JEAN M. SHEPARD
DIRECTOR

JENNIFER SCHAFFER, Ph.D.
BEHAVIORAL HEALTH DIRECTOR

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

BEHAVIORAL HEALTH DIVISION

3255 CAMINO DEL RIO SOUTH, SAN DIEGO, CALIFORNIA 92108

ALFREDO AGUIRRE
MENTAL HEALTH SERVICES DIRECTOR
(619) 563-2750/2700 • FAX (619) 563-2775/2705

SUSAN BOWER (Acting)
ALCOHOL AND DRUG SERVICES DIRECTOR
(619) 584-5007 • FAX (619) 584-5080

June 28, 2007

California Department of Mental Health
System of Care Division
1600 – 9th Street, Room 130
Sacramento, CA 95814

Attn: Eddie Gabriel

Enclosed is the Initial Mental Health Services Act (MHSA) Community Services and Supports (CSS) Implementation Progress Report for the County of San Diego.

A draft of this report was provided for public comment beginning May 22, 2007, through June 21, 2007. A copy of the Public Comment Form is enclosed, although comments were not restricted to use of this form. Public input was received via internet/e-mail, telephone, as well as through a number of public meetings staffed by County Mental Health. An advertised Public Forum was also held on June 7, 2007, during the regularly scheduled Mental Health Board meeting for the County of San Diego.

Sincerely,

ALFREDO AGUIRRE, LCSW
Director, Mental Health Services

PHILIP A. HANGER, PH.D.
Assistant Deputy Director, Adult and Child Forensic/Court Based Services
MHSA Coordinator

County of San Diego
Behavioral Health Division, Mental Health Services
Mental Health Services Act (MHSA) / Prop 63
MHSA CSS Implementation Progress Report
30 Day Public Comment Form
May 22, 2007 – June 21, 2007

PERSONAL INFORMATION

Name: _____
Agency/Organization: _____
Phone Number:_____ E-mail Address:_____
Mailing Address: _____

What San Diego County MHSA meetings did you attend? (√ all that apply)

☐ Community Meeting:	☐ Councils: ☐ Housing ☐ Children's SOC
☐ Other Committee/Meeting:	☐ Adult/TAY SOC ☐ Older Adult SOC ☐ Other

My role in the mental health system (√ all that apply)

☐ Client/Consumer	☐ Probation
☐ Family Member	☐ Education
☐ Service Provider	☐ Social Services
☐ Law Enforcement/Criminal Justice	☐ Other:

What do you see as the strengths of the report?

If you have concerns about the report, please explain.

Introduction and Overview

The County of San Diego Health and Human Services Agency (HHSA), Mental Health Services (SDMHS), was notified of the Department of Mental Health (DMH) approval of the Mental Health Services Act (MHSA) Community Services and Supports (CSS) Plan in May 2006; this report addresses the substantial implementation progress made during the period from DMH approval through December 31, 2006. During that time, CSS services and supports have enhanced mental health services for children/youth with serious emotional disturbances, and their families, and for transition age youth, adults, and older adults with serious mental illness.

Implementation activities are generally proceeding as described in the County's approved plan and subsequently adopted MHSA Performance Contract. MHSA Services were provided to clients as early as the Fourth Quarter of Fiscal Year 2005-06. As of December 31st, 2006, the majority of workplans identified in the CSS Plan had begun to provide services (nearly 55%). The remaining 45% of programs made progress toward implementation by obtaining Board of Supervisors' approval, selecting service providers and negotiating contracts. Among those programs not implemented by December 2006 are the Older Adult workplans, the TAY residential facility and the North County Walk-In Assessment Center. Delayed implementation has resulted from Request for Proposals offered more than once without receiving competitive bids. The influx of MHSA funding posed a logistical challenge as programs were competitively procured; these challenges have largely been mitigated.

MHSA CSS services are anchored in community collaboration, cultural competence, client/family-directed services, and in the principles of rehabilitation, recovery, resilience and strength-based services. As implementation progresses, many transformational activities have taken place. Examples include:

1) **Greater Client and Family Participation**, as evidenced by the Child and Adult Consumer/Family Liaison programs and hiring of consumers and Parent Partners.
2) **Serving More Clients**, by implementing new programs and expanding capacity and eligibility in existing services.
3) **Improving Outcomes.** Programs are collecting baseline data to measure outcomes, many beyond that required by MHSA, such as the extensive behavioral measures gathered by the children and adolescent programs.
4) **Decreasing Stigmatization.** Programs empower consumers by hiring them as program staff and requiring advisory boards consisting of consumers.
5) **Minimizing Barriers**, by providing more mobile outreach services and locating services in the areas with the highest level of need, identified by using GIS mapping.
6) **Planning and Use of Data**, by utilizing research and evaluation consultants to prioritize service delivery and target the greatest areas of need.
7) **Increasing Prevention** by serving the 0-5 population as well as increasing outreach.
8) **Including Primary Care in the Continuum of Care**, as evidenced by the Mental Health/Primary Care integration programs (started in January 2007).
9) **Use of Proven, Innovative, Values-Driven and Evidence-Based Programs.** New CSS programs are utilizing evidence-based models such as Incredible Years, Assertive Community Treatment, and Promotores Model of outreach

This Progress Report will be available for Public Comment from May 22, 2007-June 21, 2007. Extensive efforts will be made to ensure that the Report is widely distributed throughout the County, via electronic distribution and web based posting to our network of stakeholder and consumer communities.

Progress in implementing the San Diego County Community Services Plan has been ongoing during the period covered by this report. Although much remains to be done, significant progress has been achieved. With the support of clients, family members, and other community stakeholders, efforts to move forward towards transformation shall continue as implementation proceeds.

1. Program/Services Implementation

A. The County is to briefly report by each service category (i.e., Full Service Partnerships, General System Development and Outreach and Engagement) on how the implementation of the approved programs/services is proceeding. The suggested length for the response to this section is two to three pages per each service category. Small counties may combine service categories and provide a comprehensive update in two to three pages.

Responses are provided below, by workplan.

(i) Report on whether the implementation activities are generally proceeding as described in the county approved plan and subsequently adopted in the MHSA Performance Contract. If not, please identify the key differences.

The implementation of Community Services and Supports programs has generally proceeded as initially presented in the County of San Diego's CSS Plan Addendum submitted on March 15, 2006. Implementation status is provided by program in the following sections.

Full Service Partnership Implementation as of 12/31/06:

CY- 3 Cultural/Language Specific Mental Health Services for Latino and Asian/Pacific Islanders – Cultural Access and Resource Enhancement (CARE)

Culturally competent mental health services targeted to Latino and Asian/Pacific Islander children, youth and their families. Services "do whatever it takes" to assist clients in meeting their mental health goals, utilizing a comprehensive approach that is community based, client- and family-focused and culturally competent. For a variety of reasons these children and youth have been underrepresented in the mental health system; eligible clients that are enrolled in this Full Service Partnership (FSP) program receive comprehensive services that address a wide range of client and family needs. FSP services include case management and provide intensive services and supports as needed, and strong connections with culture-specific community organizations. Services are strength based, focus on resilience and recovery, and encompass mental health education, outreach, and a range of mental health services as required by the needs of the target population. This program began to provide services in July 2006, as outlined in the CSS Addendum.

- Services are provided by culturally and linguistically competent providers with focused outreach to Latinos, Vietnamese, Filipino and other Asian ethnicities.
- Program has recruited staff and publicized services in API and Latino specific journals and newspapers.
- Program staff have conducted extensive outreach to churches, schools, local ethnic specific community events, health clinics, and ethnic organizations
- Program employs family partners to conduct community outreach and outreach to families. Family partners speak various languages of the target population.
- Challenges:
    - As a new program, it has taken time to establish itself in the community, but extensive outreach has begun to mitigate this challenge.
    - A high number of children and families referred have not been eligible for services due to undocumented status, a County Administration restriction.
    - Some families that are uninsured have declined services because they refuse to pay the minimal UMDAP fee. Program has assuaged this issue by providing therapeutic adjustments when appropriate, but some families refuse to pay any amount.
    - Hiring a Vietnamese speaking clinician had been a challenge prior to December 2006, but one was recently hired and will begin work in April.

CY-5.3 Homeless/Runaway Mental Health Services - Counseling Cove

The Counseling Cove program utilizes a team-based approach to "do whatever it takes" to support homeless and runaway children and youth in attaining mental health services. Program staff provide Assertive Outreach and strong connections with community resources. Intensive mental health services, case management, and psychiatric services, including medication management are provided to homeless and runaway children/youth with SED (Serious Emotional Disturbance) utilizing a comprehensive approach that is community-based, client and family driven, and culturally competent. Services are strength-based, focus on resilience and recovery, and encompass outreach and a range of mental health services as required by the needs of the target population. This program began to provide services, as outlined in the CSS Addendum, in July 2006.

