Contra Costa Mental Health Commission
PUBLIC HEARING
April, 28, 2011
Minutes approved 5.26.11

1. CALL TO ORDER / INTRODUCTIONS

The meeting was called to order at 5:50 by Vice Chair Kennedy. Introductions were made around the room.

Commissioners Present**:**
Peter Bagarozzo, District V
Evelyn Centeno District II
Peggy Kennedy, District III, Vice Chair
Dave Kahler, District IV
Colette O'Keeffe, MD, District IV
Floyd Overby, MD, District II
Teresa Pasquini, District I
Annis Pereyra, District II
William Wong, District V
Sam Yoshioka, District IV

Commissioners Excused:
Carole McKindley-Alvarez, District I, Chair

Commissioners Absent:
Supv. John Gioia, District I

Attendees:
Brenda Crawford, MHCC
Suzanne Davis-Lucey, Conservatorship
Kevin, an ASL interpreter
Thui, a Vietnamese interpreter
Patricia, a Spanish interpreter from International Effectiveness Centers
Candace Tao, Jail MH
Sara Marsh, CC Interfaith Housing
Karen Wise, Anka BHI
Dr. Joyce Martin, Anka BHI

Staff:
Linda Cipolla, Staff to MHC
Susan Medlin, OCE
Suzanne Tavano, MHA
Donna Wigand, MHA
Sherry Bradley, MHA
Mary Roy, MHA
Helen Kearns, MHA
Imoh Momoh, MHA
Holly Page, MHA
Erin McCarty, MHA
Vic Montoya, MHA
Jennifer Tuipulotu, OCE
Jeromy Collado, MHA
Caroline Sison, MHA
Vern Wallace, MHA

Vice Chair Kennedy explained that there were interpreters present at the meeting.
Sherry Bradley asked that the interpreters communicate prior to beginning the meeting in order to determine if anyone in the room required their services. No one requested interpreting services.

2. PUBLIC COMMENT

The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on items on the posted Agenda as they occur during the meeting. Public Comment Cards are available on the table at the back of the room. Please turn them in to the Executive Assistant.

There were no public comments.

2. **OPENING COMMENTS BY MENTAL HEALTH COMMISSION (MHC) VICE CHAIR**
   A. Review of authority for Public Hearing – W & I Codes 5848 (a)(b)
   B. Review of Public Hearing purpose

Vice Chair Kennedy read the W&I code and purpose of the public hearing from the packet:

W & I Codes 5848 (a)(b):

"(a) Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans.

(b) The mental health board established pursuant to Section 5604 (MHC) shall conduct a public hearing on the draft plan and annual update at the close of the 30-day comment period required by subdivision (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board (MHC) shall review the adopted plan or update and make recommendations to the county mental health department for revisions."

Public Hearing purpose:

The purpose of the hearing is to receive public comment on the Mental Health Services Act Community Services and Supports Plan submitted by the Mental Health Department. The public hearing is an opportunity for the public to give comment on the plan. It is not the place for discussion of the merits of different suggestions or to make decisions. When all public comment has been received tonight, the public comment period will be closed and the Board is not required to respond to further public comments.

3. **MHSA DRAFT 2011/2012 ANNUAL UPDATE TO THE 3-YEAR PROGRAM AND EXPENDITURE PLAN by MHSA Program Manager Sherry Bradley and designated presenters from Mental Health Administration**
   Update available for review at:
   http://www.cchealth.org/services/mental_health/prop63/pdf/2010_plan_update.pdf

Vice Chair turned the meeting over to Sherry Bradley and the MHA team of presenters listed on page 2 of PowerPoint:

Suzanne Tavano, RN, PhD, Acting Mental Health Director
Sherry Bradley, MPH, MHSA Program Manager
Vern Wallace, LMFT, Children's Mental Health Program Chief
Victor Montoya, Adult Mental Health Program Chief
Mary Roy, LMFT, PEI Coordinator
Imoh Momoh, MPA, Ethnic Services & Training Coordinator
Holly Page, MPH, Planner/Evaluator – CSS Component
Laura Balon-Keleti, MPA, Planner/Evaluator – PEI Component
Caroline Sison, MPH, Planner/Evaluator – WET Component
Erin McCarty, MPH, Planner/Evaluator – INN Component

Sherry Bradley began the PowerPoint slideshow on page 3 'Summary of What's Included in MHSA FY 11/12 Annual Plan' through slide #12. *(see PowerPoint inserted as a matter of record)*

Holly Page presented CSS Outcomes beginning on slide #13 through #27

Sherry called for questions:

Vice Chair Kennedy asked for a brief description of Outreach and Engagement specifically for the TAY population. Vic Montoya said it varies, there is a lot that goes on in the shelters and there is staff assigned to shelters on a weekly basis.

Kennedy rephrased saying, you are targeting those locations with access to the most people who are in need. Montoya said the other place that is targeted is crisis stabilization or hospitalization.

Suzanne Tavano said generically since full service partnerships are voluntary in nature, it often takes reaching out to consumers in the community and engaging and moving them along towards voluntary participation. Regarding Transitional Age Youth (TAY) they tend to want to be on their own which requires a need to be a lot more proactive.

(The interpreters left the meeting at this point)

Suzanne Davis wondered about the Young Adults diagnoses, and wanted a percentage for dual-diagnosis, and wondered if it was included in the research. She felt it was a high percentage.

Holly Page explained tracking issues:
Dual diagnosis can be tracked because there is a notation available on the form. For Medi-Cal there has to be a primary diagnosis with a mental illness, and she thought that substance abuse could be noted as secondary. Even though dual diagnosis could be noted on the form, there wouldn't necessarily be a diagnosis. She said the data is available and may be in the report but it was not included in the presentation.

Acting MH Director, Dr. Tavano explained further saying that in the statistical manual there isn't a 'dual diagnosis' but they recognize they are co-occurring conditions. There are conversations going on currently around the state about this. Historically Medi-Cal put fear into the clinicians about claiming substance abuse or related diagnosis on the assessment because historically there has been a lot of denial, claiming an issue as substance abuse only, and not mental health. MHA has been engaging their clinicians in assessing for substance abuse disorders and including them as long as there is a primary MH diagnosis, you still can and should diagnose for the substance abuse disorders. Until they do that accurately they aren't adequately shaping their treatment approaches. It's being talked about and is a big initiative for this year and going forward.

Candace Tao said from BH core clients she only knew one person in several years who was not involved with substances. It would be useful for everyone to recognize one of the goals in their treatment planning was relating to substance use.
Also, she was surprised there were no stats on reduced jail days, or around criminal justice.

Holly Page said the only way to currently track that is from state mandated Full Service Partnership forms. The issue in usage of the key event tracking form, is remembering to use it. MHA knows incompletely noted forms have been occurring statewide. The case manager is supposed to fill it out when the (client/patient) goes to jail and once they leave jail another form is supposed to be filed confirming leaving

jail and including the new residential setting. MHA is hesitant to report the data since it is being underreported and can appear either as: a person goes to jail and never leaves, or that a person never goes to jail. She felt the leaning from the data was appearing as if the FSPs never went to jail.

Candace Tao agreed and felt Page's opinion was accurate and that the data didn't tell the whole story. She felt for the most part that they are successful. A key note in recognizing whether the program is successful… part of treatment is going in and out of jail and I think you're missing a big piece of that.

Page said she wasn't specifying about whether they were going in and out of jail, her point was that the forms are not being collected correctly in order to have correct data.

Dr. Tavano said it is part of the process to identify areas where we could be doing better and this sounded like one of the areas they should be looking at in terms of training.

Tao felt it wasn't easy, it's very tedious with an in date and an out date, and there can be pages and pages but if you're going to be involved in it that's one of the things you need to do.
She said it would be extremely rare that a good case worker wouldn't know their person was in jail.

Imoh Momo presented Workforce Education and Training for fiscal year 09-10
PowerPoint slides #28 - #34

Commissioner Wong asked about the Psychosocial Rehabilitation Certificate and if it authorized employment as a psychiatric technician? (no) so what's the entry level position?

Momo said the intent was to help support consumer employees and help create a ladder to increase career goals. The current plan is to create a job class that would make requirements for people to get in front of consumer at a higher level.

Wong asked what was the lowest position available. Momo responded with, 'Support Worker I'. Tavano added that the current minimum educational requirement was SPIRIT training and internship.

Commissioner Pasquini thought that family members were Community Support Workers but didn't need to take SPIRIT.
Dr. Tavano said that was a good point. It's a classification within a classification. Peer Providers in the adult system versus Community Support Workers. We tend to refer to the Community Support Workers working with families as 'Parent Partners.' Parent Partners may take SPIRIT, but they may also go through training on wrap around services, etc. to qualify as an alternate method particular to their work assignment.

Commissioner Wong asked with the certificate of Specialization in Psychosocial Rehabilitation (Slide #34) what kind of entry level position could a person obtain?

Susan Medlin said it required certification as a Psychosocial Rehabilitation Practitioner and one could get there with 2 years experience and participation and 45 hours of training – depending on your level of education.

Dr. Tavano said there is a number of students that went through the SPIRIT program, got their college course and are now enrolled in this. So in addition to building a career track it really builds more of a track for consumers to go in, enter the college scene and work their way through. When they worked with Contra Costa College to get it going they actually had to build in safeguards because they already had so many

requests from students from Cal and UCSF who wanted to come over and participate in these courses so we had to put some lines around it and prioritize consumers that were interested.

Commissioner Pasquini said the course development is great. Brenda has advocated through Health Care partnership to have SPIRIT interns at the hospital. Her concern is the strategies used supporting education opportunities for families. That will be one of my public comments so I am mentioning it early in the evening. She thought there was a support opportunity missed with NAMI's 'family to family.'

