSP Outcomes Continued

Employment FY 2008-2009



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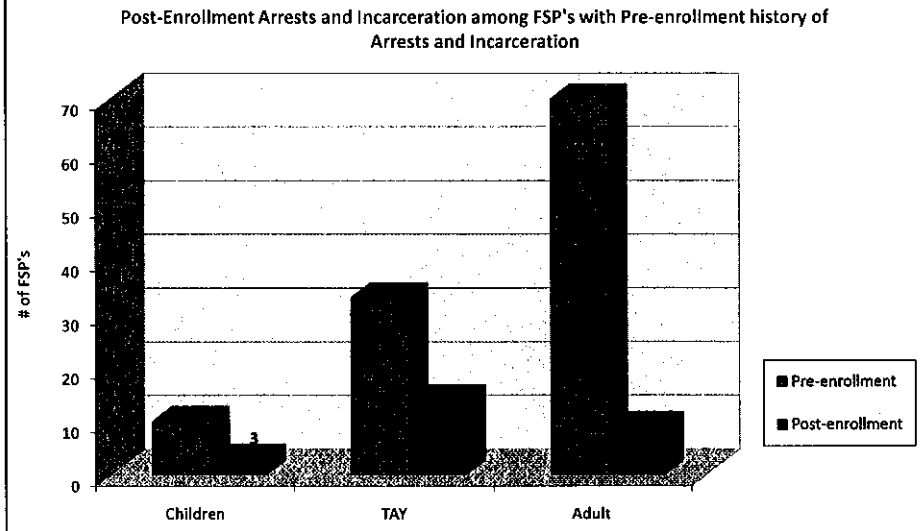
FSP Outcomes Continued

Arrests and Incarceration FY 2008-2009



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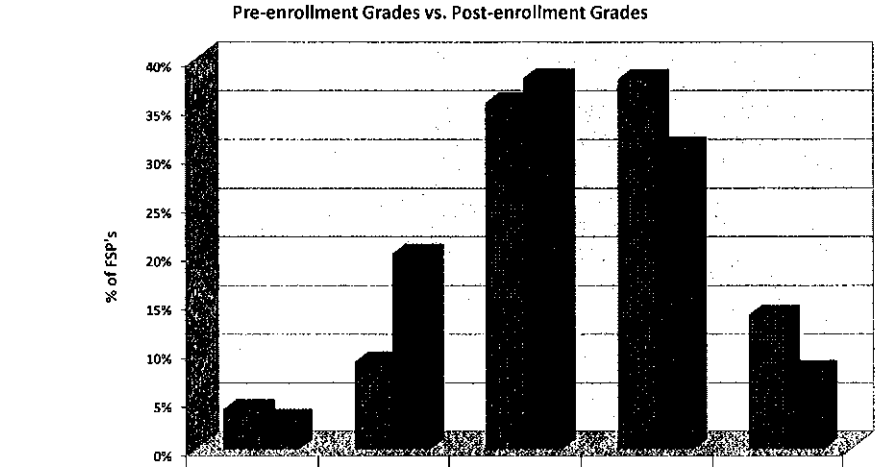
FSP Outcomes Continued

School Grades FY 2008-2009



	Very Good	Good	Average	Below Average	Poor
Pre-enrollment Grades	4%	9%	36%	38%	14%
Post-enrollment Grades	3%	20%	38%	31%	8%

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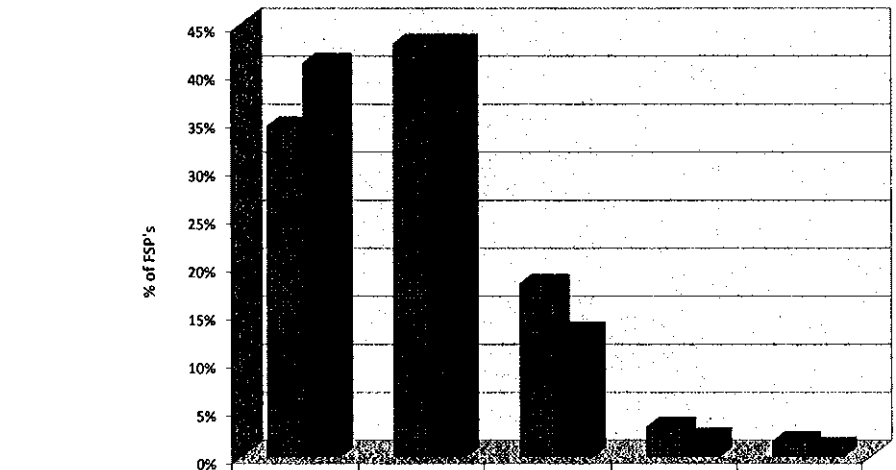
FSP Outcomes Continued

School Attendance FY 2008-2009



	Always Attends	Mostly Attends	Sometimes Attends	Infrequently Attends	Never Attends
Pre-enrollment Attendance	34%	43%	18%	3%	2%
Post-enrollment Attendance	41%	43%	13%	2%	1%

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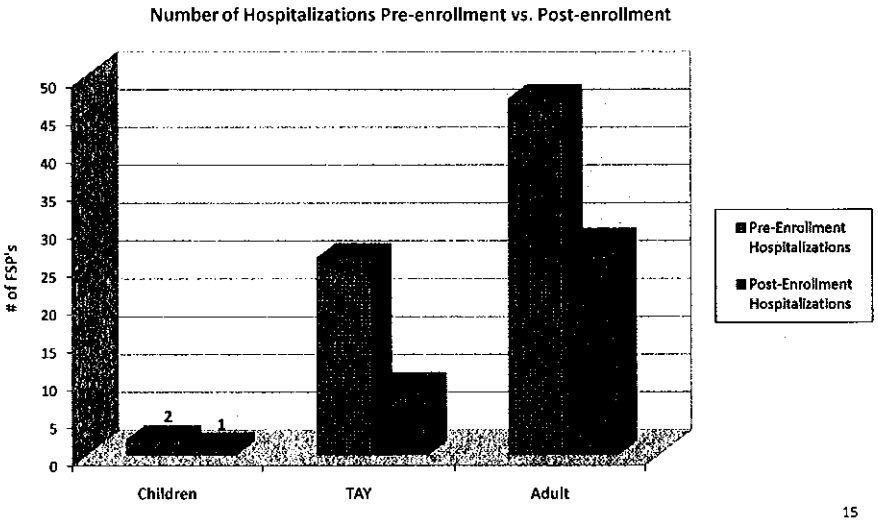
FSP Outcomes Continued

Hospitalizations FY 2008-2009



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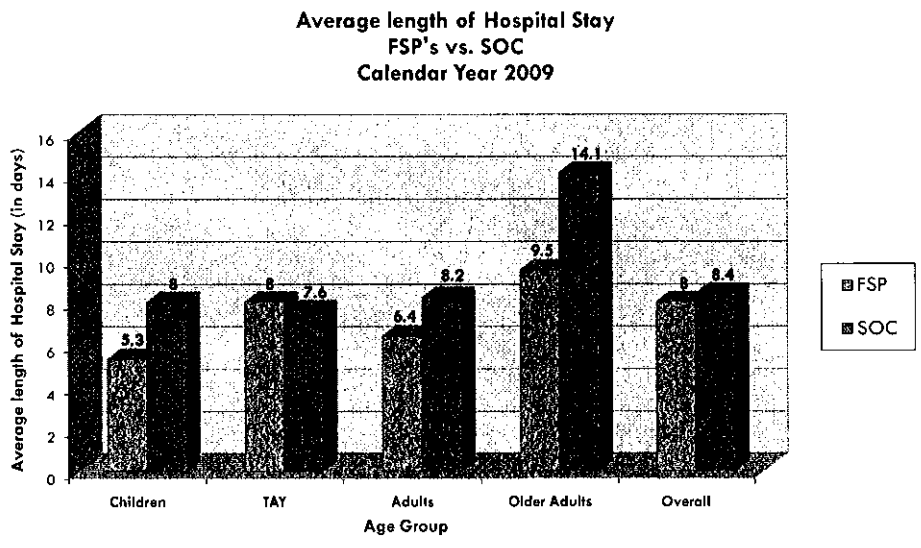
HOSPITALIZATIONS: FULL SERVICE PARTNERS VS. SYSTEM OF CARE