- Program located near a Metro area homeless youth shelter. Proximity results in immediate access to youth.
- Program staffing includes an outreach worker who works directly on the streets to engage homeless youth; Clinical staff participate in Assertive Outreach.
- Program has done extensive outreach to community providers that work with homeless youth.
- Program is connected to network that works with juvenile offenders that are chronic runaways and involved in prostitution.
- Program has implemented an Assertive Outreach model which is considered a best practice in work with homeless youth
- Program is implementing other brief interventions such as Eye Movement Desensitization and Reprocessing (EMDR) to address trauma issues present with homeless youth.
- Program is in process of becoming dual diagnosis capable to deal with co-occurring disorders, a major issue for this population.
- Conducting outreach to the school for homeless youth in METRO area and the school attendance review board (SARB) to access homeless youth who are "couch surfing" (a term to describe homeless individuals who move from temporary residence to residence) rather than living on the streets.
- About one third of the contacts are with transitional age youth; subsequently, program staff is able to promote access to new TAY programs as well as provide crisis intervention to TAY youth.
- Program employs flexible funds for outreach and to meet treatment plan objectives.
- Challenges:
    - Communication between agencies providing the array of services necessary to implement Full Service Partnership is difficult to implement and coordinate, but is improving.
    - In order to engage youth in treatment services, persistence and strong outreach efforts are required.
    - Homeless youth move around frequently and may go in and out of treatment, making this population more difficult to retain in services.
    - Attaining access to youth that are "couch surfing" makes this population more difficult to identify and requires different outreach strategies.

A-1 Homeless Integrated Services and Supported Housing- IMPACT

Assertive community treatment (ACT) is a team-based approach to delivering comprehensive and flexible treatment, support, and services. Assertive community treatment, or ACT, is for individuals who have the most serious and intractable symptoms of severe mental illness and who, consequently have the greatest difficulty with basic daily activities such as keeping themselves safe, caring for their basic physical needs, or maintaining a safe and affordable place to live. This ACT model program provides comprehensive individualized, integrated and culturally competent services. These services include rehabilitation and recovery services, utilizing Assertive Community Treatment (ACT) Team services that incorporate a "whatever it takes" approach to providing services for the client. As of December 2006, there were two contracted programs providing homeless integrated services and supported housing. One program, Impact, had already reached full case load and now is aggressively pursuing housing. The second program, North Star, has had

difficulties in hiring staff, primarily a Program Manager. Thus, their admissions have been slower. Efforts to hire qualified staff continue.

A-2 Justice Integrated Services and Supportive Housing
This integrated services and supports program also follows the Assertive Community Treatment (ACT) model. Unemployment, substance abuse, homelessness, and involvement in the criminal justice system are common problems. People who receive ACT services typically have needs that have not been effectively addressed by traditional, less intensive services.

The ACT teams provide comprehensive, individualized services in an integrated, continuous manner in collaboration with consumers. Treatment includes: psychiatric assessment, medication management, individual supportive therapy, substance abuse treatment, co-occurring disorders treatment, supportive housing, basic needs, family psycho-education, supportive employment development and legal assistance. Eligible persons must meet all of the following criteria; diagnosis of a serious mental illness or a co-occurring disorder of mental illness and substance abuse, serious impairment in daily living skills, prior mental health services have proven insufficient to meet consumer needs or the consumer has refused traditional outpatient mental health services and the person is assessed to have severe functional impairments indicating need for ACT level services as opposed to less intensive services.

The current provider, Center Star ACT, serves individuals county-wide, ages 25 to 59, that have current or recent justice system involvement with misdemeanor and/or felony charges, are in detention currently or within the previous year, have been treated for mental illness while in jail, and/or are re-entering the community from jail and are Medi-Cal eligible or indigent.

TAY-1: Integrated Services and Supportive Housing
The TAY Assertive Community Treatment (ACT) Program serves primarily foster youth who are homeless or at risk of becoming homeless. The program was scheduled to begin in July 2006 per the CSS Addendum and began to provide services in September 2006. Successful service and linkage to enrolled clients involves being very flexible, providing transportation for the youth or going to TAY directly (i.e. on the streets). More successful linkage has also resulted from outreach to foster care programs, working with case managers of those transitioning from Children's Mental Health or foster care, and by visiting identified youth in their homes, programs, schools, hospitals, Juvenile Hall or other community settings. One particular worker with high referral rates has done so by stationing herself one day a week at a Job Corps site, while her co-worker conducts outreach at a local community college.

- Challenges:
    - A primary challenge for the new TAY programs has been identifying a consistent core group of transition age youth to provide legitimacy of the program to their peers.
    - Infrequent client attendance; no-shows for scheduled appointments.
    - Frequently changing living arrangements.

General System Development Implementation Status as of 12/31/06:

CY-6 Early Childhood Mental Health Services
Mental health services are provided to children ages 0-5 and their families/caregivers, using the Incredible Years evidence-based model. Individualized, culturally competent, and strength-based assessment and treatment are provided to increase the resilience of the child and caretaker. Families are actively involved in the development of the treatment plan. Dual diagnosis services are provided using the Comprehensive, Continuous, Integrated System of Care (CCISC) model including screening, assessment and referral and a wellness, strength-based and resilience focus. This program was projected to begin providing services in July 2006 but began in August 2006.

- Targets 0 – 5 preschoolers and their parents, a highly under-served population in San Diego County.

- Program targets children in preschools in low income areas of North County that are predominantly Latino.
- Services are provided at the preschools, in home and/or other community settings.
- Program employs Promotora model to conduct outreach to the community and families.
- Services can be provided in Spanish for monolingual Spanish speaking families.
- Outreach to parents also occurs through the preschool teachers and when parents pick up their children each day.
- Program implements Incredible Years, an evidence based practice model for young children and families.
- Challenges:
    - Home visits: Families generally have a long history with Child Welfare Services, substance abuse and legal problems. These conditions may contribute to reluctance on the part of the some parents to allow the provider to come to their home. Mitigation occurs by establishing rapport with the parents at the preschool sites before home visits are approached.
    - Parent groups: Families are low income and have difficulty participating in parent groups due to work hours. Program provides child care and flexible times for groups to occur in order to engage parent participation, but this remains a challenging issue.

A-4: Family Education Services
Family Education Services provides family-driven countywide family education regarding major mental illness, stigma reduction and resources to improve access to care. The program was slated to begin in July 2006 and opened in November 2006. Outreach efforts are targeted toward Latino and African American communities. Two satellite sites are located in underserved areas, one at a primary care clinic in Logan Heights and the other at a mental health clinic in San Ysidro. An additional program site is being developed within a regional African American community to provide NAMI Education meetings. Program staff are conducting outreach, establishing rapport and providing information and referrals to clients. The program is co-sponsoring, with NAMI's Multicultural Action Center, free mini conferences for Spanish speaking residents that are seeking information about mental health issues, resources, and recovery possibilities.

A-5: Clubhouse Enhance and Expand with Employment
The clubhouse enhancement provides vocational, educational and social support for adults with psychiatric disabilities. The program, which consists of multiple contracts to provide services county-wide, was scheduled to begin in April 2006 and began to provide services by October 2006. The employment component includes an employment specialist and a job developer to assist MHSA clients to establish goals and obtain employment or volunteer opportunities. The job developer is working with the program director to establish transitional employment positions in the community which will provide additional opportunities to our members. The program has worked to provide equal opportunity and currently has a diverse vocational team which includes disabled and racial/ethnic representation. As an example, one job developer is bilingual in Spanish and English and is able to interact and converse with both English speaking hiring professionals as well as Spanish dominant individuals who own businesses in the community.

In one program, nearly 90% of clients have established either a vocational, educational or social goal, 8% have become competitively employed, and 5% have begun community based educational activities. Members are joining the workforce and have access to services related to volunteering and pursuing an education. One clubhouse has hired a kitchen manager position, who will teach members the skills required to work in a kitchen (for either a restaurant or a small business).

Linkage to programs and agencies that provide services to psychiatrically disabled homeless individuals and to those who have been incarcerated is provided. A comprehensive approach to cultural outreach is provided through presentation both to, and by, various racial/ethnic organizations specifically targeting African American, Native American and Latino populations. Educational presentations are offered, addressing issues from housing and mental health services to financial

and health support. A comprehensive referral component has been developed to receive referrals and refer members for resources.

A-6: Supported Employment Services
This program provides specific employment, educational and vocational training opportunities, and has been successful in assisting the seriously mentally ill secure jobs. Initially planned to begin services in July 2006, the program began in October 2006.

A Bilingual Employment Group is offered weekly, and ethnic-specific community providers are utilized to target unserved populations. Seriously mentally ill clients enrolled in the Serial Inebriate Program (SIP), a collaboration between the San Diego Police Department and an alcohol treatment program, are assisted in their employment search. A 'Job Club' is offered at a local club house, working, again, with the seriously mentally ill. To date, nearly 50% of clients became employed.

- Challenges:
    - Job retention: several individuals quit their jobs within the first week, though their employers stated that the clients were doing great work. These clients initially stated a desire to work, and when they quit their jobs reported, "I don't want to work."
    - For clients who have not been employed in two years or more, reentry into the workforce can be highly stressful. The most successful clients work part time, perhaps two days a week, and only 4 hours each day. Clients are encouraged to gradually increase their hours, building toward the goal of each client working at least 10 hours per week.