Susan Medlin said Gloria initiated with the MH Director to work for family to family training for family advocates, but then Gloria left.

Dr. Tavano said when they were in the process requiring Family-to-Family as a prerequisite for Parent Partners and then Gloria left so we didn't continue to move it along but it's something we need to continue to do.

Momo said there are funds for family training that they will be doing ongoing in upcoming fiscal 11-12.

Commissioner Bagarozzo said it was a great program and wondered about expansion of it to other campuses.

Momo said there were conversations with many colleges including Diablo Valley College, but they had many challenges. West County College came forward and was willing.

Commissioner Bagarozzo asked when selecting students is the community considered rather than students who are already taking courses.

Momo said the program was open to the public because it's part of the Contra Costa College curriculum, so they don't have a say as to who can take it.

Susan Medlin said in regard to SPIRIT they have 40 places set aside for their clients and for contract providers, and there is an allowance program. Some people request it through the college. We were having conversations with DVC for awhile and it was dropped when the economy bottomed. We are hoping it'll be picked it up again but it would require additional staff in order to provide that.

Commissioner Bagarozzo asked by example, whether a LMC (Los Medanos College) student could participate in the SPIRIT program at Contra Costa College.

Dr. Tavano said it's been difficult and has taken years to get off the ground. Once it was approved, the budget cuts came and the question of who is going to pay for the actual classroom etc. So MHA went to the Bay Area Work force Collaborative. They pitched that with the location of the school that consumers from Alameda, San Francisco etc. could participate and so the Collaborative agreed and came up with some of the money to support the college in providing the course.

Commissioner Pasquini asked if anyone is welcome to join SPIRIT?

Susan Medlin said it is required to be a consumer or family member to get into the course. The application form is for allowances and only clients can apply for that. They typically get 90 applications a year and 60 people are chosen to be interviewed. Then 30 people are chosen for the allowance and 10 others to hold the

place. The rest of the students have to go through the college where they are screened to determine whether the students are consumers or family members.

Imoh Momo returned to slides #35 - 48
Brenda Crawford said in terms of that project *(CBO internship program slide 39)* consumer organizations and CBO who don't have licensed people on their staff to provide supervision for interns are excluded. MHCC would never qualify for a CBO internship program because they don't have the capacity to supervise interns. Momo acknowledged the issue and said other groups also have that problem.

Commissioner Wong asked whether they could have access to the data since it deals with quality. Momo said some trainers have the data and others don't. Trainers scan the data. Part of the guidelines is to keep the data for four years.

Sherry Bradley asked if using the evaluation of that particular training, they want to look at the pre and post test information to see the outcomes. Wong agreed.

Momo completed slide #47 and asked for questions.

Sherry Bradley said essentially they are not asking for funding because they'd already received their $4.7M which is good for a total of ten years.

Vic Montoya made people aware that the following day at East County Mental Health Center, his staff having worked with NAMI, would have their first Spanish speaking Family-to-Family graduation and the Sacramento chapter will be in attendance.

Mary Roy presented PEI Programs slides #49 - #59
She said there was a lot of additional data on programs and their outcomes available to the Commissioners if they were interested but she needed to keep her portion of the presentation to five minutes.

Roy opened for questions.
Dr. Tavano extended an invitation to the Commissioners for an upcoming conference on suicide prevention on June 10 which is open to the public.

Sherry Bradley explained there was a requirement to do local evaluation on one PEI program (the one they had selected for the state) and that Laura would present that portion.

Laura Balon-Keleti presented the PEI Local Evaluation slides #60 - #69
She said there was a 39 page report available for more details.

Sherry Bradley said they do an evaluation for all the PEI programs, they just need to focus on one to present to the State. She noted the slides in the packet were difficult to read and that she would resend the slides in a readable version. She then read through the funding requests slides #70 - #73.

Erin McCarty presented an overview of first innovation program slides #74 - #77
(outcomes were not yet available.)

Bradley spoke to Innovation Funding Requested slides #78 - #80. She said there are 32 programs in MHSA which is a lot of information to provide at once. During the 30 day public review and comment period

they'd received no input. Therefore what had been presented that day was being moved forward as the adopted plan.

4. **PUBLIC COMMENT ON PLAN**

The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. **Public Comment Cards are available on the table at the back of the room. Please turn them in to the Executive Assistant**. In the interest of time and equal opportunity, speakers are requested to observe a **3-minute maximum time limit** (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur.

Vice Chair Kennedy asked for public comment cards

PUBLIC COMMENT

- Brenda Crawford: Is it too late for public comments?
  - (Bradley) No we just have not received any comments up to this point in time
- Brenda Crawford: CSS – I suggest increase amount of money with FSP to provide more support services to in home consumers so they can remain in their homes; consumers who have experienced chronic and persistent homelessness sometimes have problems that do not keep them in their homes like –i.e. Hoarding. lack of ability to develop constructive social networks. Inability to develop ways to have social inclusion in their lives which enhances their ability to remain in their homes. Maybe think about supporting CSW's, Tender Loving Care workers or folks who would provide that kind of support to help people remain in their home.
- Brenda Crawford: WET – There is currently a movement going on in the state of California to work towards certifying peer specialists so that they may be able to build. Where it's going I don't know a lot of times I feel like we are chasing our tails. There are lots of calls on it there is lots of information being exchanged among peer providing organizations statewide. WET should benchmark some of that funding to be used if in fact certified peer specialists become a reality in the state of California.
- Brenda Crawford: Older Adult – Very few Older Adults are using existing resources like our community wellness centers. Training should be provided to Wellness and Recovery staff to increase the number of Older Adult folks who are 55 and older who are isolated seniors to take advantage of the wellness and Recovery Centers in all three areas. So that folks can remain in their homes. Also some sort of in-home peer support should be developed for Older Adults because a recent study done by UCLA research policy institutes said that Older Adult MH consumers as a result of the state budget cuts are one of the prime target groups in jeopardy of being institutionalized or services being cut that allows them to remain in their home.
- Brenda Crawford: PEI – a project that provides peer support and Wellness and Recovery that would allow people to continue to remain in recovery and prevent relapse should be considered and acknowledged.
- Brenda Crawford: We use some of the MHSA dollars to develop programs that are consistent with SAMSHA's 10+10 program to increase the lifespan of consumers by 10 years over the next 10 years. By including programs that deal both with health nutrition exercise as well as mental health recovery peer support.

5. **CLOSE PUBLIC COMMENT ON PLAN**

6. **MHC COMMENT ON THE PLAN**

MHC COMMISSIONER COMMENTS

- Commissioner Wong: The budget for the innovation program showed an operating reserve. Did all the other programs have an operating reserve?
    1. We are required to have an operating reserve for each CSS component.
- Of the 4+ million is there a lot of operating reserve?
    1. Yes
- Is there a budget allocation for capital residential treatment centers?
    - The Capital Facilities and Technology needs component was a one time allocation of 10.2 million dollars some of which could be used for what is called "Bricks and Mortars/Stick Building" or renovation of existing county owned property or the acquiring properties for renovation. That's one portions of the 10.2 million dollars has been encumbered 4 million dollars of it through stakeholder process has been set aside for an assessment recovery center and also folks wants a crisis residential facility and the other 6 million went to technology needs. Secondly the county had 9.2 million dollars called the CAL-FHA funding which is available to work with developers who are interested in developing property and then they can apply for a portion of the 9.2 million. 65% can be construction and 35% can be operations in terms of the developer's application. Usually what happens is one of our other contractors may work with a developer to acquire an apartments building or to build something from the ground up such as Lillie Mae Jones in west county a portion of that will have dedicated MHSA beds. You didn't see it today because we cannot use those funds to construct anything. (Suggest scheduling a Housing presentation to MHC)

- Commissioner Bagarozzo: Are any funds given directly to consumers for let's say mortgage? Or Housing allowance?
    - No. That's why we have Program #5 Housing for FSP Program. Those are the dollars we can set aside for board and care as well as other independent living vouchers.

- Commissioner Yoshioka: Will the PowerPoint presentation be uploaded to the website?
    - Yes we can upload it after we change the background colors. Cannot do it until Monday.

- Commissioner Pasquini: I feel the three minute comment limit is unacceptable given that the topic is about a lot of money, and we have a strong responsibility to our community to ensure that these funds are properly vetted and analyzed. Could the program Chiefs possibly better use this money in their programs for any significant way? I am deeply troubled by the 2 tiered MHSA system and I have the utmost respect for my fellow CPAW members and the leadership of Sherry Bradley leading the MHSA local process and my comments are not directed towards anyone here in the room who I consider my partners. I go back to the whistle blowers complaint filed by Rose King and I go back a new statement of priorities by Rose and I will be joining her on these. I think that our county has done a really good job of drawing down MHSA dollars and providing the perception of a good stakeholder process. But I'm very very concerned that the Commission does not have a full scope of the small numbers being served by these MHSA FSP's and the huge number of consumers and family that are going without. There is no context provided in this arena and it is so hard for me to say I approve of this plan because I have no context for the greater system needs. That goes back to the gap analysis that was one of our priorities. She read a statement: "I don't believe the MHSA was intended to fix all society's ills but rather to transform the Mental health System of care as defined by the W&I code. And the creation of a two tiered system further perpetuates the codified discrimination of those consumers and families who have been waiting for

equal care with other illnesses. And as Rose King says 'Discrimination against mental illness is the law in California and the real disparity in Health Care.' 'There appears to be an infinite tolerance for tragedy and no end to the number of conferences and workshops invented to substitute for actual services.' I strongly request that Contra Costa County's Mental Health Commission put an ethical lens over this process and social justice lens over this process and really think about what we are basically rubber stamping because a two hour process is not really adequately giving knowledge to a 600 page document which in itself is a crime that our state bureaucratic process requires a 600 page document when there are people going without medication, clothes and food that we are sitting here going over a 600 page document giving the impression that our system is serving all the needs. I don't have the numbers, we have 7000 adults in our system (More) so if you take those numbers and you compare them to the FSP's and you take the small number of wonderful SPIRIT consumers 35 enrolled." As a West County family member I will speak about my brother who is a West County consumer who nobody in my family has heard from in months. I hope he's okay and I used to be able to ask Gloria to check for me on that and without a family advocate I have no idea and my elderly parents have no idea either how their son is doing. So I agree with Brenda's comments about the need to reach out to isolated adults. So while the senior adult program is great I am wondering if we are missing the boat with those that we already know are there and need help. I think we are doing a really good job of following the law I just think the law is bad. *(See Rose King document inserted as a matter of record.)*

- Commissioner Centeno: Does this budget include services to the special needs people who are not mentally ill but are developmentally and other kind of disability. Or is it another population?
    - They are not in our target population.

