TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

A Proposal to the California Department of Mental Health
in Accordance with the Mental Health Services Act

EXECUTIVE SUMMARY

April 2009

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INTRODUCTION

Tri-City Mental Health System is submitting this Community Services and Supports (CSS) plan in accordance with California Department of Mental Health Letter 05-05, dated August 1, 2005. As one of six plans required by CA DMH under the Mental Health Services Act (MHSA), the CSS plan must reflect five core principles:

- Community collaboration;
- Cultural competence;
- Consumer- and family-driven systems of care for all age groups;
- Wellness focus, including the concepts of recovery for adults and resiliency for children; and
- Integrated service experiences for consumers and their families.

The CSS plan must prioritize services for adults and older adults who suffer serious and persistent mental illness (SMI), and children and youth who suffer severe emotional disturbances (SED). Specifically, the plan must organize services around four age groups:

- Children and youth between the ages of 0 and 15, including their families;
- Transition age youths (TAY) between the ages of 16 and 25;
- Adults between the ages of 26 and 59; and
- Older adults 60 years and older.

CA DMH requires counties to invest in three kinds of services—full service partnerships, systems development, and outreach and engagement—to effect positive outcomes for people who receive services, including helping them to:

- Develop meaningful uses of their time and capabilities;
- Obtain and/or maintain safe housing;
- Develop and/or strengthen supportive networks of relationships;
- Develop ways to easily and appropriately access assistance during a mental health crisis;
- Suffer fewer number of incarcerations; and
- Experience a reduction in (and hopefully elimination of) the number of involuntary mental health treatments.

Our proposed CSS plan projects services to begin in June 2009 (this fiscal year), and continue through June 30, 2012. The State has made available to Tri-City MHC the following allocations to support our CSS plan:

- FY 2006-07: $1,907,890 (to be spent/legally obligated by June 30, 2009)
- FY 2007-08: $3,586,800 (to be spent/legally obligated by June 30, 2010)
- FY 2008-09: $3,721,400 (to be spent/legally obligated by June 30, 2011)
- FY 2009-10: $4,989,000 (to be spent/legally obligated by June 30, 2012)
- FY 2010-11: yet to be forecast by CA DMH
- FY 2009-10: yet to be forecast by CA DMH

The proposed CSS plan divides these allocations into two types of funding: (1) on-going funds to finance mental health services and supports that we expect to continue year after year, and (2) non-recurring funds to finance mental health expenditures on a one-time basis.

MENTAL HEALTH NEEDS IN THE TRI-CITY AREA

The need for public mental health services in the Tri-City area is large, and growing. One simple way to estimate need is to compare estimates of the prevalence of mental illness with the numbers of people currently receiving publicly funded mental health services. The most current data available reveals the following numbers for the tri-city area:

- Population of the three cities: 230,000
- Prevalence rate of SMI/SED in the general population: 6.5%
- Estimate of the total number of people w/ SMI/SED: 14,950
- Population under 200% of Federal poverty threshold in the three cities: 85,000
- Prevalence rate for this population: 8.5%
- Total number of people below 200% of poverty with SMI/SED: 7,225
- Estimated number of people currently receiving publicly funded services in the three cities: 1,769

What these numbers reveal is that thousands of people who could benefit from public mental health services are not receiving them, even when we restrict the analysis to people living at 200% or below of the Federal poverty threshold. Moreover, we know the need is growing as veterans return from the wars in Iraq and Afghanistan, and as more families are impacted by the worsening economic recession.

THE PUBLIC PLANNING PROCESS

Beginning in November 2008, we have made presentations to well over 1,000 people in the three cities, One of our first tasks was to increase public awareness about the MHSA planning processes and the current and emerging system of care across the three cities. We not only wanted to increase *general* public knowledge about MHSA; we also wanted to increase specific understanding of MHSA and the CSS plan, particularly among people who are currently receiving services, or could be receiving services, and their families.

Data from these presentations and small group conversations helped inform the delegates process that produced the draft CSS plan. A total of 48 delegates participated in the CSS planning processes, representing a wide array of constituencies and stakeholders. We solicited applications for the delegate positions through early outreach efforts, particularly targeting representation from unserved and underserved constituencies. We also publicized the application through local newspapers to help attract candidates who might not already have a relationship with Tri-City Mental Health Center (Tri-City MHC). We analyzed the final roster of nominations to maximize diversity of representation before submitting it to the Tri-City Governing Board for approval.