A-8: Enhanced Outpatient Mental Health Services
Enhanced outpatient mental health services are provided throughout the six Health and Human Services Agency (HHSA) regions of San Diego County. The program, which consists of multiple contracts to provide services county-wide, was scheduled to begin in April 2006 and began to provide services by October 2006.

Focused services for individuals with co-occurring substance use disorders and adult Latinos are provided. Services include group and individual rehabilitation, case management, medication management, crisis intervention, community linkages to facilitate clients' educational, vocational, and residential goals, and a Semi-Supervised Living Program (SSLP).

The enhancement of outpatient services has allowed for changes such as extensive outreach in the San Diego Community to increase access to mental health services and hiring of more bilingual/bicultural staff. Clients have expressed positive feedback regarding services offered in their "language of choice." The Adult Latino program provides enhanced services including culturally specific groups, individual counseling, case management, and crisis services. Another effort to address the disparity in access to mental health services is the design and implementation of mobile Bio-Psychosocial Rehabilitation (BPSR) services. Enabling BPSR Specialists in the Adult Latino and programs to initiate assessments and engage clients in the community has provided a valuable tool for connecting clients to the centers.

The Adult Latino Program is on target with its implementation and program goals. The Adult Latino coordinator, as well as core staff, have established relationships for employment opportunities with more than 25 businesses/employment centers. As part of the vocational focus, employment goals, progress, placement, as well as linkages and supports are tracked, through care coordination and case management.
Other program highlights include:

- Hiring a bilingual (Spanish-English) psychiatrist.
- Development of additional materials, translated into Spanish.
- Addition of one cultural focus group "Culture Counts" and a monolingual Spanish speaking group (with emphasis on Co-Occurring Disorders).

- Individual counseling, case management, and crisis intervention services provided in Spanish.
- Outreach and linkage provided through churches, schools, downtown medical facilities, Latino Health fair, and Chicano Clinic.

The Adult Asian/Pacific Islander program focuses on 3 primary ethnic groups, based on San Diego County census data: (1) Filipino, (2) Vietnamese, and (3) Chinese. While the Filipino ethnic group is the largest Asian subpopulation in San Diego, and a large percentage of Filipinos are English-speaking, many are covered by private insurance. The Vietnamese, therefore, are the largest group served, most of whom are Medi-Cal eligible, but there is an indigent subgroup. A Vietnamese therapist and psychiatrist were hired to meet the referral needs from the Vietnamese community. Outreach is performed within the Vietnamese, Hmong, Laotian, Filipino, Korean and Chinese communities as well as the chronically mentally ill and homeless populations.

- Challenges:
    - To hire staff to comprehensively meet the language needs of all of the clients we serve, including Cambodian and Laotian.
    - There is a need for bilingual/bicultural staff in all program areas, both therapeutic and administrative/clerical.

TAY-2: Clubhouse and Peer Support Services
The Oasis Clubhouse provides social rehabilitation, skill development, and vocational services to the seriously mentally ill aged 16 to 25. This program, scheduled to begin in July 2006, began providing services in September 2006. Members participate in a Clubhouse setting which focuses on individual strengths, talents, abilities, and interests. The focus is to improve the quality of life for the members by assisting them to assume responsibility over their lives, and to function as actively and independently as possible. The Oasis Clubhouse provides: mental health services, independent living skills training, educational assistance, job skills development and placement, peer mentoring, social and recreational activities and transportation assistance.
Formal outcome data has yet to be collected, but some initial data indicates that the majority of The Oasis Clubhouse's members are:

- Experiencing greater success with independent living and normative employment, and earning more income from competitive employment.
- Eexperiencing more positive social relationships and greater satisfaction with life.
- Reporting fewer symptoms of mental illness.

TAY-4: Enhanced Outpatient Mental Health Services
This Transition Age Youth (TAY) enhancement provides clinical outpatient services in a variety of clinics in the County that integrate mental health and a full array of Bio Psycho Social Rehabilitation (BPSR) and recovery services, designed to improve mental health and quality of life and to strongly support recovery for individuals with serious mental illness including those who may also have co-occurring disorders. Initially planned to begin in July 2006, the first provider began in October 2006.

MHSA funding has allowed for enhanced care, as there is more bilingual/bicultural staff to provide additional services to the diverse consumers and mobile services. In-coming phone screens are triaged to the separate departments to coordinate services more efficiently and decrease wait times. These services have shown good results in reaching youth who might otherwise not continue in their treatment when they were transitioned to adult programs. One way that we have reached these youth is to hire peer staff who support these youth by educating them on the value of treatment. Program staff is increasing outreach in the Community to increase access to mental health services. One barrier was finding clinicians bilingual in Tagalog/English, to target our underserved Filipino community. Recently a bilingual lead clinician was hired. TAY program outreach efforts include schools, National Alliance for the Mentally Ill, San Diego County Access and Crisis Line, Planned Parenthood, social services programs, and faith based organizations.

Outreach & Engagement Implementation Status as of 12/31/06:

ALL-2: Services for Victims of Trauma and Torture
The program provides outpatient mental health program services to survivors of torture and trauma. At intake, each client is interviewed and assessed by a mental health professional trained in the treatment of torture survivors. Psychotherapy services are tailored to individual needs and may include crisis intervention, individual, group and/or family therapy, home visiting, and collateral interventions with other agencies and providers. The frequency of sessions, inclusion of family members, and the use of interpreters are all determined based on the needs of the individual. To accommodate a culturally diverse client population, Therapists and staff use a flexible psychotherapy format and consider clients' experiences, preferences and cultural background in planning mental health interventions. Initially planned to begin in July 2006, the program began in December 2006. As a first time county contractor, the program required additional start-up time to adopt the county management information system.

Referrals come from the community through an established network of professionals and agencies who are familiar with the work of the agency and the unique population served. Referrals also come from existing clients. The program provides direct service and consultation to other organizations and agencies who identify torture survivors among their clientele.

CY-1 School and Home Based Outpatient Services for Uninsured Children/Youth with Serious Emotional Disturbance (SED)
Expands school based mental health services to serve the unserved. This countywide program currently provides school-based mental health services to Medi-Cal eligible children and youth (to age 19) and their families through community based contract providers. This program expands services to unfunded children and youth who would otherwise not have access to mental health care. Services are provided during the school year on designated school sites during school hours with family services and services after school hours or during school breaks offered in the home or office based locations. Service providers work closely with school personnel to engage and support SED youth and their families in defining their vision and purpose which then can be translated into strength-based goals. This program was projected to begin service provision in April 2006 and began in May 2006 following approval of the CSS Addendum.

- Ready access to kids because services are at school sites, mitigating transportation issues.
- Referral process for schools is simple and well established, thereby promoting access to care.
- Target areas of need countywide.
- Many of the schools have high percentage of Latino children and youth, a priority population as identified in our MHSA Gap Analysis.
- Frequently families are Medi-Cal eligible and referral by programs for Medi-Cal has increased. For these identified individuals, services are then delivered through EPSDT (Early Periodic Screening, Diagnosis and Treatment).
- Challenges:
    - Fewer parents are willing to participate in treatment when services are school based.
    - Home visits are offered but parents often decline.
    - Increased outreach needed to families – is planned to be addressed through CSS enhancement with addition of case manager/rehabilitative worker to each school based program.
    - Many unfunded children are undocumented and unable to access non-emergency services. Where possible, clients are directed towards other providers by referral.
    - Parents may be undocumented and reluctant to access services for their children who are citizens. Where possible, clients are directed towards other providers by referral.

CY – 5.2 Outpatient Therapy and Outreach –Juvenile Court and Community Schools (JCCS)
Integrated and coordinated outreach and mental health services are provided to SED youth attending the community based Juvenile Court and Community Schools (JCCS). Services are

expanded to serve uninsured youth county-wide and the newly expanded North Coastal and North Inland regions of San Diego County, which were not previously served due to the low prevalence of Medi-Cal clients in the North JCCS classrooms. This program was projected to begin services in April 2006, and began to provide services in June 2006.

- JCCS youth are frequently involved in juvenile justice system; youth in juvenile justice system are an underserved population.
- Some JCCS youth are expelled from their home school district and participation in counseling is a requirement to return to the home school, thereby advancing the MHSA goal to reduce institutionalization.
- JCCS program is in process of becoming dual diagnosis capable to deal with co-occurring disorders, which provides integrated service experiences for clients and families.
- Program is implementing the "Cognitive Behavioral Treatment" evidence-based practice model.
- Challenges:
    - JCCS youth drop in and out of school and move around frequently. Short term focus is utilized for treatment. Youth are hard to follow since they will often just no longer show up at school.

OT-2: Breaking Down Barriers

Breaking Down Barriers has effectively collaborated with other agencies, community groups, clients and their families members and other stakeholders in the Latino Communities in San Diego County to provide an analysis of the barriers preventing the underserved and unserved in these communities from receiving mental health services. This program was initially scheduled to begin in April 2006, but instead began in September 2006.