- Commissioner Pasquini: I want to bring attention to the NAMI national crisis report of March 2011. I had a very detailed communication with NAMI California because this report states that California is one of the 10 states that cut the most in general funds from their mental health budget from 2009-2011 cutting $547.4 million dollars from their general fund dollars so as we celebrate MHSA put it in context and we hear about the closing of Seneca even thought the mandate is gone but the services are still needed. I am really troubled by that news because I don't think we have any less kids who need their services.

7. **ACTION: DEVELOP LIST OF COMMENTS AND RECOMMENDATIONS TO THE COUNTY MENTAL HEALTH ADMINISTRATION (MHA) AND TO THE BOARD OF SUPERVISORS (BOS)**

NOTE: The MHA does not have to follow the MHC's recommendations. However, the MHA must incorporate MHC recommendations as part of the adopted plan along with appropriate analysis.

Vice Chair Kennedy asked how Crawford's suggestions would be treated.

Sherry Bradley explained they take all comments, and staff determines whether it is currently being done and if it falls within the initial three year plan; if the recommendation requires additional funding and if so, it could require cancellation or elimination of some other programs. Then it gets summarized and if there is a change to the program it's noted. In the past, there have been changes made and if that occurs she would recirculate the updated plan.

The problem is in order to achieve the funding mechanism and the way things are still being worked out because of 80/100, the funds for MHSA are committed ($861/862M) but there is a rolling plan for how all those things will be funded. There is a point in the process where MHS funds are released in the amount of

approximately 50% of our allocation and that's if we have an 'approved plan.' The problem right now is we don't know who is approving our plan. Because the State Department of Mental Health has legally, statutorily been removed, and it had been reviewing and approving bodies of those plans. So we are still sending it to the state. What I believe is being worked out internally in the state is a mechanism that will release the funds. We can't trigger that, but they need to know there is an approved plan. We got an approval thank you letter from the OAC which was weird because we had submitted our 10-11 update to the OAC before AB100 was approved. We sent it in good faith believing that the OAC would have time to review it and approve it, and then the funding trigger would occur so the mechanism from OAC would be moved to the Department of Mental Health to the Department of Finance to the State Controller's Office. There is a process that's used to pay. What happened is AB100 got passed in the middle of our plan being reviewed. We received a letter saying, 'Thank you for your letter but we no longer have the authority to approve your plan.'

Commissioner Wong : This plan is requesting $24M (yes). Is it an entitlement program? (no). So there could be a chance you might not get $24M?

Bradley provided handouts and explained:
We get allocations for each fiscal year. We've been told that the funding is physically there, and there's plenty of money at the state. The good news is apparently they still have enough there to cover us for 85% to 90% of these allocations for fiscal year 11-12, even though $861M is going to AB3632, DPSDT and Managed Care. We will have to cover the rest with either reserve funds ($11.5M) or we will use additional unexpended funds, which we have quite a lot of. There is confidence there will be enough.

Commissioner Pereyra: Please explain to newer Commissioners the process of combined allocation; if approved today, how the process would work to go back and make those changes.
Bradley: There were updates to 2010, and you can make a change to the plan at any time during the year. It has to be stakeholder driven. If there are things in the plan you are not happy with, you have an opportunity as a stakeholder to ask for changes. Any time during 11-12 we can make changes to the fiscal plan – the Expenditure Plan. But please know that it creates a trigger. A great percentage is contracted out. County can control things quickly but 70-75% is for contracting and legal processes. The Board has to approve those.

MOTION:
Commissioner Yoshioka: I'm going to make a motion as stated here on the action for this item. Which is to develop a list of comments and recommendations to the Mental Health Administration and to the Board of Supervisors. That's my motion and I have a comment that I would like to make in further discussion.

Commissioner Wong seconded for discussion. He asked whether all comments that have been made thus far are to be submitted to Board of Supervisors along with the plan.

Commissioner Yoshioka read from the agenda "The MHA does not have to follow the MHC's recommendations. However, the MHA must incorporate MHC recommendations as part of the adopted plan along with appropriate analysis." This Commission doesn't approve, it makes recommendations.

Commissioner Centeno: The problem is they need time to digest and analyze to be able to make an intelligent recommendation. She could make a recommendation in a couple of days.

Sherry Bradley: The state is required to review and do something with the plan within 60 days. In order to receive funding in 11-12 we're required to provide our plan by June 30. In order to meet that deadline she needs to have it in the mail tomorrow or Monday. Dr. Tavano: after that the process starts devolving.

Sherry Bradley: The plan was available for review for 30 days from March 7 to April 7. In defense of the plan, everyone here had plenty of time. There is 30 days to ask questions and get back to me or talk to Suzanne, or at the time, Donna. Also, when I put the scheduling issue with Carole and Peggy about the public hearing, rather than have a special meeting earlier, they chose today's meeting which was more of a calendaring issue. It's unfortunate that it's falling so close, but there actually has been a long time to look at it. I think it's a situation of when folks need to do the preparation in advance.

Mary Roy: Also there was a day long outcome event where all outcomes from 09-10 were reported, both PEI and CSS. As staff we worked really hard to make the process transparent and public for everyone.

Commissioner Wong: asked Yoshioka for an amendment to the motion, 'to submitting recommendations to the BOS,' and would add, 'add the substance of all comments that have been submitted into the plan.'

Dr. Tavano: Sherry always includes all the public comments in a grid which shows how it was analyzed and the resolutions, so that is part of their process.

Vice Chair Kennedy asked if they need to make the motion if that will happen anyway?

Brenda Crawford: I think the process isn't good. It's not a process developed by Contra Costa County, it's the state process. I am interested in reading Rose King's letter to talk about how to change this ridiculous process that is imposed upon us by the state. The reality is it does require some level of approval from MHC in order to move forward. If it doesn't get that approval. Then it can throw a monkey wrench in bringing down the money but it is not the last opportunity…

Sherry Bradley: The Commission's approval is not required.

Commissioner Pasquini: I agree and I already made that point so I want to make sure that that's clear. That I agree it's not Contra Costa County - I think we do an excellent job of following DMH's guidelines and rules. I would like to ask Suzanne and Sherry if you feel… What do you need from us? Do you want a motion? (Yes).

- **<u>ACTION:</u> Motion made to develop a list of comments and recommendations to the Mental Health Administration and to the Board of Supervisors adding the substance of all comments that have been submitted into the plan:** (M- Yoshioka /S- Wong/Passed, 8-0-2, Y- Centeno, Bagarozzo, Kahler, Kennedy, O'Keeffe, Pereyra, Wong, Yoshioka A-Pasquini, Overby)

8. **CLOSE PUBLIC HEARING**

The meeting was adjourned at 6:40pm.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours

MHSA
Fiscal Year 2011-2012

OVERVIEW

FY 11/12 Annual Plan Update to the 3-Year Program and Expenditure Plan

Presented to Mental Health Commission for Public Hearing – April 28, 2011

Introductions/Presenters

- Suzanne Tavano, RN, PhD, Acting Mental Health Director
- Sherry Bradley, MPH, MHSA Program Manager
- Vern Wallace, LMFT, Children's Mental Health Program Chief
- Victor Montoya, Adult Mental Health Program Chief
- Mary Roy, LMFT, PEI Coordinator
- Imo Momoh, MPA, Ethnic Services & Training Coordinator
- Holly Page, MPH, Planner/Evaluator – CSS Component
- Laura Balon-Keleti, MPA, Planner/Evaluator – PEI Component
- Caroline Sison, MPH, Planner/Evaluator – WET Component
- Erin McCarty, MPH, Planner/Evaluator – INN Component

Summary of What's Included in MHSA FY 11/12 Annual Plan

- Renewal/Approval of Existing Programs and funding expenditures for:
  - 6 Community Services and Supports (CSS) Programs
  - 13 Workforce Education and Training (WET) Programs
  - 10 Prevention and Early Intervention Programs
  - 2 Innovation Programs
  - 1 New Innovation Program
  - New Training, Technical Assistance and Capacity Building Funds Request

CSS Programs

Full Service Partnerships (FSPs)

- Program #1 – FamiliesForward: Children's FSP provides a comprehensive range of services and supports to Children 0-18, and their families, who have serious emotional disturbance/serious mental illness and have experienced repeated failure in learning environments and home environments. Services are based in far East County, including Brentwood, Oakley, Discovery Bay, Knightsen, Antioch and Bethel Island. The county contracts with Familias Unidas, the lead agency in the collaborative, as well as Community Health for Asian Americans. The collaboration includes county mental health staff.