Of the 48 delegates:

- At least 17% had received mental health services, and at least 21% were family members;
- 19% were African American, 6% were Asian and/or Pacific Islander, 19% were Latino, 1 delegate was Native American, and 46% were White;
- 6 delegates were fluent in Spanish, 2 in Tagalog, and 1 in Chinese Mandarin and Taiwanese;
- 35% were men and 65% were women;
- 52% lived in Pomona, 23% in Claremont, 19% in La Verne, and 6% lived outside the three cities; and
- 4 were children's advocates, 4 were TAY advocates, and 3 were older adult advocates.

Other constituencies represented included persons with co-occurring disorders, and persons who are homeless, unemployed, immigrant, disabled, or gay, lesbian, bisexual, or transgender. City and county departments represented included law enforcement, probation, LA County Board of Supervisors, LA County Department of Mental Health, and Congressman David Dreier's office.

In addition, approximately 25 observers attended the delegates meetings, including representatives from Catholic Charities, the League of Women Voters, NAMI Pomona Valley, and staff from the Tri-City Clinic and two recovery and wellness centers from nearby communities. Four members of the Ohlone Costanoan Rumsen Native American community, and a high school student writing a school paper about the planning process, also regularly attended meetings as observers.

Delegates met for a total of eight meetings between mid-December and early March. Meetings were held in the evenings from 5:00-9:00 p.m. to insure that people who work could attend. We served dinner at each gathering, and were prepared to offer child care and translation services if any delegate or observer required them (none did during this process). In between the meetings, delegates were encouraged to meet regularly with their constituencies to get their feedback and to bring back their feedback to the next meeting.

We began the delegates' process with a mini-seminar—spanning two meetings—that introduced participants to the concepts of recovery, wellness and resiliency, the concept of a system of care, and the history and evolution of the Mental Health Services Act. We then shared data about community needs and the current services in the Tri-City area, inviting delegates to supplement the formal data with stories from their own experiences and perceptions. We asked delegates to prioritize needs and potential investments to address the most urgent issues in the community, informed by the realities of existing budgets and the MHSA guidelines and allocations.

At this point in the process, delegates authorized a subcommittee to review the data that had emerged to that point, and then to develop program and budget options for the delegates to consider. The subcommittee's twelve members represented a cross section of the delegates, including people who receive services and family members. Subcommittee members met four times (over sixteen hours) during February to develop proposals for delegates to review. The delegates then met for three additional meetings to refine and revise the proposals that had emerged from the subcommittee.

Throughout the process, delegates were introduced to practices and principles that promote the emergence of collective wisdom. Rather than debate and compromise, delegates were introduced to the skills of dialogue and discernment. Delegates were encouraged to welcome divergent perspectives, treating such perspectives as neutral data rather than opposing views that people had to choose between.

For any major decision taken by the group, no voting took place. Instead, each delegate was polled using a tool called the Gradients of Agreement. (Part IV, Attachment 2) Delegates faced no pressure to agree with each other, or to develop convergent recommendations for the Tri-City Governing Board. Had the deliberations ultimately resulted in irreconcilable differences, the areas of convergence and divergence would have been fully documented and shared with the Tri-City Governing Board in the final report. In this case, however, every delegate fully endorsed the structure and budget of the CSS plan.

The plan submitted to the Tri-City Governing Board for final approval represents *a complete consensus* among the delegates.

THE ON-GOING INVESTMENTS

Delegates agreed to fund five on-going investments under the recommended CSS plan:

- Community Navigators;
- Full Service Partnerships;
- A Wellness and Recovery Center;
- Supplemental Crisis Services; and
- Field-Capable Services for Older Adults.

Community Navigators

The data regarding unmet need, and the current budget and economic realities confronting the state and counties, make it clear: as promising as the new MHSA funds are, these funds, by themselves, will not be sufficient to meet the needs of all of the people who struggle with mental health issues. In local communities, if we are committed to achieving the outcomes of the MHSA for *all people* who struggle with mental health issues, we must develop infrastructure to fully and effectively leverage all available community supports, including informal supports as well as professional services. This is the analysis driving the proposal for community navigators.