The bilingual and bicultural outreach coordinator conducts outreach events and meetings in community settings throughout San Diego County. These meetings involve engaging and educating community leaders (cultural brokers) so they can be the front line in educating and connecting their community members to mental health services in their area. When the meetings are being attended by community members, they are often conducted in Spanish. The outreach coordinator has attended and coordinated several workshops/forums throughout the county to increase awareness and to engage individuals to mental health services. Workshops have been conducted at churches, schools, and community centers throughout San Diego County. The attendees have included members of the Latino, Lesbian/Gay/Bisexual/Transgender, and HIV/AIDS affected communities.

- Challenges:
    - Overcoming the stigma against mental health illness in the Latino community. Forums and meetings were very poorly attended when newly established meetings were set up at which the topic of mental illness was presented. It proved much more effective to go into established groups and get on the agendas to talk generally about mental health issues.

Administrative Programs:

In addition to the FSP, OE, and SD programs, the County of San Diego also proposed numerous administrative programs. The majority of these programs began in 2006. These programs include efforts to improve outcome measurement, research and evaluation: Adult Mental Health Data Analysis and Performance Monitoring, Children's Mental Health Services Data Services Expansion and Administrative Services Organization Services Expansion. Other programs promote partnership with consumers and family members/caregivers: Children and Youth Consumer Family Liaison, and the Adult Consumer Liaison program. The Housing/Capital Facilities Consultant contract provides specific subject matter expertise. Programs that started in 2007 include the Community Education Coordinator and Information Technology Advisor.

1.a.ii. Major Implementation Challenges

(ii) Describe the major implementation challenges that the County has encountered.

There were a few challenges faced during the planning process. While the first submission was on December 15, 2005, approval from the Department of Mental Health was not received until May 16, 2006. This impacted CSS implementation in two ways: first, the procurement process was significantly delayed and programs were not able to begin services as initially planned. The planned implementation timelines were ambitious given the May 2006 approval, as all programs were slated to begin in April or July 2006. The average timeline to competitively procure services within the community is 6 months, which led to delays beyond the initially proposed timelines. Second, delay in CSS state approval resulted in programs that initially were to begin in FY 05-06 had to be rebudgeted for FY 06-07. The County learned the necessity to build additional time into our project action plans.

Many challenges were faced in the procurement phase. First, the MHSA workload was immense and it was logistically challenging to manage the large influx of funding. Second, the community based organizations were overwhelmed by the volume of requests for proposals (RFP) that were issued, over 36 competitive procurements in total. This necessitated additional procurement time to allow for contractors to respond sufficiently to the RFPs. Third, due to the large amount of RFPs issued, some RFPs did not receive competitive bids. Finally, some of the RFPs appeared to be under funded for the scope of services required. All of these challenges slowed the procurement process and thereby, the full implementation of CSS.

Several of the CSS workplans that were not implemented by December 31 were implemented soon thereafter. Although further details will be provided in upcoming Progress Reports, the Mental Health/Primary Care Integration programs (workplans CY 4.1, A-7 and OA-3), the remaining Older Adult workplans (OA-1 and OA-2) and services to Deaf and Hard of Hearing (ALL-1) were implemented in January 2007.
Other challenges included a major reorganization of the previously separate divisions of Mental Health and Alcohol and Drug Services into an integrated Behavioral Health Services Division. In addition, we experienced difficulty interpreting changing requirements and emergency regulations pertaining to MHSA provided by the State Department of Mental Health.

Additionally, many programs have experienced delays as a result of regional staffing limitations. Providers have reported difficulty recruiting qualified staff for the MHSA funded services. As the local area faces a shortage in available qualified psychiatrists and key mental health positions, it is a challenge for the County and providers to hire enough competent service providers to meet the cultural, ethnic, and linguistic needs of mental health consumers.

B. Highlight the County's key transformational activity/activities in any of the five essential elements:

- **Community collaboration**
- **Cultural competence**
- **Client/family driven mental health system**
- **Wellness/recovery/resiliency focus**
- **Integrated services for clients and families**

Community Collaboration is a core value of the County of San Diego and is evident throughout all service categories. An ongoing method of engaging the community in policy decisions is through the many councils hosted by County Mental Health. Pertinent councils include the Children's, Adult & Transition Age Youth, and Older Adult System of Care Councils, and the Housing Council. Each of the councils meet monthly and the members consist of representatives from the community including clients, family members, County partners, education representatives, and service providers. The councils are open to the public and community input is received at both the beginning and at the close of every meeting. Each month the agenda for the councils includes the latest MHSA implementations and updates as well as discussion on current services, service needs and future planning.

The Transitional Age Youth (TAY), Adult, and Older Adult FSP programs work closely with the MHSA funded Housing Consultant to increase access to housing for their clients. The consultant's goal is to bring the housing community in San Diego together to proactively coordinate with local housing, community and economic development agencies on the use of local housing funding and potential matches between available service supports and needed housing. Community partners include public housing entities, including local government housing departments, Section 8 officials, and private non-profit agencies that develop and operate an array of housing programs.

The opportunity to develop new, innovative programs under MHSA has led to increased collaboration with other systems, such as the justice system, including probation, the courts, and Child Welfare Services. These collaborations, working together, are vital to ensuring that clients receive a full array of services. As an example, several FSP programs have embedded probation officers within the ACT teams, an innovative wraparound program. Collaboration between agencies aids in effectively providing comprehensive services needed by the clients to move toward successful outcomes. In expanding services to children who are the direct responsibility of the County - wards and dependents - we have actively involved Child Welfare and Probation Administration in decision making and support, including shared management of a competitive procurement project.

Cultural Competence

Cultural competence and understanding of differences, including gender and sexual orientation, are required expectations of all current providers and are integrated into the County of San Diego's service delivery system. Service providers are required to hire staff that possess cultural awareness, knowledge and skills necessary to provide culturally competent services. Every direct staff person of each mental health program in San Diego is required to complete a minimum of four hours of Cultural Competency training, annually. The focus on diverse cultural and linguistic communities increases the access to care and lessens health disparities.

In the Children's mental health system, a program has been developed specifically to target underserved ethnic populations. The Cultural/Language Specific Mental Health Services for Latino and Asian/Pacific Islanders (CY-3) addresses the need for outpatient services that are tailored to the necessary ethnic values and belief systems, and receptive to the use of culture-specific practices such as the use of indigenous practitioners. Services are receptive to gender, language, religion and other cultural factors, including issues pertaining to immigration patterns and acculturation.

System Development programs that address cultural competence have also been implemented. A key factor in delivering culturally competent services includes delivering these services where the

community resides. This increases access and sensitivity on the part of providers who are now embedded in the heart of the community. The children's mental health system has also augmented services in over 300 schools using MHSA funding. These schools are primarily in low income areas and/or areas with high numbers of minority students. The Adult Family Education Services program (A-4, awarded to NAMI San Diego) provides outreach and training with a special focus on Latino and Asian/Pacific Islanders. The educators are reflective of the diverse ethnic population within San Diego County and are implementing a curriculum in English, Spanish, Vietnamese and Arabic. System-wide, programs are required to provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served and to identify a process to determine bilingual proficiency of staff.

Client/Family Driven Mental Health System

The County of San Diego strives to provide a mental health system driven by clients and family members, as evidenced by their involvement in MHSA implementation since the planning process. To ensure client and family involvement, each child, TAY, adult, and older adult provider is required to have a Program Advisory Group (PAG). This advisory group must consist of a majority of clients and/or family members. Their responsibility is to provide input to the service provider and ensure the quality of services received by the clients.

The TAY, Adult and Older Adult FSP programs require peer specialists as members of the program staff. These programs include Integrated Services and Supported Housing (TAY-1), Adult Homeless Integrated Services and Supported Housing (A-1), Adult Justice Integrated Services and Supported Housing (A-2), and Older Adult High Utilizer Integrated Services and Supported Housing (OA-1). The peer specialists within the FSP programs are to provide rehabilitation and recovery support to the clients. Family education programs under MHSA, part of the System Development category, are family run in San Diego. All trainers and participants are required to be family members. Subsequently, clients and family members are the key components to effective outreach strategies for these programs.

Within the Children's System of Care, an administrative program, the Consumer/Family Liaison, is a vital collaborator to ensure family and client professional partnership. The Family and Youth Roundtable advances system reform efforts, at the local, state and federal levels, by coordinating and prioritizing the interests of families and youth receiving services from public agencies. The program offers peer support and training on a wide range of topics that help family members develop skills in supporting their children and improving service delivery. Advocates from the Family Roundtable serve as a liaison to the County of San Diego, participating in policy development and program implementation.

Wellness/Recovery/Resiliency Focus

New recovery and resiliency services are offered within the FSP programs, including individualized Wellness and Recovery Action Plans (WRAP), skill development, peer supports, social and recreational supports, supported employment, supported education and supported housing. Staff is also trained in evidence based practices such as Copeland's WRAP, Deegan's Intentional Care, ACT, and Bartel's Evidence Based Care for Older Adults. Peer support specialists are critical to the FSP programs to promote hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer specialists throughout the FSP programs can share their recovery efforts and model the importance of resilience in managing challenges to recovery.