CSS Programs, Continued

- Program #2 – Transition Age Youth Full Service Partnership (FSP): CC TAY Program is a partnership between Fred Finch Youth Center, Greater Richmond Interfaith Program (GRIP) programs operated for the Contra Costa Youth Continuum of Services (CCYCS) of the County's Homeless Program, and The Latina Center5. The program services Transition Age Youth (16-25) with psychiatric disabilities who are homeless or at imminent risk of homelessness, living within West Contra Costa County

CSS Programs, Continued

- Program #3 – Adult Full Service Partnership (FSP) – Bridges to Home: Bridges to Home (BTH) is a collaborative program that joins the resources of Rubicon Programs, Anka Behavioral Healthcare, Community Health for Asian Americans (CHAA) and Mental Health Consumer Concerns (MHCC) as well as Contra Costa County Mental Health. Rubicon Programs is the lead agency for the collaborative. Services are provided using an integrated team approach, based on a modified Assertive Community Treatment (ACT) model of care. The target population includes adults ages 26 to 59 who are homeless or at imminent risk of homelessness, who have a serious mental illness and are not being served, or are being underserved, by the current mental health system. Services are provided in West Contra Costa County.

CSS Programs, Continued

- Program #3, Continued:
- Familias Unidas is the second Adult FSP Program within Program #3. Familias Unidas specializes in providing services to mono-lingual adults in West County.
- Behavioral Health Court is the third Adult FSP Program in Program #3. When MIOCR funding was eliminated in 2008, CCMH expanded the contract with Anka Behavioral Health to include this population as FSP's

CSS Programs, Continued

- CSS Program 5 – Housing Services:
  - Housing available in this program supports full service partners (FSP's) in CSS programs #1, 2, and 3, and subsidies to individuals who have the option to become an FSP. The individuals targeted for these services are homeless adults or imminently homeless children/TAY and otherwise eligible for FSP programs 1, 2 and 3.

CSS - System Development Strategies

- Systems Development Strategies:
  - Program # 4 – Older Adult Program: The Older Adult Program serves seniors County-wide with teams providing outreach, engagement and on-going community and home based services to the most imperiled seniors in the county. There is also a team in the primary care clinics in each of the three regions of the county which is guided by the IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) model. The target population for this program includes older adults ages 60 and older who are isolated & living in the community, and severely disabled.

CSS – Systems Development Strategies, Continued:

Program # 6 – Systems Development Strategies:

- Enhancements to Office for Consumer Empowerment
- Planning for Future Systems Development
- Peer Benefits Advocates
- Family Partner Program
- Wellness Services
- Transformation Training

– Priority Population

- All consumers (not just FSPs)

Program Capacity

- Children's FSP's Served (09/10) 147 (FSP) + 356 (O&E)
- TAY FSP 160 (FSP) + 400 (O&E)
- Adult FSP 185 (FSP) + 25 (O&E)
- Older Adult (SD) 225 + 350 (O&E)
- Housing 168
- Systems Development (Other than Older Adult) 8,700
- Administration

CSS Funding Requested

- CSS Program 1 – Children's FSP
- CSS Program 2 – TAY FSP
- CSS Program 3 – Adult FSP
- CSS Program 4 – Older Adult System Dev.
- CSS Program 5 – Housing
- CSS Program 6 – System Development Strategies
- CSS Administration

- Program 1 - $1,180,671
- Program 2 - $203,652
- Program 3 - $4,367,200
- Program 4 - $2,885,118
- Program 5 - $2,771,578
- Program 6 - $3,423,823
- Admin - $2,224,806
- Op. Reserve - $1,705,685
- Total: $18,762,533
- 57% of Those Served are FSP's

CSS Outcomes
FY 09-10

13

MENTAL HEALTH SERVICES ACT (MHSA)

COMMUNITY SERVICES & SUPPORTS (CSS) OUTCOMES

APRIL 28, 2011

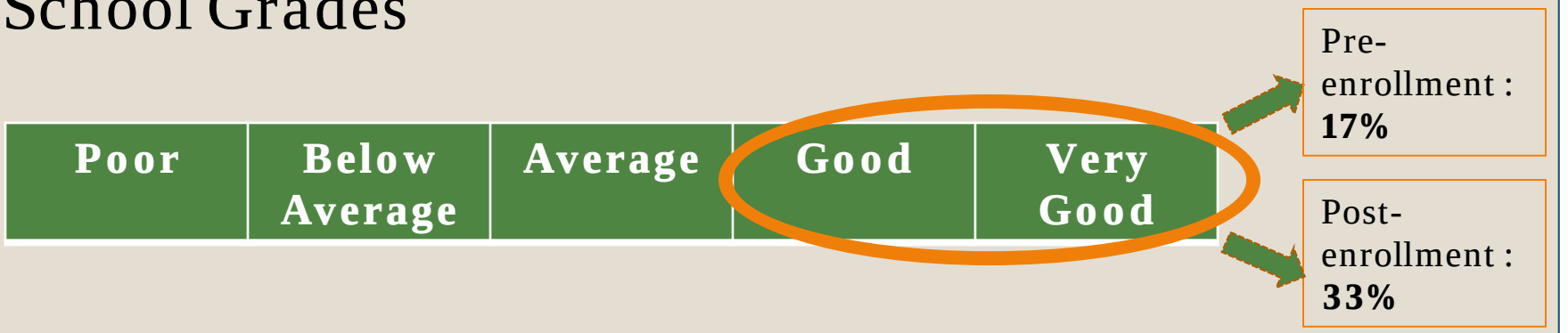
Program 1: Children's FSP

- Target Enrollment: 100 FSPs
- Served 147 during the FY
  - Average concurrent enrollment of 75
- 70% identify as Latino
- Diagnosis:
  - 26% Adjustment Disorders
  - 23% Mood Disorders
  - 22% Childhood Disorders

Children's FSP (Cont.)

- School Attendance

- School Grades



Program 2: TAY FSP

- Target enrollment: 90 FSPs
- Served 85 FSPs during the FY
  - Average concurrent enrollment is 65 FSPs
- 56% identify as African American
- Diagnosis:
  - 50% Mood Disorders
  - 29% Psychotic Disorders

TAY FSP (Cont.)

- Housing
  - 155% increase in those who live in an “apartment alone”
  - 42% decrease in those who are in emergency shelters

- CSU Visits/Hospitalizations

# of people hospitalized	# of people with CSU visits	Total # of CSU visits
56%	37%	30%

- Employment
  - 76 TAY’s (89%) reported employment as a recovery goal
    - 21 TAY’s (28%) are employed

Program 3: Adult FSP

- Target enrollment: 170 FSPs
- Served 177 FSPs during the FY
  - Average concurrent enrollment is:
    - BTH: 105 of 110
    - BHC: 20 of 30
    - Familias Unidas: 22 of 30
- Overall, 40% identify as African American and 29% as Caucasian
- Diagnosis:
  - 52% Psychotic Disorders
  - 46% Mood Disorders

Adult FSP (Cont.)

- Housing
  - 156% increase in those who live in an “apartment alone”
  - 89% decrease in those who are in emergency shelters
  - 80% decrease in those who report they are homeless

- CSU visits/Hospitalizations

# of people hospitalized	# of people with CSU visits	Total # of CSU visits
51%	30%	57%

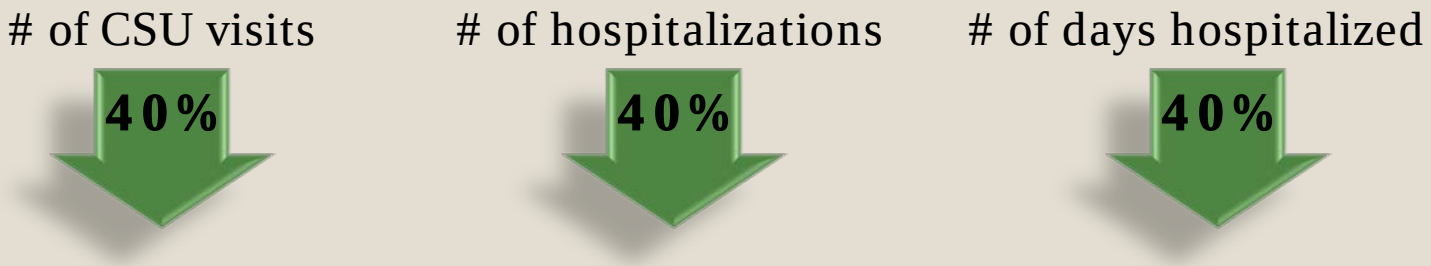
- Employment
  - 92 Adult FSPs (52%) reported employment as a recovery goal
    - 10 Adult FSPs (11%) are employed

Wellness & Recovery Centers

- MHCC provides peer support services to Adult FSPs
- Drop-in based recovery center to a membership-based recovery organization
- Developed 46 objectives to track and report to the County quarterly
- Introduced the Mental Health Recovery Measure (MHRM) to measure individual's progress towards recovery
- Intense focus on in-service staff trainings

Program 4: Older Adult Programs

- Target: 425 people served
- 180 older adults served during the FY
  - Outreach & Engagement efforts with over 500 individuals
- Intensive Care Management Teams & IMPACT
- Intensive Care Management Teams



  - Increase in older adults participating in walking groups; brown bag lunches; picnics; wellness centers and senior centers.