Community navigators and their teams will be a crucial structure to help people find the formal and informal supports they need. The navigators will help build teams of volunteers and staff from other organizations and community groups, including people who have received services, family advocates, family members, and leaders of unserved and under-served communities.

Community navigators will regularly visit community organizations, emerging and well-established health and mental health programs, law enforcement agencies, schools, courts, residential facilities, NAMI chapters, self-help groups, client advocacy groups, and others. This model provides the beginning infrastructure to implement a system of care that is responsive to the local needs of communities, people who receive services, and families.

Some of the specific responsibilities of the community navigators and their teams will include:

- Engaging people who need services and their families to help them quickly identify currently available services, including formal and informal supports and services tailored to their particular cultural, ethnic, age, and gender identities;

- Recruiting community-based organizations, faith-based organizations, and other community groups to become part of an active and ever growing locally-based support network for people in the three-cities, including groups and organizations in communities most challenged by mental health issues;

- Following-up with people with whom they have engaged to ensure that they have connected with support structures and received the help they needed;

- Using information technology and other means to map and keep up to date about the current availability of services and supports within the tri-city area; and

- Promoting awareness about mental health issues, and the commitment to recovery, wellness, and self-help that lies at the heart of the Mental Health Services Act.

Full Service Partnerships

CA DMH requires that the CSS plan devote at least 50% of its funding to full service partnerships. Full service partnerships are individualized services grounded in a "whatever it takes" commitment. Each enrolled individual, and where appropriate his or her family, participates in the development of a culturally appropriate plan focused on recovery and wellness. Each enrolled individual has a personal services coordinator (PSC), and is supported by a staffing structure that insures 24/7 support.

The plan can include all needed services, including but not limited to traditional mental health services, so long as the services and supports contribute to the outcomes of well-being defined in the plan. These outcomes include helping people:

- Develop meaningful uses of their time and capabilities, including education and employment.;
- Secure safe housing;
- Develop and strengthen a network of supportive relationships;
- Secure timely access to services, including crisis services; and
- Avoid incarceration or involuntary services.

Wellness and Recovery Center

We will create a new wellness and recovery center that will promote recovery, resiliency, and wellness for people confronting mental health issues. Staff located at this site, including peer advocates, family members, clinical staff, and others, will provide a range of culturally competent, person– and family-centered services and supports designed to promote increasing independence and wellness for people of all ages.

The center will be open 6-7 days a week, and for extended hours on many days. It will be open to anyone who wants to participate in its programs and offerings. Staff and volunteers will welcome people of all ages. Programming will focus as much on strengthening a sense of identity and connections to natural communities of support as it will on providing education and technical information.

The center will not offer intensive counseling, medications, or other more traditional mental health services. Other providers in the community do that. Instead, the center will support people who have struggled with mental health issues accelerate their movement toward independence, recovery, and wellness. We expect that many participants in Full Service Partnerships will engage with the center, but again, the center is for anyone who wants to benefit from the activities there.

Some of the specific activities and supports offered through the center will include:

- Self-help groups, and other peer and family support services: Peers and family members will be on site, both as paid staff and volunteers, to offer a wide range of supports and services, including mentoring, peer advising, self-help groups,

skills classes, classes on how to navigate the system, classes and mentoring on effective advocacy and leadership, vocational counseling, and many others.

- Services to promote increasing independence: People coming to the center will be able to access a range of support services to help them move to increasing levels of independence, including help with pursuing additional education, employment, and/or housing. These services and supports will also include leadership and workforce development training, helping participants develop effective communication, advocacy, and other related skills.

- Educational resources: People who come to the center will have access to a resource library, a computer lab, and classes focused on culturally-appropriate, evidence-based, and promising practices and therapies.

- Recreational and cultural activities: The center will offer a range of recreational and cultural activities, including exercise classes, social networking classes, classes in cultural art and music, and many others. Frequently led by peers, family members, and/or leaders and teachers from different communities, these activities will be designed to strengthen a sense of cultural identity and belonging.

- Assessment and linkage services: The site will be open to anyone who wants to participate in its programs and supports. As it becomes known in the three cities, we expect that people who may be averse to traditional mental health clinics may come to find support or help. We will have clinical staff and others on site who can engage people new to the mental health system, helping them determine the type of supports they would need. Staff will work closely with the Community Navigator teams to help facilitate access to a wide variety of mental health and other services and supports, including referrals to traditional mental health services if such referrals are warranted and desired.