In the Children's system, providers develop and implement service plans that are individualized, strength-based, culturally competent, and child and family driven. The service plan identifies outcome goals and objectives that define success for the individual client and family.

In the Services for Victims of Trauma and Torture program, awarded to Survivors of Torture, International, the goals of recovery are advanced by ensuring that services are integrated, linguistically and culturally competent, driven by client choice and anchored in rehabilitation and

recovery practices. These practices include being self sufficient and productive, having meaningful personal relationships, being able to learn, and being productive members of the community.

Integrated Services for Clients and Families
The integrated FSP programs include services to Homeless and Runaway Youth (CY-5.3), a child/adolescent program targeting Latinos and Asian Pacific Islanders (CY-3), TAY Integrated Services and Supported Housing (TAY-1), Adult Homeless Integrated Services and Supported Housing (A-1) and Adult Justice Integrated Services and Supported Housing (A-2). The programs include an array of services, including outreach and engagement, 24/7 intensive case management, wraparound services, community based outpatient mental health services, rehabilitation and recovery services and supported housing, with the TAY and adult programs additionally providing supported employment and education, peer support services and Assertive Community Treatment (ACT). These integrated programs aid in the transformation of the County of San Diego's mental health system.

The Children's Outpatient Therapy and Outreach-Juvenile Court and Community Schools (JCCS) program (CY-5.2) provides integrated school-based outreach and mental health treatment services to youth attending the community based Juvenile Court and Community Schools. The program will also provide integrated services to youth with co-occurring disorders by including screening, assessment, integrated treatment and referral, and a wellness, strength-based and resilience focus.

C. <u>For the Full Service Partnership category only</u>: If the County has not implemented the SB 163 Wraparound (Welfare and Institutions Code, Section 18250) and has agreed to work with their county department of social services and the California Department of Social Services toward the implementation of the SB 163 Wraparound, please describe the progress that has been made, identify any barriers encountered, and outline the next steps anticipated.

Not Applicable. The County has implemented the SB 163 Wraparound Program.

D. For the General System Development category only: Describe how the implementation of the General System Development programs has strengthened the County's overall public mental health services system. If implementation has not yet occurred or is an early stage of development, simply indicate that this is the situation and no other response is needed.

General System Development category programs are targeted at critical needs within the public mental health system. Under MHSA regulations, System Development funds could be used by counties to improve programs, services and supports for the target population, change the service delivery system and build transformational services and/or programs. San Diego County implemented six System Development programs prior to 12/31/06. Three of the programs were for adults, two for transitional age youth and one for children.

The adult programs include enhancement and expansion to an existing consumer operated clubhouse. These enhancements have been transformational as they significantly increased capacity and added employment services. The employment services assist members through the various steps of job searches and utilize employment specialists to assist with linkage, job development and job placement. Outpatient mental health services were also added to the adult population through augmentations to mental health clinics. These augmentations advance the MHSA goals of providing timely access to needed help and reducing ethnic disparities. Transitional age youth benefited of the implementation of two programs that incorporate evidence based practices of Assertive Community Treatment (ACT), dual diagnosis interventions such as Continuous Comprehensive Integrated System of Care (CCISC) and Dialectical Behavioral Therapy (DBT).

An innovative program was developed to target the very young 0-5 population. Using an evidence based approach, Incredible Years, the program focuses on seriously emotionally disturbed children. The program is the first in the County of San Diego to use an evidence based approach with this population.

A program was also developed to provide family education about major mental illness, stigma reduction, and resources to improve access care. The program promotes transformation of the system through development of increased family involvement.

E. If applicable, provide an update on any progress made towards addressing any conditions that may have been specified in your DMH approval letter.

Not Applicable. There were no conditions identified.

2. Efforts to Address Disparities

A. Describe your County's current efforts/strategies to address disparities in access and quality of care among the underserved populations targeted in your Plan. In your description, please highlight your successes and address any barriers or challenges that you have encountered.

Efforts to address disparities in access and quality of care in implemented CSS programs include the following.

The need for **School Based Services (CY-1 and CY-5.2)** was identified as a high priority among stakeholders. Access to care is provided in the school setting, targeting unserved/underserved areas countywide and reducing the need for transportation to clinic sites. In addition to providing MHSA services, the school based expansion has led to identification of additional Medi-Cal eligible clients and increased Medi-Cal referrals and additional services delivered through EPSDT. School Based Services offered in the Juvenile Court and Community Schools (CY-5.2) similarly increase access to care, with the added benefit of targeting underserved youth involved in juvenile justice system.

The **Homeless/Runaway Youth Program (CY-5.3)** is located near a metropolitan area homeless youth shelter. The proximity of the program location results in immediate access to youth. The program is connected to a network that works with juvenile offenders that are chronic runaways and involved in prostitution, which assists program staff in identifying and serving these difficult-to-access clients. The program is in the process of becoming dual diagnosis capable to properly address clients with co-occurring disorders, a major issue for homeless youth. About one third of the clients are transitional age youth (TAY) and the program provides crisis intervention as needed and promotes access to new TAY programs.

The **Cultural/Language Outpatient program** (**CY-3)** utilizes various strategies to address disparities in access and quality of care among the Asian Pacific Islander and Latino populations. Services are provided by culturally and linguistically competent providers of the same ethnicity of the target population which is Asian Pacific Islanders (API) and Latinos (with a focus on the Vietnamese, Filipino, and Mexican communities within these ethnic groups). Most clinic/county forms are available in the client/families primary language/language of choice, and the educational literature provided to clients and families is reflective of their culture and community. Services are provided at homes, community sites, at schools, and in the evenings and weekends to minimize institutional barriers of transportation, child-care, and inability to participate in services due to work schedules. As appropriate, staff gather information regarding immigration and refugee experiences, level of acculturation and assimilation, religious and spiritual beliefs and support systems within the community as a means to create relationships with the families and to provide appropriate services.

Program staff work closely with community providers such as county physical health clinics, family resource centers, public health nurses and community centers to bridge the gap between physical health and mental health services. The program has received a large number of referrals from public health nurses and other community providers and has effectively coordinated services between mental health and physical health services. The program has received feedback from families that they are very pleased with the cultural accommodations as well as our flexibility to provide services at convenient locations and times.

Early Childhood Intervention (CY-6) targets ages 0 – 5 and their parents, a highly under-served population in San Diego County. The program targets children in preschools in low income, high need areas of North County that are predominantly Latino. Services are provided at the preschools, in home and/or other community settings to facilitate access. The program utilizes the Incredible Years evidence based practice model for young children and families.

Integrated Services and Supported Housing (TAY-1) strives for addressing disparities in access and quality of care by being centrally located and having staff on call 24/7 to address any client

needs. Also, to assist in the client's recovery and self sufficiency, the programs will provide supportive housing services. Challenges include the frequent turnover of the population, no-shows for scheduled appointments and frequently changing living arrangements. A primary challenge for the new TAY programs has been identifying a consistent core group of transition age youth to provide legitimacy of the program to their peers.

Clubhouse and Peer Support Services (TAY- 2)
TAY-2 enabled San Diego County to add a clubhouse specifically for Transitional Age Youth who have not participated in our Adult Clubhouses in large numbers. We had received feedback that they felt the older members of clubhouses did not appreciate their music, art or slang used. As a result, they tended to underutilize our clubhouses. The TAY-2 clubhouse (Oasis) has been a quick success due to consistently asking what members want, need and what are they willing to take responsibility for. Oasis has generated a great deal of positive feedback due to the educational and vocational support they have provided to the members. Currently they have found jobs for over 30 members and with these jobs, TAY have maintained a more normal lifestyle, avoiding the SSI route and supporting a more hopeful future vision. The educational support staff member has helped 8 youth complete their GED's and many are being assisted in their effort to attend classes at local community colleges on an as needed basis. The clubhouse also offers skill-building classes in cooking, grocery shopping, budgeting, relationship skills and others as members request assistance. The program has a very vibrant feel due to the 'ownership' of the youth and the appreciation they demonstrate for 'their' program.

Enhanced Outpatient Mental Health Service (TAY-4) have done extensive outreach in the San Diego Community to increase access to mental health services. The enhanced funding has helped providers increase bilingual services in the Central region. The TAY program has been enhanced by expansion of groups that specifically target the needs of the TAY population with educational, vocational, and employment goals. TAY staff is able to work with the programs to ensure compliance with individualized and timely client plans, reassessment and differential diagnosis, case management goals, and individual counseling. Challenges in the TAY population include the TAY's resistance to services. Since peer staff members have been added to each enhanced TAY outpatient site to help deal with the resistance, these programs have benefited.

Homeless Integrated Services and Supported Housing (A-1) address disparities by including interventions that are rehabilitation and recovery focused. These interventions are client driven and embedded with the service array to include wellness and resiliency focus, individualized wellness and recovery action plans, skills development, peer supports, social and recreational supports, supported employment, supported education and supported housing. The main challenge that one program faces is not being able to find qualified staff.