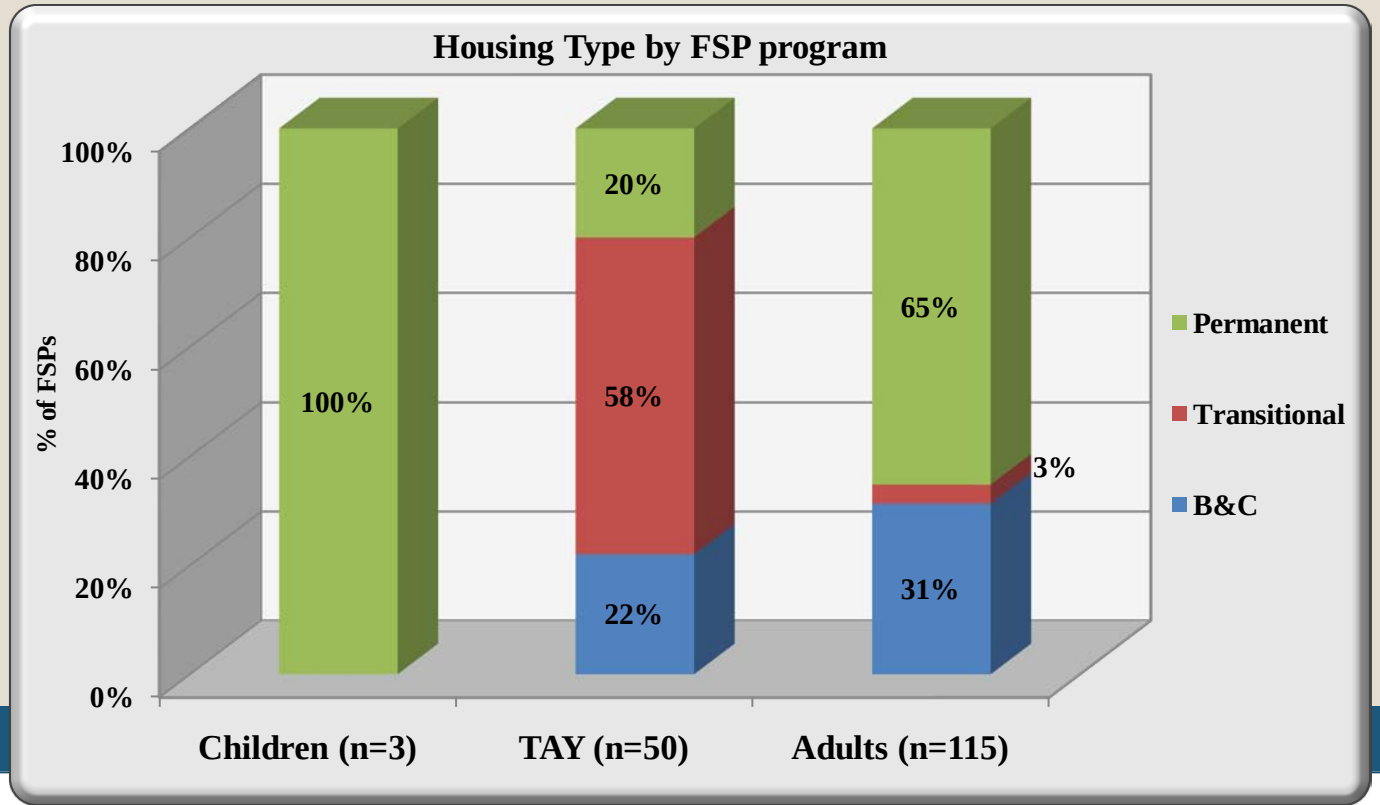
Older Adult Programs (Cont.)

- IMPACT
  - 40% improvement in PHQ-9 scores

  - Areas of greatest concern (as reported on the PHQ-9):
    - Energy
    - Depressed Mood
    - Negative Thoughts
    - Sleep

Program 5: Housing

- 168 FSPs received a MHSA Housing Subsidy
  - Permanent Housing – 88 FSPs
  - Transitional Housing – 33 FSPs
  - Board and Cares – 47 FSPs



Program 6: Systems Development Strategies

- Strategy #1: Office for Consumer Empowerment
  - Involved in many programs and initiatives
  - SPIRIT – 36 graduating students
    - 15 are employed
    - 8 are volunteering
    - 5 are continuing their education
  - 100% of SPIRIT graduates reported:
    - They can write a professional resume
    - They can dress for an interview
    - Good interviewing skills
    - Peer Counseling skills
    - They have the skills necessary to help themselves toward recovery

Systems Development Strategies (Cont.)

- Strategy #2: Plan for Future Systems Development
  - No activity as outlined in the initial 3-year plan

- Strategy #3: Peer Benefits Advocates
  - Unrealistic to measure individual outcomes
    - Tracking activities in distinct categories
      - Medication Support ~1,200 cases/FY
      - Access Line calls ~300 calls/FY
      - Bill Processing ~1,500 bills/FY
      - Daily Reports initiate:
        - 2,500 consumer phone # and address changes/FY
        - 2,000 uninsured consumers who may be eligible for benefits

Systems Development Strategies (Cont.)

- Strategy #4: Expansion of the Family Partner Program
  - The family partners and Wraparound Facilitators provided Wraparound to 210 youth during the FY.
    - West County Clinic: 70
    - Central County Clinic: 73
    - East County Clinic: 67
  - Average length of Wraparound participation: 306 days
  - Additional measures will be implemented during FY 10-11 which will allow for more in-depth analysis of outcomes.

Systems Development Strategies (Cont.)

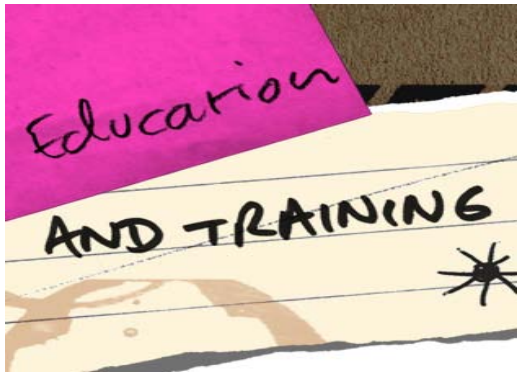
- Strategy #5: Wellness Nurses
  - 2 Wellness Nurses
    - East and Central Regions
  - Activities:
    - 158 in-home evaluations
    - Facilitated 131 groups with over 1,600 participants
    - Linked 1,409 people to primary care, pharmacy, laboratory services and support groups/programs
    - 1,114 people at the community centers were offered education and support services
    - 1,046 consultations with staff on behalf of consumers
- Strategy #6: Transformation Training
  - No activity as outlined in the initial 3-year plan

CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

Mental Health Services Act -

Workforce Education and Training (WET) Component

FY 11/12 - Annual Update



Recovery · Resilience · Wellness
Go Beyond
MHSA

WET Strategies

Funding Categories:

- Workforce Staffing Support
- Training and Technical Assistance
- Mental Health Career Pathways Programs
- Residency and Internship Programs
- Financial Incentive Programs

There are Thirteen (13) Action Items in the WET plan that fall under the above funding categories.

Funding Category	Action Items	WE&T Strategies/Objectives
Workforce Staffing Support	WE&T Coordination	• Expand postsecondary education capacity • Expand loan repayment, scholarship programs • Create stipend programs • Promote employment of clients and family members in MH system • Develop training curricula in accordance with MHSA values • Promote distance learning techniques • Incorporate cultural competency in al training and education programs • Establish regional partnerships • Increase Mental Health career development opportunities • Promote meaningful inclusion of client and family members in all training and education programs.
Training & Technical Assistance	Staff Development Training Initiative	
	Mental Health Training for Law Enforcement	
Mental Health Career Pathways Programs	Consumer Employment Strategies – SPIRIT program Expansion & Enhancement	
	Family Member Employment Strategies	
	Developing Mental Health Concentration in High School Academies	
	Community College Partnerships: Psychosocial Rehabilitation Certificate (PSR)	
	Psychiatric Technician Program	
Residency, Internship Programs	Expand Graduate Level Internship Opportunities	
	Psychiatry Workforce Development	
	Nursing Workforce Development	
Financial Incentive Programs	Scholarship Program for Bachelors Level Degrees	
	Scholarship Program for Master's Level Degrees	

WET OBJECTIVE:

INCREASE MENTAL HEALTH CAREER DEVELOPMENT OPPORTUNITIES

Psychosocial Rehabilitation Certificate (PSR)…

Develop a Mental Health Certificate Program that would support the need for well trained Staff (including Consumers & Family Members) who may not have resources to complete a bachelors or graduate degree.

Psychosocial Rehabilitation Certificate (PSR)

- Partnership with Contra Costa College (CCC) in West County.
- Curriculum from California Association of Social Rehabilitation Agencies (CASRA).
- FY 08/09: Consultation & Technical Assistance for the development of PSR program at CCC.

PSR Outcome: FY 09/10

- Two (2) Courses have been developed and integrated into existing CCC Human Services Curriculum.
- The courses will make up the core of a new 12 unit *Certificate of Specialization in Psychosocial Rehabilitation*.
- Classes began Fall 2010.

WET OBJECTIVE:

PROMOTE DISTANT LEARNING TECHNIQUES

eLearning System

- FY 09/10 Outcome: Acquisition of Essential Learning System.
  - Over 400 courses on-line
  - Continuing Education Units available
  - Courses available to all MH staff.
  - Courses available include: *Clinical skills; Cultural Competence trainings; Leadership trainings; HIPPA; Law & Ethics; Computer trainings.*

WET OBJECTIVE:

CREATE STIPEND PROGRAMS

Internship Programs

- Graduate Level Internship Program
  - CCMH offers internship to 20-30 MFT, Psychologists and Social Work interns a year.
    - Emphasis on recruiting multicultural/multilingual interns (pay-differential available)
- Nursing Internship Program
  - CCMH offers internship to 6-9 nursing interns a year
- Community Based Organization (CBO) Internship Program
  - CCMH offers opportunity to CBOs to increase workforce capacity by offering funds to hire interns.

