

# Response to Stakeholder Questions and Comments about the MHSA 2009/10 Plan Update

8/31/09

## A. The Process

### **1. Identify the stakeholders who participated in 2009/10 Plan Update and the means of providing information to consumers without e-mail. Please provide specific meeting agendas that demonstrate the Department's efforts to solicit and obtain community input (English and Spanish-speaking) into the 2009/10 Plan Update.**

Approximately 440 stakeholders, including consumers, family members, representatives of community-based organizations and county agencies, law enforcement, education, and faith-based communities were invited to submit public comment about the Plan Update and attend a public hearing. In addition, hard copies of the Plan Update and feedback forms were distributed to all persons attending the August 20, 2009 meeting of the Consumer and Family Member Advisory Committee meeting. Members of the Latino Advisory Council were also informed of the posting and encouraged to submit comments or questions.

E-mail is used as the primary means of communication because it is quick, cost-effective, targeted to interested stakeholders and wide-reaching. The MHSA stakeholder e-mail list is continually updated and, of course, anyone wishing to be included in the list is always added. We are confident that our extensive stakeholder e-mail list reaches most of the individuals and organizations that have demonstrated an interest in MHSA-related programs and issues. Note that we have often experienced a "multiplier effect" in which announcements are received by individuals not on the original mailing list.

For those who do not have or do not want to use e-mail, we have always maintained, and will continue to maintain, a policy of mailing hard copies of MHSA Plan updates and related materials on request. A number of print and broadcast media outlets throughout the County receive announcements about all public hearings conducted by the Mental Health Commission.

### **2. Will ADMHS ask the Mental Health Commission to assist in developing an integrated Three-Year Plan by conducting an inclusive and strategic planning process within a quality framework in which all MHSA components support the County's mental health service system? When does ADMHS plan to start developing the initial integrated Three-Year Plan for FY10/11 through FY12/13?**

The California Department of Mental Health (DMH) has not yet released the Integrated Three-Year Plan guidelines. When it does, ADMHS will work in collaboration with the Mental Health Commission to comply with the guidelines.

### **3. If any member of the Mental Health Commission requests a change in any Work Plan, how can that be done during the two-hour public hearing? What is the protocol? Do the Commissioners receive questions and answers prior to the Public Hearing?**

Input received during the 30-day public comment period is considered by Commissioners during the Public Hearing, and Commissioners may approve or reject at Plan at the conclusion of the Public Hearing.

**4. Please note that the 2009/10 Plan Update was distributed to members of the Consumer and Family Member Advisory Committee (CFMAC) on August 20, 2009, but not discussed at the meeting.**

It is correct that the 2009/10 Plan Update was not discussed at the August 20, 2009 CFMAC meeting. On July 28, 2009, multiple stakeholders, including CFMAC members, received an announcement of the start of the 30-day public comment period and information was provided on how to find the plan and how to provide feedback. Since the inception of CFMAC, MHSA program representatives have attended CFMAC meetings, shared information, listened to feedback and answered participant questions.

**5. Mental Health Commissioners should receive stakeholder questions and answers in advance of Public Hearings to have time to consider this information prior to making a decision.**

ADMHS wishes to improve the stakeholder process and will take this recommendation under consideration in conjunction with the Mental Health Commission.

## B. Overall Plan Characteristics

**1. Describe specific plans and programs that will implement each of the following: 1) consumer-driven and operated services; 2) services to clients with co-occurring conditions; 3) community partnerships for early intervention and prevention; and 4) help clients meet developmental milestones.**

The 09/10 Plan Update explains how these objectives are reflected in the proposed programs.

**2. There are other potential models for providing medical care described in the Plan Update. Why is the department proposing to add costly medical staff when an alternative model exists that could improve the partnership with local community clinics by co-locating clinical staff within community clinics? This would serve individuals with severe mental illness at a much lower cost per client than the plan being proposed.**

ADMHS has sought to develop programs that use evidence-based practices offering a blend of treatment, rehabilitation and support services through an integrated team approach.