Justice Integrate Services and Support Housing (A-2) addresses disparities by helping people stay out of the hospital, reduce jail time, minimize homelessness and to develop skills for living in the community so that their mental illness is not the driving force in their lives. Assertive Community Treatment (ACT) offers services that are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day, seven days a week. The ACT team is a service delivery system that takes responsibility for providing a customized array of services to help people attain a life that is not driven by their illness. ACT should not be confused with case management programs that broker services from other agencies or providers. Rather than sending people to other programs for services, the team provides the services people need. If people need a service the team is unable to provide—for example, specialized medical care—the team is responsible for making certain the individual obtains that service.

The program quickly realized that placing clients in hotel rooms defeated the purpose of promoting the sense of community and nurturing the client-centered and client driven approach to treatment. Clients reported feeling isolated and "triggered" when living in a hotel room and typically felt a sense of loneliness and boredom despite frequent visits by staff and enrollment in socialization programs such as the Corner Club House and attendance at community based support groups. As supportive

housing became more available, clients responded in a positive manner and gained tremendous progress in terms of developing social skills, interpersonal communications and self-sufficiency. Peer-to-peer support and advocacy is evident with the development of more selected homes in safe neighborhood settings.

Many of the clients are now enrolled in college courses, volunteer, and have part-time employment. A sense of community is demonstrated as peers attend community functions together and exhibit accountability and community spirit in the supportive housing units.

The challenge of the lack of stable housing can have a devastating impact on people with psychiatric disabilities. For people whose impairment is episodic, or mild, or for people with sufficient resources, mental illness is often a manageable challenge. For people with serious mental illness who are poor and dependent on the social services system for housing and supports, the effects of their illness can be much more debilitating.

Because of the lack of opportunities in the mainstream rental market, and with public funding support for housing declining, many mental health consumers fall through the cracks of the social services system and are unable to find decent, safe, and affordable housing. The result is an escalation of the number of consumers who find themselves homeless. Center Star Act has provided the opportunities for severely mentally ill individuals to be afforded transitional housing and eventually permanent housing.

Family Education Services (A-4) provide family-driven countywide family education about mental illness, stigma reduction and resources to improve access to care. Each class aims to address the disparities in access of care and to provide resources for family members. The challenges faced are to complete the translation of the course curriculum into Vietnamese and Arabic. Currently, the course is offered in English and Spanish.

Clubhouse Enhancements and Expansion with Employment (A-5) address disparities in specific ways depending on the primary population of the individual clubhouse. For example, one clubhouse targets the Asian Pacific Islander mental health consumers of San Diego. A Vietnamese employee was hired to help with facilitating some of the groups, including a Vietnamese WRAP-Wellness, Recovery, Action Plan Group and also to teach English as a Second Language (ESL). A Cambodian employee was also hired to meet the needs of the Cambodian community. She assists with facilitating Cambodian groups, and also with ESL. There has been success with the program due to more consumers taking leadership amongst the group. They are showing more interest in understanding and actively participating in a recovery process. The addition of more ESL classes and also computer classes has been welcomed by the Clubhouse members.
One clubhouse that received MHSA enhancement funds has done excellent work in addressing the needs of our Latino consumers in the South Region. This clubhouse has supported our consumers in dealing with communication issues and provided peer support for monolingual Spanish speakers to meet educational needs. Consumers report that the clubhouse has created a ‘family’ environment and offers many opportunities to share information on cultural activities, communication and food that supports their interests.

A challenge in many of the clubhouses is the current facilities capacity. Many of the clubhouses are outgrowing the space they have available. An additional challenge for the clubhouses is there are more clients than programs are able to handle.

Supported Employment Services (A-6) provides an array of job supports to help the person with serious mental illness that needs a wide array of long-term job supports to obtain competitive employment, while building on the client’s strengths. The program offers a weekly bilingual employment group, and ethnic-specific community providers are targeted to reach unserved populations. The primary challenge is retention. Many clients find work stressful, even working part-time. To address this, clients are encouraged to gradually increase their work hours.

Enhanced Outpatient Mental Health Services (A-8) has reduced disparities in access and quality of care by having more bilingual/bicultural staff to provide more services to the diverse clients in San Diego County. The staff is also cross-trained to be able to provide cultural and age-appropriate services. An additional method to address access to care is the design and implementation of mobile services. The PSR specialists are able to initiate assessments and engage clients in the community, has provided a valuable tool for connecting clients to the centers. A barrier has been finding bilingual/bicultural clinicians, especially in Tagalog/English.

B. Describe your County's outreach efforts and the progress made to date to involve the underserved populations that are specifically targeted in your Plan. Please be specific in identifying the strategies and approaches employed.

In expanding services in **School Based programs (CY-1)**, emerging outreach challenges include: parents less willing to participate in treatment in school based, rather than clinic based programs, and home visits are offered but often declined by parents. Parents may be undocumented and reluctant to access services for their children who are citizens. These challenges have highlighted the need for increased outreach to families. If approved, the CSS expansion plan will address this through addition of Case Manager/Rehabilitation worker to each school based program.

Cultural Language Specific Outpatient Program (CY-3) established specifically for underserved Latino and Asian Pacific Islander families. Services are provided by culturally and linguistically competent providers of Latino, Vietnamese, Filipino and other Asian ethnicities. To conduct community outreach and outreach to families, the program employs family partners that speak various languages of the target population. The program has recruited staff and publicized services in Asian Pacific Islander and Latino specific newspapers and publications. Extensive outreach has been conducted in churches, schools, local ethnic specific community events, health clinics and ethnic organizations. The CARE program actively provides outreach to ethnic and community-based organizations throughout San Diego County to inform and educate regarding services provided by CARE and to increase collaboration. As a new program, it takes time to gain acceptance within the community but extensive outreach mitigates this challenge. In a few months' time, great progress has been made in reaching the target populations, as evidenced by the number of referrals the program continues to receive. Hiring a Vietnamese speaking clinician has been a challenge that was not accomplished until after December 31, 2006.

Specific outreach mechanisms are being employed in the **Homeless/Runaway Youth program (CY-5.3)**, such as dedicated outreach workers that go out on the streets to engage homeless youth. Clinical staff use assertive outreach model which is considered a best practice for this population. In addition, the program has done extensive outreach to community providers that work with homeless youth. Collaboration with a school for homeless youth and School Attendance Review Boards (SARB) has proven effective in identifying homeless youth who are couch surfing, or living in short-term arrangements, rather than living on the streets. Different outreach strategies are required based on the type of homelessness the client experiences. The program utilizes flexible funds for outreach and to meet treatment plan objectives.

The **Early Childhood Intervention Program (CY-6)** provides services in Spanish for monolingual Spanish speaking families. The program employs Promotores to conduct outreach to the community and families. Outreach to parents also occurs through the preschool teachers and when parents pick up their children each day. Home visits have at times posed a challenge; some parents are reluctant to allow providers in their home. Families generally have a long history with Child Welfare Services, substance abuse and legal problems. Mitigation occurs by establishing rapport with the parents at the preschool sites before home visits approached. Parent group sessions are offered, though families have difficulty participating due to work obligations. To mitigate this, the program offers incentives such as child care and flexible times for groups to occur in order to engage parent participation.

Integrated Services and Supported Housing (TAY-1)

Our TAY-1 program has served many homeless and at-risk of homelessness youth. They also continue to work with shelters, foster care transition programs (for youth who are aging out of foster care) and youth who are on the streets. The program has provided housing and the full array of mental health services to these youth and continues to educate those who are reluctant to participate so that they might in the future.

Clubhouse and Peer Support Services (TAY-2)
Currently, some youth are underutilizing the mental health system by only receiving medications, they are gradually being educated on the value of more intensive services to support them in their transition to adulthood. They begin to understand that they do not have to be a 'patient' all their life (something they are eager to avoid), but that by obtaining the services they need now they might prevent hospitalization or other more intrusive types of services and help them to stabilize their lives. Currently, the clubhouse serves a very diverse cultural group, perhaps in part because program staff includes strong representation from African-Americans, Latinos and Asians.

Enhanced Outpatient Mental Health Service (TAY-4) promotes outreach through collaboration with the San Diego Community College district through the Disabled Student Services Department. The programs also reach out to the community through adult education programs and the Department of Rehabilitation. The new TAY clubhouse is also a valuable resource to reach out and to involve the TAY population in the services offered.

Homeless Integrated Services and Supported Housing (A-1) have conducted extensive outreach to the unserved populations through collaborations. Collaborations include the Homeless Outreach Team (HOT), the Psychiatric Emergency Response Team (PERT), inpatient and emergency room units, the Sheriff's Department, the San Diego Police Department, and the Probation Department. The programs have also partnered with homeless providers such as St. Vincent de Paul, the Rescue Mission, Veteran's Services, Alpha Project, Rachel's Women's Center, and Volunteers of America.