Internship Outcomes: FY 09/10

- 21 Graduate Level Interns for FY 09/10
- 2 Nurse Practitioner Interns for FY 09/10
  - Four(4) interns were bi-lingual and were either fluent in Spanish, Vietnamese, French, Farsi and Russian)
    - CCMH has capacity to provide stipends for up to for 24 interns, and 7 bi-lingual graduate level interns
- Implementation of the CBO Internship program
  - For FY 10/11 Five (5) Community Based Organizations (CBOs) were awarded funds to hire interns for FY 10/11.

WET OBJECTIVE:

EXPAND POSTSECONDARY EDUCATION CAPACITY

Development MH Curriculum for High School Academies – FY 09/10 Outcomes

- Convened workgroup to develop MH curriculum in High School Health Academies.
- Workgroup included County Staff, educators, and contractor from California Institute of Mental Health *(CiMH)*.
- Pilot of MH curriculum to begin at Vicente Martinez High School in Winter 2011.

WET OBJECTIVE:

PROMOTE EMPLOYMENT OF CONSUMERS AND FAMILY MEMBERS IN MH SYSTEM

Service Provider Individualized Recovery Intensive Program (SPIRIT)

- SPIRIT is a 24-week consumer employment training program offered at Contra Costa College in West County.
- In FY 09/10 the program had 35 graduates.
- 69% of the graduates are either working in a mental health organization, volunteering or have gone back to school.

WET OBJECTIVE:

DEVELOP TRAINING CURRICULA IN ACCORDANCE TO MHSA VALUES

Trainings – FY 09/10 Outcome

- 130+ Trainings offered to CCMH staff and contract providers.

- Some of the trainings topics included:
  - *Crisis Intervention Training for Law Enforcement*
  - *Unlocking Suicidal Secrets*
  - *Mental Health Across Cultures*
  - *Various LGBTQ trainings*
  - *Psychopharmacology for Interns*
  - *Law & Ethics for Behavioral Health Providers*
  - *Community Support Worker Peer Support and Training*

WET – Tools Used Measure Outcomes

- Training Lists
- Personnel Records & Reports
- Pre-and-Post Training Tests
- Intern Records
- Training Evaluations
- Quarterly Reports

FY 11/12

- NO CHANGES IN ANNUAL UPDATE –

Continue program planning and Implementation

Funding Category	Action Items	WE&T Strategies/Objectives
Workforce Staffing Support	WE&T Coordination	• Expand postsecondary education capacity • Expand loan repayment, scholarship programs • Create stipend programs • Promote employment of clients and family members in MH system • Develop training curricula in accordance with MHSA values • Promote distance learning techniques • Incorporate cultural competency in al training and education programs • Establish regional partnerships • Increase Mental Health career development opportunities • Promote meaningful inclusion of client and family members in all training and education programs.
Training & Technical Assistance	Staff Development Training Initiative	
	Mental Health Training for Law Enforcement	
Mental Health Career Pathways Programs	Consumer Employment Strategies – SPIRIT program Expansion & Enhancement	
	Family Member Employment Strategies	
	Developing Mental Health Concentration in High School Academies	
	Community College Partnerships: Psychosocial Rehabilitation Certificate (PSR)	
	Psychiatric Technician Program	
Residency, Internship Programs	Expand Graduate Level Internship Opportunities	
	Psychiatry Workforce Development	
	Nursing Workforce Development	
Financial Incentive Programs	Scholarship Program for Bachelors Level Degrees	
	Scholarship Program for Master's Level Degrees	

PEI Programs

- Overview of PEI Programs for FY 2011/2012 – Presented by Mary Roy, PEI Coordinator

Program 1. Building Connections in Underserved Cultural Communities

Program Activities	Plan	Performance FY 09/10	Programs
• Strengthen Community • Strengthen Communications • Provide Mental Health Education / System Navigation Support	• **Activity 1**: Build strengths, wellness, and connectedness in their community • **Activity 2:** Select and implement an effective curriculum for improving intra-family communication • **Activity 3:** develop or expand culturally appropriate methods through system navigation	• Six programs were initiated in FY 09-10 serving: • Native Americans • LGBTQ • Latinos • African Americans • Afghans • Russians • Bosnians and • Iranian communities In 2011 two new contracts were added to serve the Asian/Pacific Islander Communities.	• Native American Health Center • Rainbow Community Center • YMCA/BBK • Jewish Family and Child Services • La Clinica de la Raza • Asian Community Mental Health • Lao Family Community Development

Program 2. Coping with Trauma related to Community Violence

Program Activities	Plan	Performance FY 09/10	Programs
• Coping with Community Violence • Community Mental Health Liaisons for Trauma	• Provide immediate direct early intervention with individuals and families affected by trauma; • Be available in the community and to law enforcement to organize CISD trainings and offer support to CISD providers including law enforcement; and • Identify and offer linkages to other trauma-related resources and supports available within Contra Costa County and beyond.	• RYSE Center has implemented the Trauma Response and Resilience System to address issues community violence, restorative justice systems change. • Developing a coordinated multi level response to critical incidents • They have also developed a youth justice project to work with youth involved with the juvenile justice system.	• RYSE

Program 3. Stigma Reduction and Awareness Education

Program Activities	Plan	Performance FY 09/10	Programs
• Speaker's Bureau • Wellness and Recovery Taskforce • Mental Health Perspectives TV Show	• The Speaker's Bureau • Wellness and Recovery Task Force, targeted outreach /independent requests for a speaker's event. Mental Health Perspectives will be available on the general public that watches local cable television. • The Wellness & Recovery Task Force and Speakers Bureau will also work with the Mental Health Reducing Disparities Workgroup to sponsor an anti-stigma educational conference in its first six months that will target mental health providers. • The Cable TV show Mental Health Perspectives will be re-initiated with new episodes produced.	• Staff for these projects were not hired until FY 10-11 • Speakers Bureau,& Community Partnership began in 10-11 • Wellness and Recovery Task Force and television show in planning stages	• Office of Consumer Empowerment

Program 4. Suicide Prevention

Program Activities	Plan	Performance FY 09/10	Programs
• Plan – Development of a Suicide Prevention Taskforce • Campaign- Suicide Prevention Campaign Committee • Crisis Line Capacity Expansion - Multi-lingual staffing	• Development of a Suicide Prevention Task Force that will collaborate and coordinate with the State Department of Mental Health and regional efforts, and will develop a county-wide Suicide Prevention Plan. • Appointment of Suicide Prevention Campaign Committee that will host a first annual Suicide Prevention Campaign countywide in 2009-10. This first campaign will be universal in nature. • Through an RFP Process, strengthening the language and cultural capacity of an existing, nationally certified suicide crisis line serving the county through expansion of multi-lingual staffing of those service.	• The crisis line capacity has been expanded to include Spanish and Asian language capacity. • The Suicide Prevention Committee has been meeting for the past 10 months and is in the process of developing a Suicide Prevention Plan for the County. • PEI funded 200 persons training throughout the county in suicide assessment and intervention.	• Contra Costa Crisis Center • Contra Costa Mental Health PEI Suicide Prevention Committee

Program 5. Supporting Older Adults

Program Activities	Plan	Performance FY 09/10	Programs
• Expanding Senior Peer Counseling • Community Based Social Supports for Isolated Older Adults	• Add Spanish and Chinese Speaking staff to the existing Senior Peer Counseling Program. This program is based on the Senior Peer Counseling model from the Center for Healthy aging in Santa Monica, CA. • The current program has 15 volunteer senior counselors and serves approximately 200 older adults a year. • Through an RFP process, CCMH will contract with one or more community providers for social supports and activities for isolated older adults.	• The Expansion of Senior Peer Counselors to include Latino staff member was added in October 2010 and Chinese speaking staff members was added in May 2010. • Two new contracts were executed in September 2009 one with Lifelong Medical to reach isolated older adults in public housing sites in Richmond. The other to pilot a youth senior peer mentoring project.	• Senior Peer Counseling • Lifelong Medical Care • Center for Human Development

Program 6. Parenting Education and Support

Program Activities	Plan	Performance FY 9/10	Programs
• Partnering with Parents Experiencing Challenges • Parenting Education and Support • Multi-Family Support Groups • Programs • Linkages to County Mental Health & Providers of Other Needed Services • Collaboration and System Enhancements • Intended Outcomes • Coordination with Other MHSA Components	• This is a selective prevention and early intervention project designed to educate and support parents and caregivers in high risk families to support the strong development of their children and youth. • Each has a prevention component and/or facilities early intervention for not only signs of mental illness, but signs of other stressors/factors which diminish mental wellness and resiliency such as domestic violence in the home, parents under stress, and other child developmental issues.	• In September 2009 Six CBO's received contracts to provide Parenting Education and Support. All implemented evidence based programs, three within the context of a larger program.	• Child Abuse Prevention Council • Family Stress Center • Latina Center • Contra Costa Interfaith Housing • La Clinica de la Raza

Program 7. Supporting Families Experiencing the Juvenile Justice System

Program Activities	Plan	Performance FY 09/10	Programs
• Community Supports to Youth on Probation • Screening, early intervention and discharge support at the Boys Ranch • Linkages to County Mental Health & Providers of Other Needed Services • Collaboration and System Enhancements • Intended Outcomes • Coordination with Other MHSA Components	• This is an early intervention project with two programs to identify youth in the juvenile justice system and provide individual and family supports that will help the youth to become strong, healthy, law abiding member of their communities.	• The three county positions were filled in 09/10 • One working with youth who voluntarily request services at Orin Allen Youth Center • 2 Community Liaisons to Probation helping youth to successfully return to or stay in their communities.	• County run supports for children and families