**3. Please provide the monitoring tool and data pertaining to County and CBO-operated MHSA programs for current level by number and percentage of bilingual and bicultural staffing and current level by number and percentage of self-reported Latinos who indicate a preference for Spanish-language services.**

Data have been collected by ADMHS Human Resources and from Community-Based Organization (CBO) reports submitted to ADMHS Contracts staff. ADMHS is in the process of developing a standardized reporting tool. Over the past two years, MHSA programs have consistently reached the goal of maintaining 20% bilingual/bicultural staff among all direct service personnel. This includes bilingual staff in a variety of disciplines ranging from Psychologist to Peer Recovery staff. The Department has determined that a commitment to increase the proportion of MHSA direct service staff persons who are bilingual and bicultural will result in increased access.

**4. I am pleased that ADMHS has set a goal of recruiting and maintaining a direct service staff that is 40% bilingual and bicultural. I hope that there is follow-up.**

ADMHS will track data and monitor progress toward achieving this goal.

**5. How many unduplicated clients are expected to be served by the \$10 million minus the \$1,250,000 set aside for the Prudent Reserve?**

MHSA CSS programs seek to serve approximately 4,750 clients in FY09/10. This includes an estimated 2,880 individuals receiving CARES Mobile Crisis services on a telephone and face-to-face basis.

**5. Were any funds rolled over from FY2008/2009?**

Yes. \$1,504,000 for the required Prudent Reserve and \$432,000 in rollover MHSA funds.

**6. Is there a detailed plan for the \$1,588,000 administration funds?**

The breakdown for administration funds is:

• Salaries & Benefits	\$597K
• Services/Supplies	136K
• County Allocation costs (A-87)	93K
• ADMHS Mgmt/Acctg/MIS/HR alloc	882K*
• County IT/Phones/Insurance	<u>24K</u>
• Total	\$1,732K
• Less Interest Income	<u>150K</u>
	\$1,582 K

\*MHSA is allocated approximately 16% of Departmental Administrative costs. These allocated costs (\$882K) represent 3.7% of FY2009/10 MHSA budgeted "use of funds." The ADMHS allocation is based on a State-approved formula and approved by the County Auditor-Controller.

**7. It would be much easier to evaluate the Plan if there were an opportunity to compare the planned budget to last year's budget and actual expenditures. Additionally, the areas where increases are planned should have more detail and discussion of how successful the services have been to warrant expansion and/or illustrate the potential for cost savings.**

The format of the FY2009/10 Plan Update conforms to DMH reporting requirements. Additional explanatory financial and programmatic information is included in the PowerPoint presented at the Public Hearing.

**8. Why aren't older adults included in the 2009/10 Plan Update?**

Older adults are served by the following MHSA Community Services and Supports (CSS) programs: five Full Service Partnerships, Justice Alliance, Bridge to Care, Partners in Hope and CARES Mobile Crisis.

**9. Members of the National Alliance for Mental Illness (NAMI) have been concerned that the MHSA has led to a two-tiered system of care. However, the ADMHS 2009/10 Plan is a solid step in moving toward a more integrated system.**

ADMHS will continue to seek an integrated system of care consistent with MHSA guidelines and standards.

**10. How may the dually diagnosed, especially those recently incarcerated or at risk of incarceration, receive mental health services?**

Persons with dual mental health and substance use disorders represent a significant percentage of all persons served in our ADMHS system. ADMHS Clinics, CARES, ACT

**Supported Housing, and Residential Services have a responsibility for identifying persons with dual disorders and addressing their particular service needs. Responsiveness to persons with dual disorders is an area that ADMHS recognizes as a high priority for ongoing system improvement. Persons in jail receive mental health services through the Sheriff Department’s contracted provider, Prison Health Services.**

**11. Could ADMHS collaborate with Probation to ensure that Probation clients receive the mental health services they need?**

ADMHS values our partnership with Probation and agrees that ongoing collaboration with Probation is very important to supporting persons who face the challenges of both a mental health condition and involvement with the criminal justice system.