Justice Integrated Services and Supported Housing (A-2) target primarily the seriously mentally ill and most have co-occurring disorders and have been detained or had some interaction with the criminal justice system. Much of the outreach has been focused on individuals incarcerated in jails throughout San Diego County and the Mentally Ill Offenders Unit Probation Department. Other outreach efforts targeted primary referral sources who deal with this population and most of the clients are referred from sources such as: Conservatorship, hospitals, Justice system (jails, Public Defenders Office, etc.), community-based organizations (including Indian Health Council, women's shelters) clubhouses, Psychiatric Emergency Response Team, Board and Care facilities, START programs, Access Center, Dept of Labor, Dept of Vocational Rehabilitation.

Family Education Services (A-4) collaborate with mental health services such as clubhouses and active outreach is made to families by providers, clients and other family members and friends to promote attendance at their classes. The primary mode of successful outreach is via word of mouth.

Clubhouse Enhance and Expand with Employment (A-5) has a variety of outreach methods based on the clubhouse and their target population. A clubhouse targeting the Asian/Pacific Islander population has used outreach methods such as:

1) Radio and news interviews with ethnic-specific programs – targeting Vietnamese, Korean communities
2) Community Fair/Festival participation – targeting Vietnamese, Hmong, Laotian, Filipino, Chinese and chronically mentally ill and homeless
3) NAMI – targeting general public, consumers and family members

Another example is an East County clubhouse that has made an effort to reach the unserved population of Native Americans. In October 2006 clubhouse staff and members attended the Native American Men and Women's Wellness Conference #6. They distributed flyers about their programs and networked with the Native American Health Center. Members of the Southern Indian Health

Council (SIHC) were then invited to the clubhouse where they gave a presentation to our members and learned about our program.

Supported Employment Services (A-6) target ethnic-specific community providers to reach unserved populations in the community. The supported employment program also conducts extensive outreach to the local employers to provide a variety of work environments for the clients.

Enhanced Outpatient Mental Health Services (A-8) include numerous sites throughout San Diego County. Examples of outreach and collaboration include:

1) Community Collaboratives
2) START (Systemic, Therapeutic, Assessment, Respite and Treatment) programs
3) Organizations serving AIDS/HIV patients
4) Career Centers, including Goodwill Industries
5) Family Resource Centers

C. Describe the steps you used towards providing equal opportunities for employment of individuals from underrepresented racial/ethnic and/or cultural communities.

Supported Employment Services (A-6) - The main goal of this new MHSA program is to provide equal opportunities for employment for clients from underrepresented racial and/or cultural communities. This program also has special efforts to target Latinos and Asian/Pacific Islanders. The staff members are required to be culturally competent and understanding of differences. Thirty-three percent (33%) of the staff members are required to be bilingual. The program also establishes relationships for employment opportunities with local businesses and employers. To ensure equal opportunities for employment, the program tracks employment goals, progress and placement. It also provides linkages and support as part of the care coordination.

The Clubhouses are an excellent resource for employment opportunities for clients from all communities. The clubhouses are responsible for providing employment screening and job placement through onsite and/or offsite volunteer and/or paid vocational opportunities. The Clubhouses also provide ongoing job supports via activities within a network of supportive relationships of peer staff, members who are employed and those seeking employment. Peer employment specialist assist and support members to engage in vocational activities by identifying group and individual employment opportunities in the community, negotiating with employers for positions, accompanying members to on-the-job training, and identifying and problem solving with the members.

The Clubhouses all possess cultural awareness, knowledge and skills necessary to provide culturally competent services, particularly to African Americans, Latino, Asian/Pacific Islanders, and women of all ethnicities.

In each of the FSP programs for TAY and adults, an employment specialist is embedded in the program. The employment specialists provide job readiness, job supports and job placement. The FSP programs are modeled after the evidence based SAMHSA's ACT Implementation Resource Kit (2003) that states "ACT emphasizes work and vocational expectations for all consumers, while accepting individual differences in capacity and interest in competitive employment." Each contractor is responsible for staff members that are culturally competent to serve the diverse backgrounds, especially those of the underrepresented racial and/or cultural communities.

The majority of the programs have a requirement to have peer specialists on their staff. In addition, staff must be culturally competent to serve the clients within the program. Many programs have already made strides to hire clients form underrepresented racial and or cultural communities. Examples include:

- The Justice Integrated Services and Supported Housing program (A-2) has employed two consumers as Peer Specialists and one consumer as a Supportive Employment Specialist. These staff members comprise 30% of the total staff.

- A Clubhouse (A-5) targeting the Asian/Pacific Islander population has hired additional staff of one Cambodian consumer and have five consumer volunteers, 2 Korean, 2 Filipino and 1 Caucasian.

D. Indicate the number of Native American organizations or tribal communities that have been funded to provide services under the MHSA.

Collaboration with Indian Health Services provider agencies is planned under the Mental Health and Primary Care Services Integration program, which did not begin to provide service prior to December 31, 2006. However, Native American clients are served in programs throughout our system of care.

E. List any policy or system improvements specific to reducing disparities, such as the inclusion of language/cultural competency criteria to procurement documents and/or contracts.

The following insertions are found in all program contracts:

From the Children's System of Care:

1.1 Contractor shall design and implement outreach and engagement mechanisms that are culturally appropriate and effective for the target population. Outreach is defined as efforts to locate and engage the target population for the purpose of increasing access to mental health services. Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency, and among professionals that enables that system, agency, or those professionals to work effectively in cross-cultural situations. It includes language competence, and views cultural and language competent services as methods for elimination of racial and ethnic mental health disparities. Sensitivity to gender and sexual orientation is part of the cultural competency expectations.

1.2 Contractor shall comply with the Children's Mental Health Services cultural competence requirements as referenced in the CMHS Organizational Provider Operations Handbook.

1.3 Contractor shall provide a Human Resource Plan that includes how Contractor shall recruit, hire, and retain bilingual and culturally diverse staff.

1.4 Contractor shall implement and maintain a Program Advisory Group (PAG). The PAG will meet regularly thereafter to advise Contractor on program and service issues and improvements. The PAG membership shall include a simple majority of clients or family members of clients and shall reflect the ages and cultures of the client population. A Family/Youth Support Partner from the Family/Youth Support Services Program shall be invited to attend. Meeting minutes and action items based on PAG input shall be reported to the Program Monitor.

1.5 Contractor's program shall adhere to the CMHS Organizational Provider Operations Handbook training requirements and any additional training requirements within specified time frames as required by the County. Staff training shall include 10 hours of cultural competency training within the first month of the program and at least one hour monthly throughout the life of the contract. Staff shall receive specific training in best practices for the targeted cultural/language groups on an ongoing basis.

1.6 Contractor shall determine bilingual proficiency of staff prior to hiring in, at a minimum, the threshold languages for the County. Contractor shall provide direct services in Spanish, Vietnamese, and Tagalog.

From the Adult System of Care:

1 Contractor shall develop referral methods to engage with clients who meet the target population criteria.

   a. Specific outreach and engagement efforts will be made for Latinos and Asian/Pacific Islanders.

2 To support that this service is primarily operated and delivered by persons with client experience, all peer support services program staff, including the program manager, shall have experience with their own mental illness and recovery process. Some exceptions can be made with the approval of the Program Monitor—for example, staff who are affiliated with the program to provide small amounts of indirect and/or management services may not have personal experience with mental illness; also, significant consultation may be needed during the program's first year of operation, and the consultants may not necessarily have experience with their own mental illness.

3 Cultural Competence: Contractor shall comply with AOAMHS' cultural competence requirements as referenced in the AOAMHS Organizational Provider Operations Handbook, and shall demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

   a. Contractor shall provide a Human Resource Plan that includes how contractor will recruit, hire and retain bilingual and culturally diverse staff.

   b. Contractor shall identify a process to determine bilingual proficiency of staff at a minimum in the threshold languages for the County. It is expected that at least 33% of staff will be bilingual.

4 Program Advisory Group (PAG): Contractor shall have a Program Advisory Group that meets on a monthly basis to advise on Contractor's implementation of recovery-oriented services.

   a. The PAG voting membership shall include at least 75% clients, and shall reflect the ages and cultures of the client population. The Program Monitor may attend meetings.

5 The program site shall be welcoming to the various cultural populations in the community and to individuals with co-occurring disorders (COD) by providing materials, brochures, posters and other information regarding cultural competence and COD.

6 Linkages and referrals to community based organizations, including – but not limited to – primary care clinics and alternative healing centers and organizations, (including those which treat culture-bound illness syndromes), faith based institutions, ethnic organizations and peer run programs such as Clubhouses.

   a. The use of best practices and evidence based practices, as identified for the deaf and hard of hearing population, shall be demonstrated in the development of culturally appropriate services which are also recovery oriented.

7 Staff the program with person/s who have experience as a recipient of mental health services.

8 Utilize outreach methods that are culturally appropriate to effectively engage with a variety of clients in order to expand the voice of clients throughout the system.