Public Hearing – April 5, 2010

FSP's vs. SOC



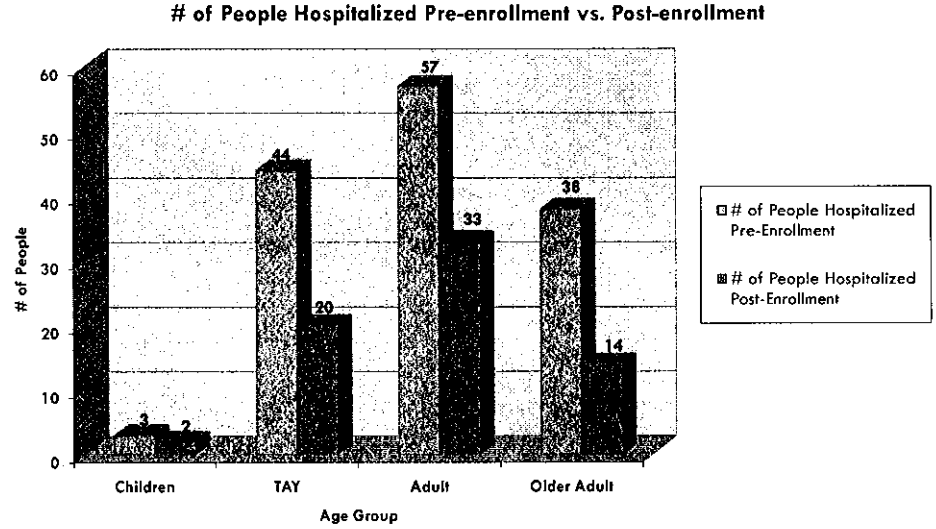
Pre-FSP status vs. SOC

Population:	Pre-FSP	SOC
Time Period:	12 months prior to enrollment	Calendar year 2009
# visits/person:	1.6	1.3
# of days/person:	18.5	12.9
# of days/visit:	11.8	9.4

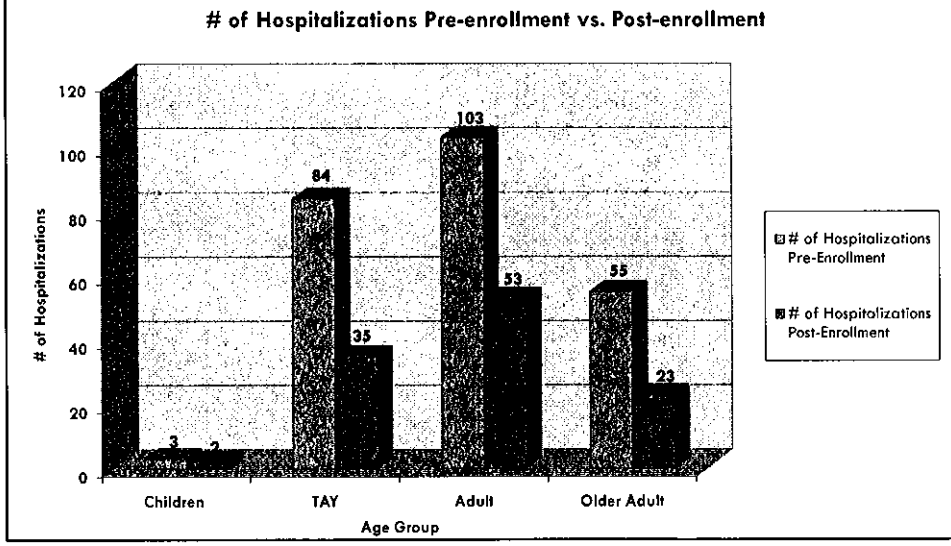
FSP's: Pre-enrollment vs. Post-enrollment

Full Service Partners	Pre-enrollment	Post-enrollment
# of Visits	245	113
# of Days	2,742	1,240
# of People	142	69

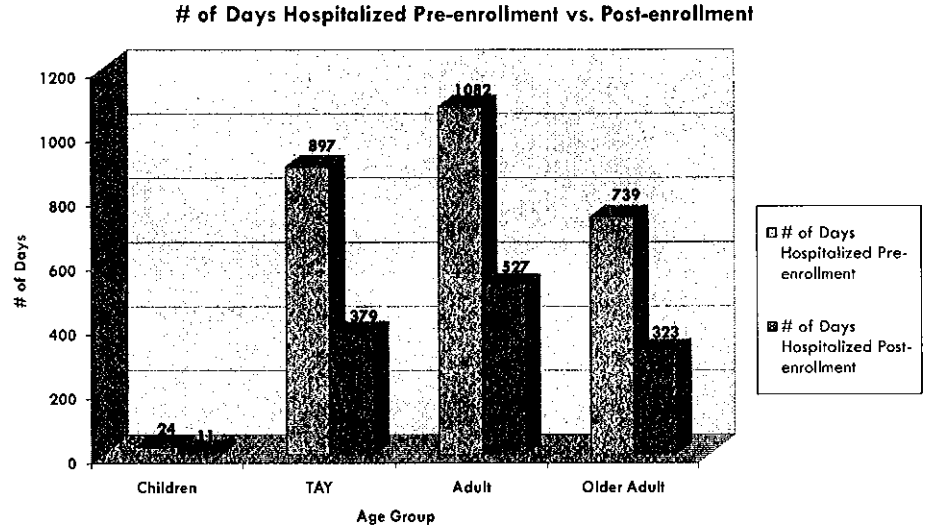
FSP's: # of People Hospitalized



FSP's: # of Hospitalizations



FSP's: # of Days Hospitalized



Summary

- The average length of stay for FSP's and the SOC is approximately 8 days
- However, the FSP program effect on hospitalizations is significant
- When current FSP's are compared to the SOC prior to program intervention, they had significantly higher hospital utilization

MHSA Prevention & Early Intervention

2010/2011 ANNUAL UPDATE

Project 1: Building Community in Underserved Cultural Communities

These Programs Targeted Three Elements

- ***Strengthening Community***
- ***Strengthening Communications***
- ***Provide Mental Health Education/System Navigation Support***

Awardees Include

- **Center for Human Development** — $81,000
  - African American Community Mental Health Education and System Navigation Support
  - Culturally appropriate Mental Health Education
  - Health Support groups and assistance

- **Native American Health Center** — $213,422
  - Support Groups for Elders and Youth
  - Parenting Education
  - Mental Health Education and System Navigation System support

- **Rainbow Community Center LGBT** — $138,955
  - Groups for Youth Seniors Families and Adults
  - Counseling

- **YMCA of the East Bay, Iron Triangle Community** — $178,125
  - Family Camp
  - Peace Talks
  - Dinner Dialogues
  - Block by block education and advocacy
  - Parenting Support
  - Mental Health System Navigation Support

- **La Clinica de la Raza - Latino Community** — $144,139
  - Health Screenings for Depression, Substance Abuse, Domestic Violence, Social Isolation and Emotional Stress
  - Psycho-educational Groups Identified areas of Distress

- **Jewish Family and Children's Services** — $159,699
  - Mental Health Education to refugee communities - Latino, Afghan, Bosnian, Iranian and Russian
  - Mental Health Counseling and System Navigation
  - Mental Health Training for staff from community agencies working with culturally diverse communities

PROJECT 2: COPING WITH TRAUMA RELATED TO COMMUNITY VIOLENCE

- **RYSE – Multi-Cultural Youth** $143,848
  - Trauma Response and Resilience System
  - Critical Incident Response and Planning
  - Community Organizing to Build Community and Lower Rates of Violence
- **Community Mental Health Liaisons for Trauma** $350,000
  - Immediate Intervention for families experiencing Trauma
  - Train Law Enforcement is CISD
  - Create linkages to other Trauma Response Systems in Contra Costa County

PROJECT 3: STIGMA REDUCTION AND AWARENESS EDUCATION

- **Office of Consumer Empowerment** $83,000
  - Speakers Bureau
  - Anti-Stigma Training
  - Wellness and Recovery Task Force
  - CCTV Mental Health Perspectives

PROJECT 4: SUICIDE PREVENTION

- **This is a joint project between Contra Costa Mental Health PEI and Contra Costa Crisis Service** $283,000
  - Suicide Prevention Task Force
  - Suicide Prevention Campaign
  - Crisis Line Language Capacity Expansion
  - Suicide Prevention Conference and Training