Program 8. Supporting Families Experiencing Mental Illness

Program Activities	Plan	Performance FY 09/10	Programs
• Programs • Linkages to County Mental Health & Providers of other Needed Services • Collaboration and System Enhancements • Coordination with Other MHSA Components	• Through an RFP process, one or more community-based providers will be selected to develop and provide respite for family care-givers. • Support of care-givers contributes to prevention of mental illness in the caregiver and increases their capacity to support their loved one with mental illness.	• The Program was successfully launched in 09/10 exceeding the projected numbers of people served.	• Contra Costa Clubhouse

Program 9. Youth Development

Program Activities	Plan	Performance FY 09/10	Programs
• Programs • Linkages to County Mental Health & Providers of Other Needed Services • Collaboration and System Enhancements • Intended Outcomes • Coordination with Other MHSA Components	• The programs proposed here are primarily early prevention efforts, therefore linkage to assessment or extended treatment for mental illness or emotional disturbance will not a significant focus. • It is the intent of CCMH to recruit contractors that are ready, motivated and have the capacity to deliver effective programming. • Youth engaged in the proposed programs will develop their/strengths/assets, feel supported and connected in their communities and will less be likely to develop mental illness or SED.	• 5 community programs were initiated in 09/10. All programs are meeting or working towards their targeted goals . These include: • RYSE Health and Wellness • New Leaf • People Who Care • STAND! • James Moorehouse Project- El Cerrito High	• RYSE • People Who Care • Stand! • El Cerrito High School James Moorehouse Project • Martinez Unified School District New Leaf Program

Program 10. Intensive Early Psychosis Intervention

Program Activities	Plan
• Prevent Mental Illness from becoming severe and disabling • Provide support to individuals experiencing the onset of Mental Illness and their families.	• Community Outreach and Education • Assessment • Treatment, including family psychoeducation, multi-family groups, Supported education and employment, medication

PEI Local Evaluation

- PEI Local Evaluation Project – Supporting Older Adults – Presented by Laura Balon-Keleti, Planner/Evaluator

PEI Local Evaluation

- State Requirement.
- Program 5 – Supporting Older Adults selected.

PEI Local Evaluation

Purpose:

- The purpose of the project is to identify isolated older adults, and through early identification and intervention, minimize the need for more intensive mental health services.

Strategies:

The strategies selected to target these individuals include:

- Expansion of the existing Senior Peer Counseling Program to include Spanish and Chinese-speaking coordinators.
- Creation of community base social supports for isolated older adults.

PEI Local Evaluation
SPC Program Description

Senior Peer Counseling:

- Trains volunteers 55 years of age or older to provide peer support and lay-counseling to other older adults.
- Attend an 8-week training course and are asked for a one year commitment .
- Attend weekly 2-hour group supervision and monthly in-services to continue learning about services and increase counseling skills.
- Supervised by licensed clinical staff.

PEI Local Evaluation
Lifelong Program Description

Lifelong Medical Care:

- Non-profit, federally qualified community health with a 34-year history as a "safety net" provider of health and social services to low-income and underserved residents of the East Bay.
- Provide isolated older adults in West Contra Costa County with enjoyable opportunities for social engagement and linkage to mental health and social services through the Senior Network & Activities Program (SNAP).
- This program is provided in 3 housing developments that lack on-site social services: Friendship Manor, Hacienda, and Nevin Plaza.

PEI Local Evaluation
CHD Program Description

Center for Human Development:

- Community-based organization that offers a spectrum of services for at-risk youth, individuals, families, and communities in the Bay Area.
- Provide opportunities for youth to develop caring, mutually beneficial relationships with older adults.
- Local young people are matched with local seniors in the Youth-Senior Mentoring Project.
- Each youth and senior pairing will have the support and supervision of a trained Senior Peer Counselor who facilitates the mentoring sessions.

PEI Local Evaluation
SPC Results

Senior Peer Counseling:

- Delayed due to the hiring freeze and challenge of recruiting the right individuals to provide culturally and linguistically appropriate services.
- In May 2010, the Older Adult Mental Health Program Manager was able to successfully locate and hire a Chinese Program Coordinator.
- In October 2010, a Spanish Program Coordinator was hired.

PEI Local Evaluation
Lifelong Results

Lifelong Medical Care:

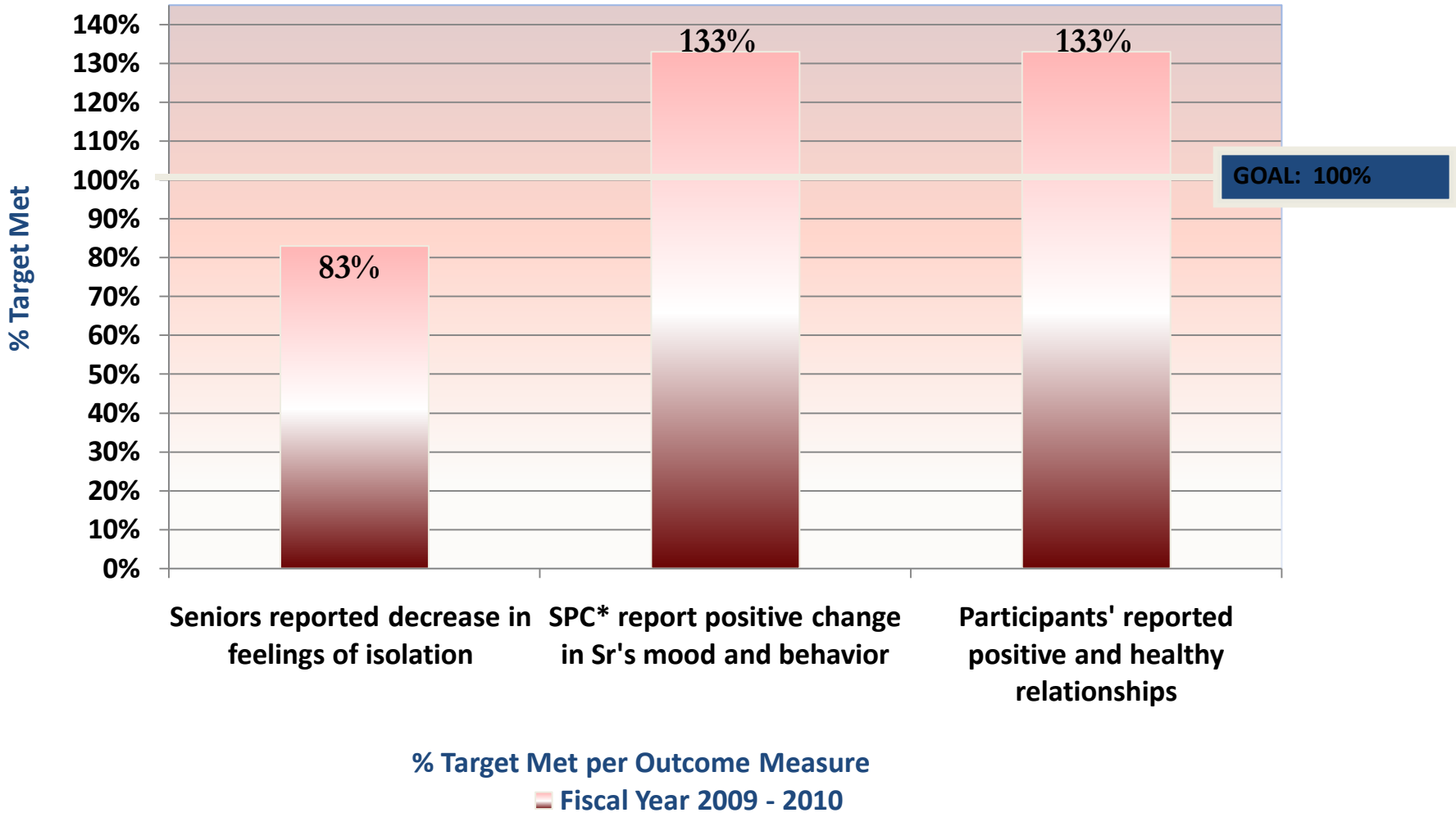
- SNAP! reached approximately 180 public housing residents.
- Engaged predominantly English-speaking African Americans (80%).
- Gender almost equally divided between men and women.
- All are residents from Richmond, California (West County).
- 31% may be socially isolated (based on scores of <12 on the LSNS-6 screen).
- 29% may have issues with depression (based on scores of 3 or higher on the PHQ-2).

PEI Local Evaluation
CHD Results

Center for Human Development:

- Engaged 69 participants.
- Age ranges are: 13-17 (55%), 18-21 (1%), 60+ (22%), and No Response: (22%).
- Gender: Female: (64%), Male (14%), and No Response (22%).
- Geographic Area of Residence: Primarily Central County (87%), East County (9%), and West County (4%).
- Ethnicity: Caucasian (45%), Asian/PI (17%), Hispanic/Latino (7%), Other (6%), and No Response (25%).
- Language: Predominantly English (87%), Asian (9%), and Spanish (4%).