3. Stakeholder Involvement

Provide a summary description of the involvement of clients, family members, and stakeholders including those who are racially/ethnically, linguistically and culturally diverse and from other underserved or unserved communities, in the ongoing planning and implementation of the Initial CSS Three-Year Program and Expenditure Plan

The County of San Diego conducted extensive community outreach in the development of the Community Services and Supports Plan, with the goal of maintaining a high level of community involvement in the ongoing planning and implementation of the Initial CSS Three-Year Program and Expenditure Plan. The primary mode of involvement is via the numerous councils: the Adult, Older Adult, Housing and Children's Councils. Each council embodies a diverse representation of the community including clients, family members, advocacy groups, County partners, education, and community service providers. The Councils provide a forum for both Council representatives and the public to stay informed and involved in the planning and implementation of the many MHSA programs.

Stakeholder involvement is encouraged through participation in community events and education. One example is administrative program, System-Wide Community Education (OTO-1), that offered a series of radio shows on a local station. The radio spots ran from May 2006 through December 2006. Topics ranged from Mood Disorders in Children, Suicide Prevention and Older Adult Needs Assessment. One session was specifically targeted to Latino's access to mental health. The hour radio segments allowed for the listeners to call in to make comments and give their input and to reach a wide and diverse population.

Throughout the planning process, pre proposal conferences were held for each competitive procurement, or Request For Proposal (RFP), released. These meetings, open to all stakeholders, provided the opportunity to learn about program development, the specifics of the Statement of Work, and the timelines for submission of the RFP. Questions were answered in writing and posted on the County's BuyNet website. This website is accessible to anyone wishing to view the specifics of the RFPs.

An additional avenue to ensure client and family involvement are the Program Advisory Groups (PAGs). The PAGs are a requirement of each MHSA funded program. The PAGs consist of a minimum of 51% of clients and/or family members. The members of the PAGs are required to be ethnically, linguistically and culturally compatible to the clients of the MHSA program. These advisory groups are responsible for reviewing the services provided and meet on a monthly basis.

The County of San Diego implemented a Children's and Adult Liaison program to guarantee that client and family member/caregiver voice is heard. The liaison programs are required to hold forums throughout San Diego County to share the County's planning and implementation process and solicit community input. The Liaison then meets regularly with County staff to discuss the client feedback. The Liaisons attend monthly internal meetings solely focused on MHSA, and are then responsible for relaying the information back to the community.

Finally, County staff members attend community events and local conferences to address the services and programs. An example of these events includes hosting a Cultural Competence Resource Team Retreat. This retreat was represented by individuals from diverse communities including the Deaf and Hard of Hearing, Survivors of Torture, Transgender, Blind, Chaldean, Asian Pacific Islander, Latino, Older Adults, Transition Age Youth, and East African communities. Other conferences held locally allow for the County to share information and receive valuable input from the community.

4. Public Review and Hearing

Provide a brief description of how the County circulated this Implementation Progress Report for a 30-day public comment and review period including the public hearing. The statute requires that the update be circulated to stakeholders and anyone who has requested a copy.

The suggested response length for this section is two pages (or one page for small counties). This section should include the following information:

A. The dates of the 30-day stakeholder review and comment period, including the date of the public hearing conducted by the local mental health board or commission. (The public hearing may be held at a regularly scheduled meeting of the local mental health board or commission.)

This document was posted for the 30-day stakeholder review on May 22nd, 2007. The public hearing was conducted at the June 7th Mental Health Board meeting.

B. The methods that the County used to circulate this progress report and the notification of the public comment period and the public hearing to stakeholder representatives and any other interested parties.

San Diego County Mental Health used a variety of methods to circulate this progress report and to notify stakeholders of the public hearing and opportunity for public comment to any interested parties. Initial emails were sent to Mental Health Board members and the membership of each mental health System of Care (SOC) Council: Children's, Adult and TAY, Older Adult, and Housing. The councils consist of a broad representation of community stakeholders, who in turn share MHSA information with their constituents and other groups and individuals involved in mental health services and issues in San Diego County, including the Family and Youth Roundtable and Partners in Care consumer liaison programs. Additionally, the CSS Progress Report was an agenda item at each SOC council meeting, making it available for discussion and input in these venues. A copy was posted on the Network of Care for Behavioral Health website:
http://sandiego.networkofcare.org/mh/home/ca_prop63.cfm

C. A summary and analysis of any substantive recommendations or revisions.

A feedback form was included in the report to facilitate public comment, and feedback was solicited using a toll-free comment line ((888) 977-6763) in the threshold languages and an MHSA e-mail address (MHSProp63.HHSA@sdcounty.ca.gov).

- No feedback forms were received from stakeholders.
- One comment was received via e-mail:

  A contracted provider under MHSA confirmed the accuracy of the program description and acknowledged the county's assistance in overcoming the challenges of contracting with the county for the first time.

A public hearing was convened at the Mental Health Board Meeting on June 7, 2007. The following comments were received:

1) A Mental Health Board member commented that the progress report did not include enough quantitative accomplishments.

2) A client advocate stated that she was proud of the accomplishments. However, she didn't think the word is getting out nor that the mental health board meeting constituted as a public forum. She suggested announcements in newspapers, radio stations and other local media.

3) An older adult client advocate requested that a housing unit manager be added.

4) A client advocate with the adult client liaison stated that the Councils are failing in their effectiveness and clients are not directly at the table, and that the comments made in the Councils do not reach the written reports.

A public hearing was convened at the joint meeting of the Children and Adult System of Care Councils on Transition Age Youth (TAY) on June 11, 2007. The following comments were received:

5) A community provider stated that the report helps identify the growth that has occurred. Regarding undocumented children, or children with undocumented parents, the report does not clarify where they are served in a non-emergent basis if not in our system.

6) A question was raised regarding accommodations for deaf and blind individuals in the residential facilities and clubhouses. Though there is a specific deaf and hard of hearing MHSA program, what efforts have been made to ensure accommodation in other programs?

7) A community provider stated that he would like to see additional support and enhancement of school-based programs.

8) A community representative and caregiver emphasized the need for support for children that have been adopted out of the foster care system, especially those that are TAY.

9) A community provider stated that some children's providers are not considered to be TAY providers, yet serve 16-18 year olds. More formal linkage and communication should be developed between these providers and the adult system. Another community provider commented that part of the challenge is that there are two systems of care and that transitions may feel abrupt.

10) A provider asked about the comments on page 10 that "Home visits are offered but parents often decline." She wondered if we are "selling ourselves short" with this description and whether other services may be offered to increase family/caregiver participation. A school-based provider commented that the flip side of the benefit of school-based programs is that there is generally less family/caregiver participation.

11) An adult client and advocate asked about what is done to engage and serve runaway youth.

Actions taken based on public comments:

1) The Mental Health Board and community partners were provided with a copy of the Exhibit 6, which provides quantitative implementation results.

2) Client and community participation was sought in the stakeholder review process through the Mental Health Board meeting, four Council meetings (Children, Adult, Older Adult and Housing) and through County-staffed community meetings such as the Commission on Children, Youth and Families and Hospital Partners. For the next progress report, mental health staff will work with the internal Office of Media and Public Affairs to better publicize through local media.

3) Housing leads have received this feedback and have taken it under advisement. The community will receive feedback through the Housing Council.

4) Feedback was given regarding expanded involvement of consumers and families at all levels of mental health administration, including internal MHSA planning meetings, youth representative on Children's System of Care Council and other efforts. Also noted to community our request for CSS enhancement funding to augment client liaison programs. 5) Language in the report was clarified.

6) As noted during the council meeting, additional funding for interpreter services was included in the CSS Enhancement plan. County reported that the recommendation would be taken under advisement, working with the providers in clubhouses to provide professional translation, peer translation, or other adaptive needs for any individuals with specific needs.

7) The provider was reminded of the extensive transformation of our school-based mental health services in our original CSS plan, with additional augmentation requested through the Enhancement.

8) Agreed to gather additional information related to this expressed need.

9) Acknowledged evolving system of integration between "child" TAY services and "adult" TAY services, with ongoing efforts by County to move towards a more seamless system of care. Accepted additional community input that often consumers have provided feedback that they were more attracted to a process of "graduating" from the "children's" TAY services, expressing a desire to feel they have actually transitioned into the adult system.

10) County continues to emphasize that school-based services make considerable effort to engage family/caregivers, including offering all available alternative service options to maximize family participation – contract providers of this service are continually monitored on the level/type of effort these family outreach efforts include.

11) The provider of the MHSA Homeless/Runaway program responded that homeless shelters and other known sites are targeted, and that using the Assertive Community Treatment model, the staff work in the community and on the streets to identify and engage clients. And that, through this new program, homeless youth are engaged in vocational, educational, and prosocial activities.

5. Technical Assistance and Other Support

As a means for guiding the state level efforts to provide technical assistance to the Counties, the following information is requested:

a) Identify the technical assistance needs in your County for supporting its continued implementation of the Initial CSS Three-Year Program and Expenditure Plan.

- Eligibility criteria- underinsured definitions
- Outreach and engagement- tracking tools

b) Identify if there are any issues that need further policy development or program clarification.

- Uniform Method of Determining Ability to Pay (UMDAP) - this state sliding scale needs revision, as it was last revised in 1989.