PROJECT 5: SUPPORTING OLDER ADULTS

- **Senior Peer Counseling Service** $250,000
  - Expand Senior Peer Counseling by training Peer Counselors
  - Expand Language and Cultural Capacity to include Spanish and Vietnamese Assessment
  - Health Navigation
  - Interagency Coordination with CSS
- **LifeLong Medical Care**
  - Community Based Social Support Programs for Isolated Older Adults $112,941
  - SNAP! Senior Network and Activity Program
  - IMPACT Geriatric Depression Screening
  - Elders Learning Community, outings and information and Referral
- **Center for Human Development – Senior Peer Outreach Program** $63,000
  - Senior-Youth Peer Outreach Program
  - Triad meetings with Senior Peer Counselors, Youth and Isolated Seniors

PROJECT 6: PARENTING EDUCATION & SUPPORT FOSTERING RESILIENT FAMILIES INITIATIVE

These Programs Targeted Three Elements

- ***Partnering with Parents Experiencing Challenges***
- ***Parent Education and Support***
- ***Multi-Family Support Groups***

AWARDEES INCLUDE

- **County Based Program: Partnering with Parents Experiencing Challenges** — $288,000
  - Assessment for families with a child or adult with serious emotional disturbance
  - Assessment for families in Emergency Foster Care
  - Early Intervention Support Services
  - Linkages to community resources

CONTRA COSTA HEALTH SERVICES MENTAL HEALTH DIVISION

- **La Clinica de La Raza, Familias Fuertes – Strong Families** — $112,611
  - Risk factor screening
  - Assessment
  - Parent Coaching
  - Parent education using evidence based model – Los Niños Bien Educados

La Clínica

- **Child Abuse Prevention Council – The Nurturing Parent Program** — $111,828
  - Evidence based, culturally, and linguistically appropriate parenting classes
  - Serving the African American Community and the Latino Community in West and Central County

CHILD ABUSE PREVENTION COUNCIL of Contra Costa County

- **Family Stress Center - Triple P Positive Parenting Program** — $303,803
  - Provide Parenting Education to caregivers County-Wide including those in STAND! shelters and other targeted high risk groups

FAMILY STRESS CENTER

- **The Latina Center – Primo Nuestros Niños** — $109,240
  - STEP Systemic Training for Effective Parenting classes to monolingual/bilingual parents and grandparents
  - Train parent partners to provide mentoring, support and systems navigation
  - Family activity nights, creative learning circles

THE LATINA CENTER

- **Contra Costa Interfaith Housing – Strengthening Families Program** — $52,834
  - Evidence based Parenting Program on site to formerly homeless families with one parent with Mental Health Diagnosis
  - Support for sobriety groups
  - 4 day a week homework club

CONTRA COSTA INTERFAITH HOUSING

PROJECT 7: SUPPORTING FAMILIES EXPERIENCING THE JUVENILE JUSTICE SYSTEM

These Programs Targeted Two Elements

- ***Community Supports to Youth on Probation***
- ***Screening, Early Intervention and Discharge Support for Youth at the Oren Allen Youth Rehabilitation Facility (Boys Ranch)***

AWARDEES INCLUDE

- A County Run Early Intervention Program $290,000
  - Will utilize two Mental Health Liaisons and one .33 Clinical Supervisor to support youth as they transition out of custody and into the community.
  - Assessment
  - Provide linkages to resources
- A County Mental Health Clinician at OAYRF $85,000
  - Will assess and screen youth for Mental Illness and provide linkages to the community as they transition out of custody.

CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

- West Contra Costa Youth Services Bureau $290,000
  - Countywide support for youthful offenders who are ineligible for Medi-Cal
  - Academic Support
  - Life Skills Training
  - Employment Readiness Training
  - Job Placement
  - Intensive Group Support
  - Younger Sibling Support

WEST CONTRA COSTA

- Family Institute of Richmond – East and Central County $110,012
  - Brief Strategic Family Therapy in home or clinic
  - Case management

PROJECT 8: SUPPORTING FAMILIES EXPERIENCING MENTAL ILLNESS

This Component Targeted Three Areas

- ***Out of Home Activities for Consumers which also Provides Respite for Families***
- ***Transportation for Consumers, particularly on Evenings and Weekends***
- ***In-Home Respite***

- **Contra Costa Clubhouses** $342,460
  - Life Skills the "workday" Clubhouse model
  - Recreation, including evening programming
  - Transportation Services
  - Meals
  - Health and Wellness Programs
  - Outreach Services
  - Respite Services in home at caregiver request

Contra Costa Clubhouses

Project 9: Youth Development

- **Martinez Unified School District – New Leaf Program** $170,080
  - Career Academies
  - Individual Learning Plans
  - Service Learning Projects
  - Career testing
  - Internships
  - Support for the completion of High School Diploma
  - Life and Career Skills Training
  - Counseling

MARTINEZ UNIFIED SCHOOL DISTRICT

- **STAND! Against Domestic Violence** $122,731
  - Evidence Based Programs: Expect Respect and You Never Win with Violence provided at school sites throughout Contra Costa County to reduce dating violence, bullying and sexual harassment
  - Support Groups for those who are at risk or already have experienced violence

STAND!

- **El Cerrito High School** $75,100
  - Alcohol and Other Drug Abuse Prevention
  - Teen Alive Program for Anger and Violence
  - Arts/Spoken Word for those with incarcerated family members
  - Bereavement Groups
  - Peer Conflict Mediation
  - Pregnant, Parenting and Caretaker Teens Group

JAMES MOREHOUSE PROJECT

- **People Who Care – Hip Hop Car Wash** $156,753
  - 6 day a week and after school employment and career opportunities
  - Anger Management Group
  - Academic and Educational Support
  - Peer Based Juvenile Delinquency Prevention

- **RYSE – Health and Wellness Program** $286,275
  - Drop in, Recreational, and structured events to promote health and wellness, arts and culture, education and career and youth leadership and organizing.
  - Monthly cultural events
  - Street-based outreach
  - Youth Assessment and Referral

RYSE CENTER

Workforce Education and Training (WET)

Activity for FY 08-09

4/5/2010

CONTRA COSTA
HEALTH SERVICES

Go Beyond

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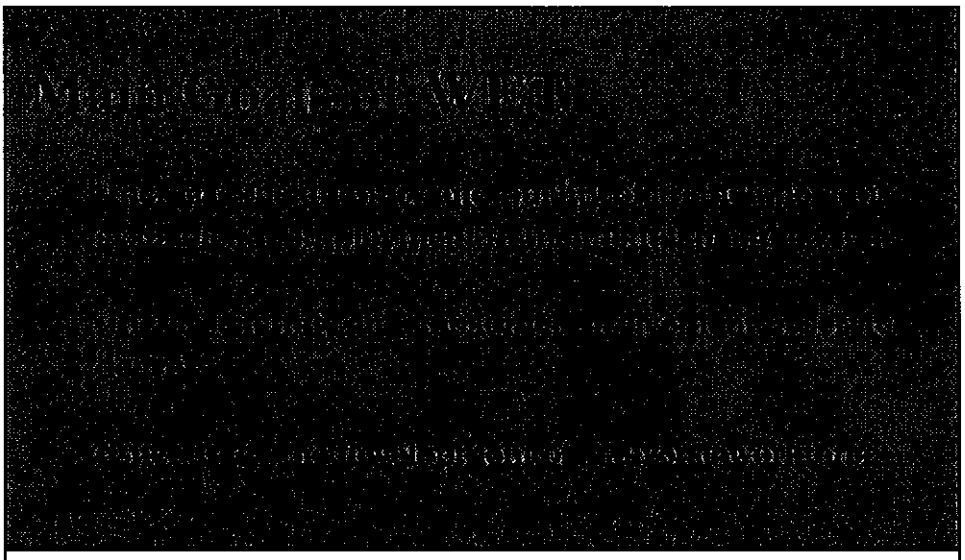
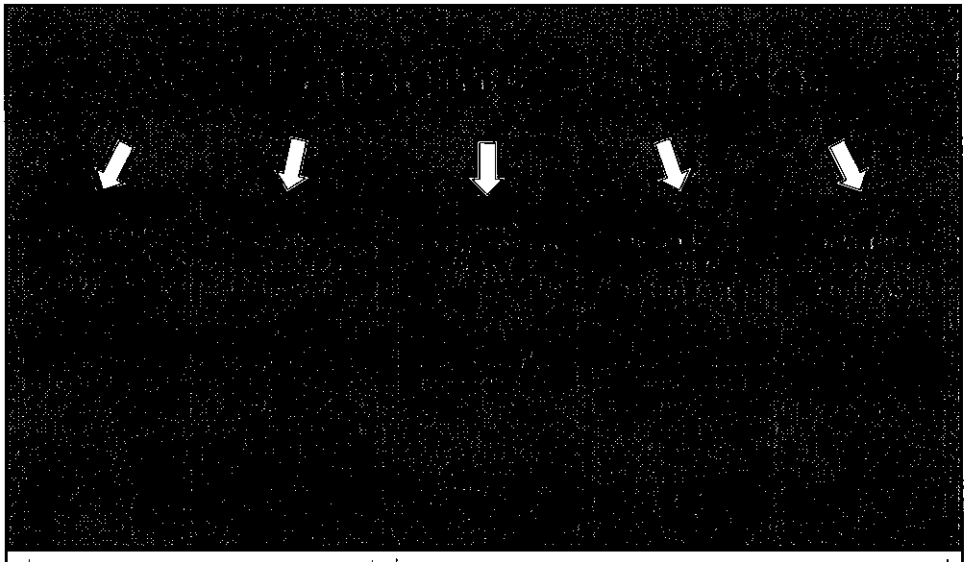