- Specialized supports and services for TAY: A special section of the site with a separate entrance (or a separate site very near the center) will be dedicated to transition age youth. This part of the site will be staffed primarily by highly skilled peers who have life experience relevant to young people struggling with mental health issues. Professional staff will support the peer staff. Staff will offer a range of support and transition services to TAY. This part of the center will be open after-hours to provide a safe place for TAY to come who may have no place else to go. Staff will work to develop trusting relationships with these youth in order to support them in accessing the help they need.

Over time, we expect that most staff and management of the center will be a diverse array of people who have received services and family members. The center will also be guided by an advisory council whose members will come from diverse communities in the three cities, particularly unserved and underserved communities.

Supplemental Crisis Services

While the Tri-City clinic, and other providers in the area, offer 24/7 crisis support for *people they are serving,* people who are not currently receiving services who suffer a crisis during the evening or on weekends must rely on Los Angeles County's Psychiatric Mobile Response Team (PMRT). Given that the three cities are on the eastern edge of the county, response times can sometimes take hours. Such long response times before a clinician is available to support the person in crisis and his/her family increases the likelihood that the situation will deteriorate, resulting in a 5150, the person being sent to an emergency room, or the person being incarcerated.

While Tri-City MHC cannot afford to reconstruct its own after-hours system to replace LA County's after-hours PMRT, we propose to supplement this after-hours system with clinical support. Specifically, we intend to contract with several clinicians who will provide coverage after-hours and on weekends.

These clinicians will not be LPS qualified; they will not have be able to write 5150s or 5585s. What they will be able to do is respond to police calls, meet the police at the location of the crisis, and offer support to police, the person in crisis, and others present. they would also be able to travel with police and the person to another location if such movement might help diffuse the situation. If ultimately a 5150 has to be issued, the clinician will wait with the person and the officer until the PMRT arrives. We believe that such clinical support will likely diffuse many situations and ultimately avoid a 5150, an emergency room referral, or incarceration. These after-hour clinicians will also be connected to the Community Navigator teams, so that if referrals for the person in crisis are needed, they will have up-to-date information about services and supports that are available. This program advances the goals of the MHSA by avoiding unnecessary involuntary commitments, incarcerations, or hospital stays.

Field-Capable Service for Older Adults

Older adults are the fastest growing population in the cities of Claremont and La Verne. While a number of programs provide health and social supports for older adults, there are few services to meet the mental health needs of this population. Older adults, especially frail elders, need more accessible mental health services provided at locations convenient to them—e.g,, in their homes, senior centers, and medical facilities.

Tri-City Mental Health system will hire or contract with one or more clinicians (equal to 1.0 FTE) with expertise in older adult mental health issues. This clinician (or clinicians) will spend much of his/her time engaging with seniors who have serious mental health issues in their homes, in senior centers, and other places where seniors are present. They will integrate their work with other providers of senior services in the Tri-City area, and with the Community Navigator teams.

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Administration

The administration funds in the CSS plan will finance the needed infrastructure to support an integrated mental health system in the three cities. There currently is no system in place to coordinate the various providers and services in the tri-city area; no data system to support planning, billing, and to track outcomes; and no contract monitoring infrastructure to allow straightforward subcontracting of services. All of this infrastructure will have to be created. We will begin to create this infrastructure through the CSS plan, and continue its development through future MHSA plans.

The Non-recurring investments

In addition to recommendations for programs funded with on-going CSS dollars, delegates also reached consensus on a number of investments with available non-recurring funds. These investments include funding to:

- Support the planning process that helped produce this plan;
- Create reserve accounts to help support services when there are fluctuations in state revenues;
- Design, purchase or build, and furnish the wellness and recovery center;
- Support one-time expenditures—e.g., building rehabilitation, technology, and other infrastructure—to support the staff and services funded through the CSS plan.

Conclusion

We believe that the mental health system now emerging in the Tri-City area will ultimately be stronger and more effective than anything that has gone before. We believe the funding and implementation of this CSS Plan be a significant step toward a transformed system of care for the residents of Claremont, La Verne, and Pomona. We look forward to your feedback and support for this exciting effort.