PEI Local Evaluation
CHD Outcomes



SPC = Senior Peer Counselor

PEI Funding Request

	Funds Requested:
• Prog 1 – Building Connections in Underserved Cultural Communities	• $1,235,789
• Prog 2 – Coping with Trauma Related to Community Violence	• $593,154
• Prog 3 – Stigma Reduction and Mental Health Awareness	• $175,137

PEI Funding Request, Cont'd

Program Name	Funds Requested
• Prog 4 – Suicide Prevention	• $375,405
• Prog 5 – Supporting Older Adults	• $505,409
• Prog 6 – Parenting Education and Support	• $994,050
• Prog 7 – Support for Families Experiencing Juvenile Justice System	• $813,506

PEI Funding Request, Cont'd

Program Name	Funding Requested
• Prog 8 – Supporting Families Experiencing Mental Illness	• $462,000
• Prog 9 – Youth Development	• $873,161
• Prog 10 – Early Intervention for Psychosis	• $721,562

PEI Funding Request, Cont'd

Program Name	Funding Requested
• Subtotal for All 10 Programs	• $6,749,173
• Administrative Costs (15%)	
• Operating Reserve (10%)	• $1,012,376
	• $776,155
• Total MHSA Funds Requested	• $8,537,704

CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

2010/-2011 MHSA Annual Update Innovation

Contra Costa County

April 28, 2011

INN01: Social Supports for Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Two-Spirit (LGBTQQI2-S) Youth

3 Year Work Plan Approved by MHSOAC 4/28/2010
Innovation Funding Approved by MHSOAC $1,454,228

County Solicits RFIs

2 Contracts Awarded

RCC and Partners will:

- Develop a Social Support Model and determine if the Model can engage existing as well as potentially new social supports influencing the health of LGBTQQI2-S Youth/TAY population by educating and increasing the participation of families, peers, and communities in the lives and mental health services of the youth
- Attempt to reduce family, peer, and/or community rejecting behaviors and increase accepting behaviors and
- Establish baseline information to later assess if these changes promote positive health outcomes for LGBTQQI2-S Youth/TAY

Contract 1. *(Initiated FY10/11)*
Lead Agency:
Rainbow Community Center (RCC)

Partner Agencies:
Center for Human Development
Gender Spectrum
James Morehouse Project
RYSE Center

Contract 2. *(Initiated FY 10/11)*
Development of Educational Materials:
Dr. Caitlin Ryan and SFSU- Marian Wright Edelman Institute's Family Acceptance Project

RCC's key activities for Year 1 will include:

•Forming a Learning Community to include key partners and allies who will work together to develop mental health and social support services that promote family (peers and other social members) acceptance of LGBTQ youth and TAY and address their needs across the spectrum defined by the Social-Ecological Model

•Developing a new Mental Health community counseling capacity in Contra Costa County, this will work with the key social support elements defined in the work plan to specifically target LGBTQQI2-S Youth/TAY

INNFT01: Promoting Wellness, Recovery and Self-Management through Peers

- Approval/Thank You Letter from MHSOAC in April 2011
- Currently Awaiting Funding
- Implementation will occur FY 11/12

- Peer Providers will serve as trained wellness, recovery & chronic disease self-management coaches
- Determine if using Peer Wellness Coaches will:
  - improve service navigation
  - ↑ # consumers participating in health education &/or wellness activities
  - improve health outcomes
  - enhance mental health recovery/resiliency

INNFT02: Interagency Perinatal Depression Treatment Program

- Currently Awaiting Funding
- Implementation will occur FY 11/12

Purpose:

- Promote interagency collaboration between MH, Public Health (PH) & WIC
- Provide & integrate MH screening & intervention (for perinatal depression) in Central County WIC

Overview of Learning Goals:

•What are the most effective length & frequency of treatment?

•What medications are appropriate & @ what intervals?

•Are services more effective w/ particular sub-populations?

•Is the service approach replicable?

• Will the interagency collaborative effort result in improved working relationships & a shared sense of purpose between MH & PH?

•Will the provision of screening & intervention for depression @ WIC result in ↑ compliance with treatment?

•Will the provision of MH services @ the WIC site ↑ awareness about MH & ↓ stigma of receiving MH services?

•Will the women who participate in this pilot engage in their recovery?

•Will the women who participate in this pilot experience a ↓ in depression?

Innovation Funding Requested

Program Name	Funding Requested
• INN01 – Social Supports for LGBTQQI2-S Youth/TAY	• $768,480
• INNFT01 – Promoting Wellness, Recovery and Self Management through Peers	• $250,000
• INNFT02-Interagency Perinatal Depression Treatment Program	• $250,000

Innovation Funding Requested, Cont'd

Program Name	Funding Requested
• 15% Indirect Administrative Costs	• $190,272
• 10% Operating Reserve	• $145,875
• TOTAL REQUESTED:	• $1,604,627

Total MHSA FY 11/12 Funding Request

Requested Component	Funding Requested
• Community Services and Supports Request	• $18,762,533
• Prevention and Early Intervention Request	• $8,537,704
• Innovation Request	• $1,604,627
• Sub-Total Requested:	• $28,904,864
• Less Unexpended Funds	• $4,034,237
• Final Total Requested:	• $24,870,627

Program Descriptions

- Please see Executive Summary handout provided at the start of the Public Hearing. The Executive Summary includes brief description of the CSS, WET, PEI, and Innovation Programs.

For additional information on MHSA related programs/services, go to CCHS website at:

http://www.cchealth.org/services/mental_health/prop63/

April 27, 2011

TO: FRIENDS AND ADVOCATES.

FROM: ROSE KING

The stark reality is mental illnesses are not properly treated, needs of desperately ill people are not respected, and mental health is still not honored as essential to well-being

This message is to urge you to:

1. Tell Governor Brown and his administrators, and tell the DMH, OAC, and legislators to end discrimination against mental illness—get money to direct services through compliance with MHSA law and through parity in public mental health.
2. Get answers from your county supervisors. What are they doing about the misuse of MHSA funds and the inequities in mental health budgets?
3. Take a close look at the agenda of membership organizations paid to serve your interests. Are your concerns represented by any capitol advocates?

INDEPENDENT ACTION: Grief, tragedy, despair, energizing outrage, and a wavering attachment to hope, combine to mobilize individuals who are still working for humane, ethical, and effective mental health systems. Professional advocates often do not speak out for fear of jeopardizing prospective grants or political favors. And some consumers, family members, and providers are silenced by a threat of retaliation. At the same time, many individuals believe no consequences could be worse than the reality of today's disgraceful standard of care. We must take independent action.

POLITICS—DEFENDING STATUS-QUO: County mental health was *"Underfunded From the Start"* through 1991 Realignment revenue, according to a 2000-01 Senate report, and conditions in the base system have not improved in the last decade, despite billions in new MHSA revenue.

- Discrimination against mental illness in health systems is legislated, tolerated, and unchallenged.
- Progress is overwhelmed by waste, incompetence, potential conflicts of interest, and undue influence of special interests;
- Commissions and paid advocates fail to mobilize community-wide support or maximize access to private insurance, and, instead, vie for control of diminishing resources, with miniature expectations for consumers, and minimal impact on policy or political discourse;
- Local stakeholders lack essential information, direction, and independent resources, and communities are denied the tools to be effective advocates.

Are you satisfied with the status-quo?
Mental Health Advocates debate incidentals; **OAC** evaluates and surveys the obvious; **Politicians** move on to other issues. Little is demanded, the Capitol agenda is microscopic and myopic, and the minutia of bureaucratic meetings and maneuvers to gain more power is an expensive diversion from priorities. **There is an infinite tolerance for tragedy – and no end to the conferences, workshops, and stakeholder meetings that substitute for actual services.** Please review the attached, and ask what your advocates are doing about these priorities. Thank you for continuing encouragement.

April 27, 2011 FROM: Rose King

PRIORITIES: In these changing conditions, issues of immediate importance are:

FIRST, MHSA Law Changed but DMH Regulations Remain Out of Compliance.
MHSA continues to fund a Two-Tier System.. Governor Brown and the Legislature modified MHSA law, eliminating the state pre-approval process and costly bureaucracy, and paving the way for counties to fulfill the purpose of Prop 63. But state regulations remain out of compliance with the law—and counties cannot act to reduce local bureaucracies, generate savings, spend more on direct services, and integrate programs, until the state brings regulations in line with the law.

DMH regulations dictate county MHSA spending parameters. Thus, counties continue to divert MHSA revenue from core services in order to fund a separate MHSA system, perpetuating two tiers of service. MHSA pays for comprehensive services for a select few clients in a top tier, but short-changes the great majority of consumers who are served by a substandard, lower tier system. Countless news stories, budget cuts, clinic and crisis center closures, and personal accounts from consumers, families, and providers report deteriorating services. Both children and adults have been affected by service cuts, families cannot compensate for diminished resources.

NOW, **DMH regulations must be changed to comply with the law, ensure county savings, and raise the standards of service in systems of care, as the law intended.** The CMHDA position on the "two-tier system" provides a guide for equity and an integrated system, state regulations must allow counties and local stakeholders to dismantle the two-tier system and make better use of Prop 63 revenue.

SECOND, 2011 Realignment Proposal and Legal Discrimination Threaten Systems of Care. Today, realignment funds are inadequate, but a secure source of county support. NOW, a new realignment proposed by Governor Brown DOES NOT SECURE FUNDING for core services. If enacted, the 2011 Realignment would combine county funding for the children's, adult, and older adult systems of care with entitlements of EPSDT, AB 3632, and other mental health service demands that can draw down funds and force further cuts to core services. Entitlement programs are caseload-driven, and potentially could consume all realignment allocations for mental health. While county realignment funds also pay for state hospital civil commitments and services to adults in IMD's, MHSA revenue could become the primary source of funding non-institutional/outpatient services for adult consumers.

Discrimination against mental illness is the law in California—and the **real disparity in health care.** Adults are not entitled to treatment, as current law states that non-entitlement services are to be provided by counties *"to the extent resources are available."* MediCal-insured adults are entitled to necessary services for physical illnesses—but no guarantees for mental illnesses, insured or not. Your legislators and capitol advocates should focus on entitlement and a guarantee in 2011 Realignment.

Questions. Will the state make any guarantees? What will counties do when entitlement caseloads demand more funding? Are your family, consumer, professional groups, and your county and state officials keeping the promise of Prop 63? Have they challenged betrayal of MHSA law and the lack of parity in public mental health?