Improve health outcomes for MH consumers



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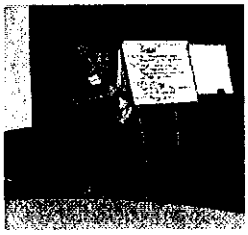
Workforce Training Advisory Group

Develop and support the WET plan

- **Workforce Training Advisory Group**
  - Convene at least 3 times per year
  - Create Annual Training Calendar
  - Important in organizing and implementing the trainings



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Training & Technical Assistance

Educate staff to improve patient care

- **Staff Trainings**
  - Mandatory *Law & Ethics*
  - *Confidentiality in Behavioral Health*
  - *Addressing Inequities in Health*
  - *Youth Suicide and Self Harm*

- **Explore E-learning Products**
- ***Recovery in Diverse Communities* Conference**
- **Law Enforcement Crisis Intervention Training**
  - Component of Behavioral Health Court
  - Consumers involved in training law enforcement to respond to crisis situations involving MH consumers safely

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Workforce Development

Provide alternative pathways to encourage people to work in mental health

- **Contra Costa College**
  - ***Service Provider Individualized Recovery Intensive Training* (SPIRIT) Program**
    - Wellness and recovery skill building
    - 32 completed internships with Anka, Rubicon, Crestwood
  - **Implementation of the *Psychosocial Rehabilitation* (PSR) *Certificate* Program**
    - Curriculum developed by CASRA, an alternative to a AA or BA
    - Recommend adding 2 new courses to the PSR curriculum
- **Training Family Partners**
  - Engage consumers and family members as employees
  - Training topics: *Documentation, Wraparound Training, and Strengths, Needs, and Culture Discovery*

8

[redacted]

Provide on-the-job experience for graduate students

- **Graduate Level Internships**
  - 21 Interns placed in outpatient clinics and hospital
  - Improves health: 1,825 distinct services in provided in outpatient clinics

- **Developing the nursing workforce**
  - Collaboration with UCSF
  - Psychiatric Nurse rotation begun in Pittsburg Clinic
  - Initial feedback from instructors and staff have been positive

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[redacted]

- For current staff who are interested in pursuing Bachelors and Master's Level Degrees in Social Work
  - Scholarships in exchange for service
  - Activity scheduled to begin FY 09-10

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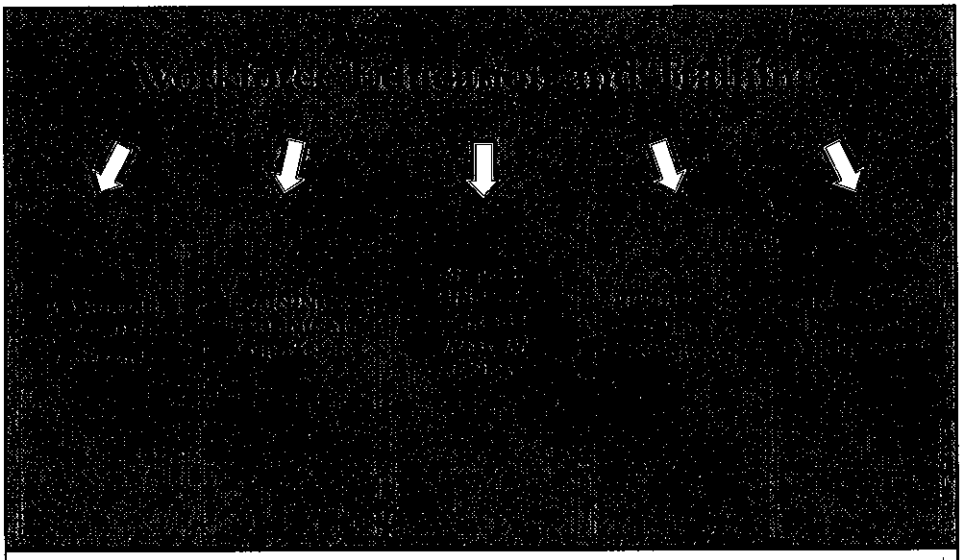

Well trained, diverse staff = improved health outcomes for mental health consumers

A. Workforce Staffing Support

Action #1: Workforce Education & Training (WET) Coordination

The Workforce Training Advisory Group plays an integral part in supporting the activities of the Workforce Education and Training plan. The group, which began with 18 members who represent county administration, clinical and non-clinical staff, met twice during the fiscal year. These meetings were vital in shaping the execution of the WET plan in Contra Costa and ensuring the trainings would serve the county's training needs. A number of training and technical assistance opportunities were offered to Contra Costa Mental Health's (CCMH), community-based organizations and network provider staff during FY 2008-2009. A total of 23 trainings were conducted during the fiscal year. To ensure that family members, consumers, and underserved/underrepresented communities were included as trainers and participants, efforts were made to conduct trainings that were lead by consumers. Consumers who participated as trainers were central to the SPIRIT program curriculum. SPIRIT is a consumer-lead course that includes guest lecturers who are consumers. Class sessions lead by consumers cover topics such as *Ex-Patient Movement and Recovery Concepts, the Mental Health Services Act, Consumer Employment,* and *Strategies for How to Become an Effective Consumer Advocate.*

As outlined in the WET plan, CCMH has continued work with local education institutions to enhance programs that address the workforce needs in mental health. The increase of available information related to regional education and employment opportunities, including internships, has lead to a successful intern orientation for FY 08-09. Twenty one students participated in Contra Costa's intern program and worked in a variety of placements, such as Chris Adams center, County Children and Adult clinics and Contra Costa Regional Medical Center. Increasing the availability of information related to educational and employment activities supports the development of the psychiatric workforce in the county.

B. Training and Technical Assistance

Action #2: Staff Development Training Initiative

Trainings that advance staff competencies, contribute to job satisfaction and retention, and serve to attract new employees are central to CCMH's staff training initiative. During FY 08-09, there were over 20 staff development training opportunities, including *Law, Ethics and Confidentiality in Behavioral Health, Addressing Inequities in Health,* and *Youth Suicide and Self-Harm.*

CCMH has worked to increase its internal agency capacity by identifying staff and conducting trainings for which they serve as internal experts and offer technical assistance on best practices. Included in the training list for FY 08-09 are trainings which include CCMH staff as "subject matter experts". During FY 08-09, CCMH staff conducted 16 these training sessions, covering topics such as *Documentation, Partnership Plan, CALOCUS,* and *Subpoena training* for various audiences, including Community Support Workers, nurses, and interns.

In addition to on-site trainings, conferences, and face to face meetings, the option for internet-based learning was explored to enhance staff trainings in Contra Costa County. During FY 08-09, CCMH staff participated in an online meeting with Essential Leaning to view a demonstration of their product and invited a number of staff members to pilot the online *Law and Ethics* course. Following the end of the course, a survey was administered to the participants and found that for most survey items, a majority of the respondents were generally satisfied with the course. In the spring of 2009, CCMH staff reviewed Essential Learning's Community Access Site through which consumers, family members and advocates could access selected online curriculums and updates. Pricing estimates were provided by Essential Learning and CCMH will purchase an online learning product in spring 2010 as a resource for improved workforce training.

Finally, during fall 2008 the planning process for the "Recovery in Diverse Communities Conference" was initiated. The Recovery Planning Group was created in October 2008 and includes 19 members who represent Contra Costa Mental Health Administration, community stakeholders, as well as consumers and met three times during FY 08-09. The main focus of the Planning Group was to:

- Refine the purpose of conference to encourage multicultural communities involved in reducing disparities to work together to share their expertise, and
- To raise awareness of the recovery model and bring multicultural communities together to share their expertise in addressing health disparities

Action #3: Mental Health Training for Law Enforcement

To help local law enforcement respond to crisis situations involving mental health consumers safely and effectively, Crisis Intervention Training was offered twice to law enforcement and mental health staff during FY 08-09. There were thirty five training attendees in each session from agencies such as the Sheriff's department, and law enforcement from Concord, Pleasant Hill, and Pittsburg. Consistent with the philosophy of MHSA, consumers and family members were included as guest speakers for the training. Consumers were invited to share their past experience involving law enforcement, suggest methods to communicate more effectively with consumers and their families and provide insight related to promoting an integrated service experience with law enforcement. In order to support Contra Costa's diverse mental health consumer population, cultural issues were addressed throughout the trainings. Topics related to gender issues, non-verbal cues, and language were addressed by the presenters throughout the training session to bring awareness and offer strategies to handle specific situations. Participant evaluation of these initial CIT trainings has yielded positive responses. To continue this trend, annual CIT trainings will be provided annually to support local law enforcement, ultimately improving the interactions between mental health consumers, their families and law enforcement in the county.

C. Mental Health Career Pathways Programs

Action #4: Consumer Employment Strategies - SPIRIT Program Expansion & Enhancement

Contra Costa Mental Health, in conjunction with Contra Costa College in West County, offered the Service Provider Individualized Recovery Intensive Training (SPIRIT) Program during the 2008 spring semester. SPIRIT is a 14-week consumer training program followed by a supervised internship. During FY 08-09, SPIRIT was negotiated with Contra Costa College by Vidya Iyengar, John Hollender, and Anna Lubarov, along with the help of consultant Tim Stringari, who created the application materials for CCMH to include SPIRIT in the college catalog. To support collaborations with contract agencies, Susan Medlin provided training workshops to the clerical staff and the interns. Additionally, she conducted presentations for nurses and clinical staff during on-site meetings at contract agencies to inform and educate staff regarding the SPIRIT program.

During the 08-09 school year, the SPIRIT program experienced a successful term with 35 students enrolled and 32 students completing their internships at various agencies such as Contra Costa Mental Health and with contract agencies such as Anka, Rubicon, and Crestwood. To provide ongoing support and resource sharing, the SPIRIT club was created as a network for students after graduation. The SPIRIT club is coordinated by SPIRIT alumni Hillary Westbrook from the Office for Consumer Empowerment (OCE), and is assisted by other OCE staff members. The club has 76 SPIRIT graduate contacts, from which about a fourth participate in club-sponsored events. The SPIRIT course and alumni network continues to be a valuable piece to the mental health recovery for consumers in Contra Costa demonstrated by the success and growth of the program.

Action #5: Family Member Employment Strategies

During FY 08-09, creating a training program for family member employment in the public mental health system was initiated by CCMH staff. CCMH explored integrating existing curriculum and collaborating

with subject matter experts to guide the structure of a family member training program for employment. In efforts to formalize the family support worker position, CCMH staff recommended updates to the duties and responsibilities to the family support worker position. To support the engagement of consumers and family members as employees, a number of staff development trainings were offered to family partner staff/volunteers. As outlined in the WET plan, trainings in 2008 covered topics such as *Documentation, VanDenBerg High Fidelity Wraparound, Strengths, Needs, Culture Discovery (Part I): What is Culture,* and *Strengths, Needs, Culture Discovery (Part II): Changing Deficit-Focused Dialogue to Strengths.* In 2009, training sessions covered topics such as *Wraparound Training* and *Transitioning,* to help parent partners gain skills necessary to be effective advocates and navigate through the system, become less dependent on the traditional services and build upon the community and natural supports.

Action #6: Developing MH Concentration in High School Health Academies
No activity during FY 08-09

Action #7: Community College Partnerships - Psychosocial Rehabilitation Certificate (PSR)
Building on the partnership with Contra Costa College, CCMH worked to implement the Psychosocial Rehabilitation Certificate Program during FY 08-09. Contra Costa Mental Health initiated working with the California Association of Social Rehabilitation (CASRA) in January 2009 for a year-long contract in the amount of $35,000 to provide consultation and technical assistance with regard to the development of the PSR program at CCC. Two consultants, Tim Stringari and Debra Brasher, participated in the planning to include new PSR detail in CCC's curriculum.

The PSR certificate consultation and coursework recommendations were developed in June 2009 by consultant Tim Stringari. Based on conversations with Contra Costa Mental Health and Contra Costa College and recommendations from Tim Stringari, a proposal was submitted to Contra Costa College, which included the following recommendations:

- Add two new courses in PSR curriculum which will be collaboratively developed and integrated in to existing Human Services curriculum and would make up the core of a new 12 unit *Certificate of Specialization in Psychosocial Rehabilitation*
- Provide in-service trainings for faculty and staff related to PSR and the Recovery paradigm, teaching techniques and students with psychological and psychiatric disabilities.

The PSR program has been developed and classes expected to begin fall 2010. Additionally during FY 08-09, the PSR Advisory Group met to assist with the promotion and recruitment for the PSR program. Twenty four individuals representing consumers, family members, community-based providers, CCMH, as well as the Department of Rehabilitation and Contra Costa College were included in the Advisory Group. Betty Dahlquist of CASRA facilitated the advisory meetings, which focused on the following areas:

- To identify and build upon employment opportunities for graduates
- To identify and build upon opportunities for educational support, including employers, the Department of Rehabilitation, NAMI and other local advocacy groups and the community college itself.
- To review and contribute to the development of the curriculum for the 2 proposed courses.
- To develop recruitment strategies for multiple audiences: e.g., current CCMH staff, SPIRIT graduates, students in other human services programs, other social service providers, etc.
- To develop an evaluation protocol to provide data on whether the project is meeting its goals.

Action #8: Psychiatric Technician Program
No activity during FY 08-09

D. Residency & Internship Programs

Action #9: Expanding Graduate Level Internship Opportunities

Providing graduate level internship opportunities is imperative for supporting the success of the county's mental health workforce. These opportunities provide exposure to the mental health field, an opportunity to integrate current best practices, and encourage recruitment from the graduate pool. In FY 08-09, 21 interns participated in the Mental Health Internship program, of which fourteen provided outpatient services in our clinics. Seven interns provided services in other settings, such as hospitals, where they were part of treatment teams.

The placement of interns in both clinics and hospitals has enhanced care for mental health consumers in Contra Costa County. Specifically, the services that were provided by those working in our outpatient mental health clinics include 1,825 distinct services to 135 unduplicated consumers. Because the services provided in settings such as the hospital are not provided by individuals, but by the treatment team, the numbers of services and the unduplicated client count for services specifically provided by the interns working in these settings are unavailable.

Action #10: Psychiatry Workforce Development

To help alleviate the shortage of needed staff in psychiatry, such as psychiatrists, nurses, and licensed technicians, Contra Costa is working to expand the professional shortage designation areas to include more of the county. This state designation allows for incoming psychiatric staff to be eligible for various state loan forgiveness programs, thereby making Contra Costa a more attractive option for employment for new graduates. Contra Costa currently has two professional shortage area designations granted by the state (Central Richmond and North Antioch); additional areas are currently being examined in order to expand the geographic areas eligible for loan forgiveness. The outcome of the designation process will complement our work to enhance the psychiatric workforce in the county.

Preliminary discussion around developing the Psychiatry Workforce in Contra Costa County was initiated during FY 08-09. The two main ideas developed during these discussions included creating a Contra Costa College-based Community Psychiatry Fellowship in association with UCD or UCSF and creating a Community Psychiatry elective for psychiatry residence in either UCD or UCSF. Future work to develop the County's workforce plan includes getting buy-in from CCMH administrative staff and affiliated Universities and developing a curriculum.

Action #11: Nursing Workforce Development

During FY 08-09, CCMH had an executed contract affiliation agreement between the Regents of the University of California, San Francisco, School of Nursing for clinical placement of Psychiatric, Mental Health, Nurse Practitioners, Post Masters, graduate students, into our clinical internship program.

In February 2009, Pittsburg Mental Health Center was designated as UCSF's first student clinical rotation, which ended 11/24/2009. The creation of clinical placement protocols was developed with input from Program Managers, Psychiatrist and Nursing staff. During their placements, students participated in CCMH internship orientation program and required HIPPA, EMTALA, and CPI trainings. Following the students' rotation, verbal feedback obtained from UCSF interns, instructors, and a CCMH psychiatrist regarding student clinical rotation has been outstanding, as clinical objectives have been met and placements have been excellent. CCMH has a longstanding contract affiliation agreement between Samuel Merritt College; however, during 2008-2009, we did not receive nursing placement request from their university. Outreach and recruitment efforts to Samuel Merritt College and UCSF University, will continue for subsequent years.

E. Financial Incentive Programs

Action # 12: Scholarship Program for Bachelors Level Degrees

No activity during FY 08-09

Action #13: Scholarship Program for Masters' Level Degrees

No activity during FY 08-09

Mental Health Services Act (MHSA)
Capital Facilities Project Proposal

Questions to be Addressed:

1. According to State DMH Guidelines, what can these funds be used for?
2. How does Contra Costa County propose to use the funds?

1

Mental Health Services Act (MHSA)
Capital Facility Project Proposal

MHSA Capital Facilities Guidelines

DMH Info Notice 08/09 – Encl. 2

- Allowable Expenditures Include:
  - Acquire and build upon land that will be County-owned
  - Acquire buildings that will be County-owned
  - Construct buildings that will be County-owned
  - Renovate buildings that are County-owned
  - Establish a capitalized repair/replacement reserve for buildings acquired/constructed with Capital Facilities funds

2

Mental Health Services Act (MHSA)
Capital Facility Project Proposal

MHSA Capital Facilities Guidelines

DMH Info Notice 08/09 – Encl. 2 (cont.)

- Allowable Expenditures for Renovation:
  - For treatment facility – must describe how renovation will benefit clients to be served
  - For Administrative facility – must describe how those offices will augment/support County's ability to provide programs/services
  - Describe how renovations are reasonable and consistent with what prudent buyer would incur
  - Demonstrate method to protect capital interest in the renovation

3

Mental Health Services Act (MHSA)
Capital Facility Project Proposal

MHSA Capital Facilities Guidelines

DMH Info Notice 08/09 – Encl. 2 (cont.)

- Specific Requirements include:
  - Funds shall only be used for those portions of land/buildings where MHSA programs, services, and administrative supports are provided, consistent with goals of CSS and PEI
  - Land acquired/built upon/or construction/renovation .....for MHSA programs/services/supports....for a minimum of 20 years

4

Capital Facilities

MHSA Capital Facilities Guidelines

DMH Info Notice 08/09 – Encl. 2 (cont.)

- Specific Requirements, continued:
  - Must comply with zoning, codes, etc.
  - May establish capitalized repair/replacement reserve.
  - Under limited circumstances, may "lease/rent to own" a building.

5

MHSA Capital Facilities Guidelines

Example of Costs **Allowed**

- Purchase a building/land for a clinic, clubhouse, wellness/recovery center, office space (County must be owner of record)
- Purchase building/land where vocational, educational & recreational services provided...to support MHSA services (County owner of record)
- Make existing buildings more accessible (ADA, etc.)
- Establish capitalized repair/replacement reserve for building acquired with CapFac Funds

6

MHSA Capital Facilities Guidelines

Example of Costs **Allowed** *(cont.)*

- Purchase modular building for mental health services located on school grounds.
- Cover costs associated with construction of new building/land including parking lots, sidewalks, easements, lighting, etc
- Renovate existing space to create common room for clients to meet and/or for computer room for client access

7

MHSA Capital Facilities Guidelines

Example of Costs **NOT Allowed**

- Master leasing/renting of building space.
- Purchase of vacant land with no plan for building construction.
- Facilities where the purpose is to provide housing.
- Acquisition of land/buildings/constructions & establishing capitalized.
- Repair/replacement/reserve when owner of record is non-government entity.

8

MHSA Capital Facilities Guidelines

Example of Costs **Not Allowed** *(cont.)*

- Acquiring facilities not secured to foundation that is permanently affixed to the ground (i.e., cars, buses, trailers, recreational vehicles)
- Operating costs for the building (insurance, security guard, taxes, utilities, etc)
- Furniture/fixtures not attached to the building

9

MHSA Capital Facilities Guidelines

About Restrictive Settings

- Restrictive Setting Definition: Facility which utilizes a secured perimeter and/or locked exit doors and/or where other mechanical or electrical means are used to prevent clients from exiting at will
- In general, Capital Facilities funds shall be used for buildings that serve clients in less restrictive settings
- There are exceptions, but need must be demonstrated as per the Guidelines

10

Contra Costa's Facility/Technology Component Proposal

Capital Facility Portion of Component Proposal, Approved 2/2009 by State DMH includes:

- New construction on property adjacent to the existing Contra Costa Regional Medical Center in Martinez
- Freestanding multi-program mental health center with a continuum of services that will provide a comprehensive recovery focused setting
- A rapid response at entry including immediate mental health care which would lead to less restrictive levels of care more quickly

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Contra Costa's Facility/Technology Component Proposal

Approved 2/2009, Included:

- Closing gaps in the traditional medical-model/hospital-based psychiatric units by providing a continuum from restrictive to less and less restrictive settings
- Location is on frequently used public transportation line
- Campus will serve Adult, Child & TAY FSP's, Older Adults and other mental health consumers

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Mental Health Services Act (MHSA)
Capital Facility Project Proposal

Contra Costa's Facility/Technology Component Proposal

Reasons for Location/Structure of the Multi-Program Recovery Campus

- With multiple programs on the campus *(including a restrictive Psychiatric Health Facility)*, a continuum of care will include the most acute psychiatric care possible, and will allow an individual to transition from one level of care to another quickly and easily as needed
- The proposal is consistent with the five fundamental concepts inherent in MHSA identified in CSS
- The proposed multi-program campus reflects a true integrated service experience for mental health consumers and their family members.

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Mental Health Services Act (MHSA)
Capital Facility Project Proposal

Contra Costa's Proposed Capital Facility Project:

- Construction of new facilities for a Mental Health Assessment and Recovery Center (MHARC) on County owned property located at 20 Allen Street, Martinez
- Facility would be 6000 square feet which will include mixed use, variable upon demand.
- Business and operations support facility needs to support the new facility are included in the request (parking space, medical records, dietary, housekeeping, staff lounge).

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Mental Health Services Act (MHSA)
Capital Facility Project Proposal

Contra Costa's Proposed Capital Facility Project

- Services to be provided at the MHARC include voluntary urgent mental health care up to 16 hours per day for all ages, and also for discrete involuntary children's mental health care services (no MHSA funding is being sought for this portion of the site).
- The MHARC will include an assessment center for children and youth, encouraging the participation of family members in the asessment process, with a discrete/separate waiting room and entrance for young people and their family members.
- The MHARC will include discrete services to be provided for adults and older adults.

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Mental Health Services Act (MHSA)
Capital Facility Project Proposal

Contra Costa's Capital Facility Project Proposal

- Total Funding Requested: $4,000,000
- There has been a deviation in the way the funds were initially distributed in the Component Proposal (Letter of Intent);
- Given the changes in the economy during the past 14 months, stakeholders recommended that $6.2 million be spent on behavioral health system information technology structure in order to provide Electronic Health Records, Personal Health Records, Electronic Prescribing, and other recovery and consumer oriented information system availability.
- Stakeholders had also expressed concerns about sustainability of a larger scaled mental health facility as discussed in component proposal.

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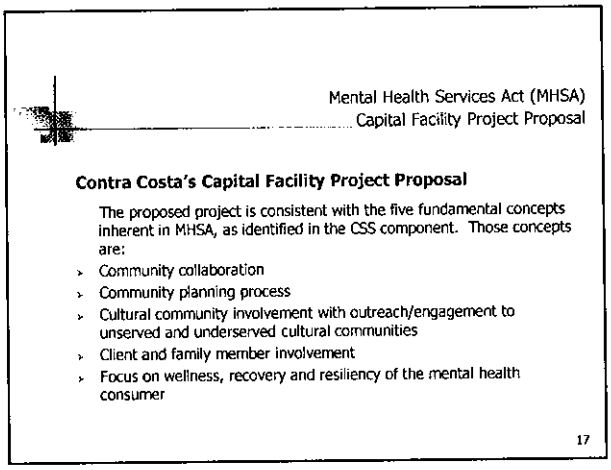
Mental Health Services Act (MHSA)
Capital Facility Project Proposal
Contra Costa's Capital Facility Project Proposal
The proposed project is consistent with the five fundamental concepts inherent in MHSA, as identified in the CSS component. Those concepts are:
Community collaboration
Community planning process
Cultural community involvement with outreach/engagement to unserved and underserved cultural communities
Client and family member involvement
Focus on wellness, recovery and resiliency of the mental health consumer
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California Mental Health Planning Council

Crisis Residential Programs

March 2010

Handout from Annis Pereyra

California Mental Health Planning Council
1600 9th Street , Room 420
Sacramento, CA 95814
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Crisis Residential Programs

Issue: Crisis residential programs reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same, or superior outcomes to those of institutionalized care. As the costs for inpatient treatment continue to rise, the need to expand an appropriate array of acute treatment settings becomes more urgent. State and county mental health systems should encourage and support alternatives to costly institutionalization, and improve the continuum of care to better serve individuals experiencing an acute psychiatric episode.

Background:

Starting in 1963 with the Community Mental Health Centers Act and through the Olmstead Decision of 1999 and beyond, the intent of the federal government has been for states to provide community-based services in the least restrictive environment possible. The phase-out of hospital beds and institutionalized services was meant to be replaced by community-based services operating on recovery-oriented principles.

In 1978, the Community Residential Treatment Systems Act established non-institutional alternatives to institutionalization as the policy of the California mental health system. Crisis Residential Programs (CRPs) were one the types of programs established under that Act. Crisis residential programs (CRPs) are a lower-cost, community-based treatment option in home-like settings that help reduce emergency department visits and divert hospitalization and/or incarcerations. These include peer-run programs such as crisis respites that offer safer, trauma-informed alternatives to psychiatric emergency units or other locked facilities. Although credible as a cost-effective and successful treatment model, particularly as part of a broader crisis response system, the number of programs remain disappointingly small. CRPs should be the preferred treatment option as mental health systems remain persistently vulnerable to funding reductions or elimination and jails and emergency departments become the de facto guardians of someone experiencing a psychiatric crisis. Yet, after nearly thirty years of operation, the CRP is sidelined as an exception rather than a principle player who is an equal partner in the care continuum with law enforcement, emergency departments, or community referral agencies. This lack of consideration as a legitimate resource can result in inappropriate referrals that do little to legitimize the value of the treatment received at a CRP or demonstrate its cost-effectiveness.

As Steve Fields observed in the *Crisis Residential Treatment Manual*[1], the CRP is "...a level-of-care as opposed to a type of treatment intervention" that "is often established in communities desperately searching for less expensive forms of acute, 24-hour care." Programs have a very distinct role to play in providing intensive services to mentally ill patients experiencing acute psychiatric episodes, and may also be useful in shortening hospital stays. Ideally a CRP would have a working agreement with acute psychiatric

[1] This is a draft, unpublished document submitted to SAMHSA for inclusion in its EBP Toolkit.

hospitals, hospital emergency rooms, mobile crisis teams, hospital inpatient psychiatric units, law enforcement and other related entities that will ensure appropriate referrals. Provided that the level-of-care needed determines placement, it is the most cost-efficient and effective service option available.

Crisis residential treatment is a positive, temporary alternative for people experiencing an acute psychiatric episode or intense emotional distress who might otherwise face voluntary or involuntary commitment. Programs provide crisis stabilization, medication monitoring, and evaluation to determine the need for the type and intensity of additional services within a framework of peer support and trauma-informed approaches to recovery planning. CRPs often include treatment for co-occurring disorders based on either harm-reduction or abstinence-based approach to wellness and recovery. The safe, accepting environment nurtures the individual's process of personal growth and is essential to individuals as they work through crises at their own pace. They operate under a flexible, social rehabilitation model that adapts to the needs of the client at the time. They emphasize mastery of daily living skills and social development using a strength-based approach that supports recovery and wellness in homelike environments. CRPs do not schedule services for the convenience of the facility or arbitrarily assign systemic requirements for the sole purpose of consistency and efficiency. Their residential setting creates a continuum of care with links to community resource centers and supports that ease the transition into independent living.

The flexibility of the CRP model makes it extremely well-suited to address the specific needs of special populations such as Transition Age Youth, who are increasingly institutionalized due to lack of alternatives. Over the last twenty years, CRPs have successfully admitted and treated individuals who are at risk of harm to themselves or others, may be dually diagnosed, or have otherwise come to the attention of the psychiatric emergency system. Experience has shown that there are no kinds of behavior that that cannot be addressed successfully at this level of care.

Target populations of CRPs may vary, but the following principles are consistent throughout the most successful models:

- Creating a residential community/setting that places an expectation on the client to participate in the day-to-day operation of running a household, practice basic living skills of budgeting, meal preparation, and housework, and social/interpersonal skills, even when distracted by personal or external crises.
- Recruiting staff (including mental health clients/survivors/persons in recovery) that bring a wide range of experiences and perspectives, are not uncomfortable with clients in psychiatric distress, and with enough flexibility to skillfully function in an open, rather than clinical, environment.
- Involving clients in creating their own treatment plan, defining their immediate and long-term goals, and deciding how those goals will be met.

- Differentiating the program from institutions by creating program flexibility, individualizing treatment, and committing to the principle that no types of behavior should be excluded, yet maintaining awareness of the therapeutic capacity of the facility to avoid overloading staff and residents.

- Recognizing that the open environment of a CRP is a strength that allows recovery to proceed unimpeded, uses a more trauma-informed approach, and provides a more accurate assessment of the client's ability to function outside of the program.

Existing Treatment Systems

When articulating the argument for re-orienting public perception of CRPs from that of an "alternative" to a preferred, mainstream care system, it is helpful to frame the premise as - an alternative to what? The loss of institutional beds was not balanced by the establishment of community-based care systems originally envisioned by the Community Mental Health Centers Act. California has the largest population nationwide and the poorest array of care options. Between 1995 and 2008 California lost 42 psychiatric facilities and their corresponding 2,816 beds[2]. The California Hospital Association Center for Behavioral Health reports that California had a total of 6,179 inpatient care psychiatric beds to serve its population of 36.5 million in 2007[3]. The national average is 1 psychiatric bed for every 2,734 persons. California's average is 1 bed for every 5,916 people. Twenty-five California counties do not have any inpatient psychiatric services at all. Increasing the number of CRPs could help fill that gap.

Acute care hospitals are a necessary component in the mental health system of care when physical health issues are present in people experiencing an acute psychiatric episode. Emergency Departments in these hospitals can and do have a role to play during times of acute crises but are not equipped to provide psychiatric care once emergency physical health issues are resolved. Acute psychiatric hospitals and acute inpatient psychiatric units in medical hospitals should only be used for individuals in the most acute phase of their psychiatric crisis and should be considered more of a last treatment resort rather than a first option.

Many people who experience an emotional crisis are likely to have experienced psychological trauma, and have reported feeling re-traumatized when they were hospitalized and forcibly treated[4,5]. Too often, patients languish in acute medical and

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[2] California Hospital Association Center for Behavioral Health chart "Acute Psychiatric Inpatient Bed Closures/Downsizing - California 1995 - 2008 www.calhospital.org/PsychBedData

[3] California Hospital Association Center for Behavioral Health data on number of psychiatric beds in California is sourced from Office of Statewide Health Planning Healthcare Information Division and includes city and county hospitals, but not State Hospitals, and includes county owned Psychiatric Health Facilities.

[4] U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Situational Analysis for the Development of the CMHS Resource Center to Address Discrimination and Stigma Associated with Mental Illnesses: Final Report*, 2002

[5] Delphine Brody, *Normal People Don't Want to Know Us: First-Hand Experiences and Perspectives on Discrimination and Stigma*, CNMHC Bay Area Regional Self-Help Project, 2007. The Executive Summary can be viewed at http://delphinegrrl.googlepages.com/execsum. The full report may be downloaded at http://strategiesforchange.googlepages.com/.

psychiatric beds due to lack of alternatives, creating a potential civil rights infringement issue as well as an uncompensated expense for the hospital. Many who have experienced involuntary hospitalization consider it to be an act of discrimination[6]. In California, data shows that African Americans are forced into treatment and hospitalized more often than other groups[7]. Individuals with psychiatric illnesses and no emergency physical health needs are increasingly being transported and abandoned in hospital emergency rooms because of a lack of alternative treatment settings. Hospital emergency rooms are neither a safe nor appropriate place for psychiatric treatment. The increased dependence upon emergency department has resulted in an increase in waiting times and diversions for individuals in need of life sustaining physical health emergency medical care.

Psychiatric Health Facilities (PHFs) are licensed and certified by the Department of Mental Health and provide short-term, acute, psychiatric care, although not necessarily in the least restrictive environment. Stays usually range from three to seven days. PHFs can be either publicly or privately run. The Office of Statewide Health Planning Department (OSHPD) reporting system lists 24 licensed PHFs in 19 counties providing 678 beds as of June 2009[8].

California Association of Social Rehabilitation Agencies (CASRA) sponsored legislation in the mid-1980's to establish the "social rehabilitation" facility category under Department of Social Services Community Care Licensing (CSS/CCL) and to establish DMH oversight through a programmatic certification process. CRPs fall under this category and are eligible for Medicaid reimbursement. As of December 15, 2009, the State of California Department of Social Services Community Care and Licensing Division reports that there are currently 35 short term crisis residential facilities operating in 18 counties, and providing a total of 417 beds. Current licensing specifications limit the client load to a maximum of 15 per facility, although there are exceptions based on previous or original licensing requirements that were grandfathered in.

The State Maximum Allowance (SMA) for Short-Doyle Medi-Cal Reimbursement rates posted by the Department of Mental Health illustrates a substantial difference in reimbursement rates for 24 hour care between hospitals, PHFs, and CRPs.

24 HOUR CLIENT DAY STATE MAXIMUM ALLOWANCES FOR FISCAL YEAR 2009-10 Short-Doyle/Medi-Cal Reimbursement Rates		
CRP	**PHF**	**Hospital Inpatient**
$330	$585	$1,129

[6] *Ibid.*

[7] A 2002 DMH State Quality Improvement Council study shows that a far greater Medi-Cal dollar amount has been spent per African American client, and that African Americans have been placed in inpatient units with far greater frequency per client than other ethnic groups, even while African Americans are under-represented in penetration rates for outpatient services.

[8] The OSHPD data list of 2009 also reports that three of the PHFs are in "suspense" status, which amounts to a net loss of 105 beds, and Sacramento County Mental Health Treatment Center reduced its census by 50 beds to due to budget cuts in 2009. The actual number of PHF beds is currently 523.

Due to their lower overhead costs for medical staff and general facility expenses, CRPs can operate far less expensively than hospitals or PHFs. In 2008-09, the cost for CRP care was nearly half the cost of PHF care, and slightly more than 25% of the cost of Hospital Inpatient Care.

Aside from the cost savings, CRPs are more effective than PHFs because the smaller scale created by reduced staffing ratios and fewer beds allow for focused, individualized recovery-oriented treatment plans. The homelike environment of a residential setting creates a safe base from which clients can assess their needs and assist in framing their own recovery plan.

Considerations:

- Legislation and court rulings have favored community options for the last 50 years. The Olmstead Act was instituted in 1999 as a mandate to states to integrate those living with disabilities into their communities and accommodate their needs. Crisis residential programs exemplify the intent of the Olmstead Act by providing services in the least restrictive environment in the comfort of a client's own community. Since that time, it has been an upward battle for states to meet that mandate and programs that attempt it seem to be the last funded and the first to be cut. Mental health programs in particular face the double whammy of poor representation due to concerns about stigma, and competing, or incompatible federal and state regulations related to licensing and/or reimbursement.

- The level of care found in CRPs exemplifies the spirit, intent, and guidelines of the Mental Health Services Act (MHSA). It is a recovery-oriented, client-driven system that modifies to the needs of the client for optimal outcomes. Peer-run programs should also be considered and encouraged as part of the MHSA vision.

- The flexibility of the CRP is well suited to meet the specific psycho-social needs of adolescents, adults, and older adults, and the scale is appropriate for addressing and treating co-occurring disorders.

- Substance Abuse Mental Health Services Administration (SAMHSA)/Community Mental Health Services (CMHS) consistently ask for data on reducing the number and duration of involuntary hospitalizations. State mental health funding applications require states to set annual goals of reduced institutional admissions every year and then report on their success in adherence to those goals. Unfortunately, in terms of establishing crisis residential programs as a viable alternative to PHFs and hospitalization, this creates a "chicken and egg" situation. State systems are encouraged to seek community care options, but crisis residential programs have not been standardized enough to mine outcome data and prove their success rates. Most federal grant opportunities typically

require states to incorporate evidence-based practices (EBPs) and use the protocols associated with them, but the lack of standardization has resulted in insufficient baseline criteria or outcomes to merit EBP status. Without funding, the system cannot be standardized and quantified, and without quantified outcomes, the system won't be funded.

- Social awareness and governmental identification and policy support need to be increased. For example, existing Medicaid and Medi-Cal policies serve as disincentives due to ambiguous distinctions between 'room and board' and treatment in residential settings. This lack of identification and definition makes it difficult to establish a less restrictive, individuated client-centered system of care. Federal Medicaid regulations prohibit billing for room and board, but neither the federal nor the state governments have fully defined what is, or is not, "room and board" in the context of a residential treatment facility. Counties have been allowed to define room and board since 1992, but the State Department of Mental Health has not confirmed its agreement with county definitions, and residential treatment providers frequently find their billing challenged during audits.

Recommendations:

1. Request MHSA funding to create additional CRPs, including peer-run crisis residential programs. Capital Facilities funding could be requested to acquire facilities, and Community Services and Supports (CSS) funding could be requested for operational support. This would meet the MHSA funding regulations by not supplanting any funding streams, increase infrastructure of care, and could fill in funding gaps left by inconsistent Medi-Cal/ Medicaid regulations. The flexibility to blend Medi-Cal and MHSA funding might ensure a better array of services, more individualized care, and better provide "whatever it takes" services to a larger group of people.

2. State and community mental health systems should take the opportunity presented by the architecture and intent of the new 1115 waiver proposal to advocate for crisis residential programs as the foundation of the restructured system of care. They fully meet the goals of the new waiver in that they have demonstrated improved outcomes, can slow the long-term expenditure growth rate, and emphasize coordinated care.

3. Improve existing performance indicators and data collection to document effectiveness of crisis residential treatment facilities. SAMHSA should support studies that compare outcomes of hospitalizations and CRPs and demonstrate their respective efficacies.

4. Request that the DMH produce and post data showing expenditures for 24 hour modes of service by county annually.

5. Request that the DMH create a resource directory that includes information on Americans with Disability Act (ADA), Fair Housing law, and site/zoning considerations. The DMH should contract with a professional organization to provide technical assistance to people wishing to establish crisis residential programs in their community.

The MHSA is intended to transform the "fail first" crisis-based system to a "help first" recovery-based model. MHSA Services and supports are based on the successful AB 34/2034 model, which reduced clients' hospitalization days by 55.8%[9]. Mental health funding has always been the most vulnerable of all the social services and, in the face of ongoing state budget troubles remains the last apportioned and the first to be cut.

In keeping with MHSA principles, DMH set a benchmark for CSS implementation to increase client-run services, including crisis services, and reduce institutional care[10]. Despite nearly thirty years of research and documentation demonstrating their effectiveness and cost-efficiencies, CRPs still face the barriers of public and professional resistance, federal and regulatory biases, lack of facilities, and the political will to support them. Clients use crisis residential programs, including peer-run crisis respite programs, when they are available.

Recovery, resilience, wellness, and community have always been the cornerstones of the Crisis Residential Program model, and they are entirely congruent with federal and state mandates for community-based mental health services. The economy and effectiveness they represent makes the need to "mainstream" them into the community an essential priority for every county mental health department straddling the two worlds of human needs and fiscal constraints. Crisis Residential Programs are a time-tested yet long-underutilized model whose time has come.

[9] CA Dept. of Mental Health (DMH) Director Stephen W. Mayberg, *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness*, May 2003, P. 5.
[10] DMH, *Vision Statement and Guiding Principles for the DMH Implementation of the Mental Health Services Act*, February 2005.