**C. Santa Barbara County Full Service Partnerships (FSPs)**

**1. Please identify the final proposed enrollment number for each of the FSP components.**

- Santa Maria ACT: 100
- Santa Barbara ACT: 100
- Santa Maria Supported Housing: 130
- Santa Barbara Supported Housing:130
- Lompoc ACT 100

**2. Explain the difference in services available to people in an Assertive Community Treatment (ACT) model program and a non-ACT FSP.**

The ACT team includes a full-time doctor, a psychiatric technician in addition to two RNs, and four master-level clinicians. Supported Housing includes 0.75 FTE doctor, two RNs, and two master-level clinicians. ACT offers virtually all necessary mental health services to clients in its team, including 24/7 coverage for emergencies. ACT programs are designed to serve the clients at high risk for hospitalization and homelessness. Supported Housing offers a Full Service Partnership in close collaboration to CARES for the provision of emergency services on the evenings and weekends. Clients served in Supported Housing are at less risk of hospitalization and homelessness than those in the ACT program, but with higher needs for services that are not provided at the clinic level.

**3. Why were ACT services curtailed for Santa Barbara and Santa Maria clients?**

ACT services were not curtailed for Santa Barbara and Santa Maria clients.

**4. Isn’t the Department simply moving the Supported Housing services into the MHSA arena? If so, what is the amount of new funding being applied to this augmented Supported Housing Model?**

ADMHS is reconfiguring Supported Housing Services. ADMHS proposes to add Psychiatric staff, allowing clients to be fully served within this program in both North and South County. The proposed number of persons served in the North County Supported Housing Program will increase from 50 to 130. The proposed program cost is \$2,335,000 of which \$1,285,000 is covered in the proposed Plan Update.

**5. What is proposed per client cost difference between the current Supported Housing model and the “ACT-light” model that is being proposed? In light of the proposed increase in costs for expanding the current Supported Housing model, please provide the**

**data that demonstrate the superior outcomes of the more costly ACT programs vs. the existing cost of the Supported Housing model currently funded by ADMHS.**

The per capita cost for ACT/FSP is \$15,978. The per capita cost of the Supported Housing FSP is \$9,201. Cost differences reflect differing levels of service intensity based on client need.

**6. The proposed movement of clients into the augmented Supported Housing model will do little to address inadequate staffing and high caseloads, since the reassigned consumers will be “backfilled” by referrals from the CARES sites. What are the outcomes for the clients served at each county mental health clinic vs. the outcomes of the clients served by the Full Service Partnerships (FSPs)?**

The FSP programs are designed for clients who need higher levels of care and service. State DMH has designed FSP outcomes that may include homelessness, hospitalization, employment, and other such issues. Although clinic-based services may include similar outcomes, FSP programs are typically designed to serve individuals with somewhat higher acuity.

**7. What are the client care costs per client seen at the County mental health clinics vs. the cost per client served by the FSPs?**

The cost per client at a county mental health clinic is \$3,470. The cost per client in Supported Housing FSP is \$9,201. The cost per client in an ACT FSP is \$15,978.

**8. How does this plan assist the highest number of people in crisis, such as homeless consumers, achieve permanent supportive housing? Would alternate models help people with a similar success rate at the same or a lower cost? Please provide the data, based on best practices, detailing a comparison between the program models.**

In FY08/09, the adult mental health system faced significant financial challenges, and approximately 300 people across the County experienced changes in their service delivery. The priority of ADMHS is to ensure stability of the system and expand access to the fullest extent possible.

**9. Weren't psychiatrists included in the Supported Housing staff prior to the 2009/2010 Plan Update recommendation?**

No.

#### D. CARES Mobile Crisis

**1. Are CARES Mobile Crisis services currently available on a 24/7 basis and if so, who qualifies for these services and how are services assessed?**

CARES Mobile Crisis services are available 24/7. People eligible for these services are individuals who experience mental health crises or emergencies. Emergencies are assessed on a case-by-case basis.

**2. Will any of the four proposed alcohol/drug treatment specialists be shared with the Partners in Hope program?**

No.

**3. Are the Alcohol and Drug Specialists proposed for CARES Mobile Crisis in addition to the existing AOD specialists employed by CADA and Good Samaritan Services that are located at CARES, or is the department proposing to shift the costs of these specialists**

**into MHSAs? If the proposed AOD specialists for CARES are existing staff, how does that not constitute supplanting?**

These positions were previously funded through the Alcohol and Drug Program (ADP). Funding for the positions was terminated as of July 1, 2009. MHSAs support for these positions does not constitute supplantation.

**E. New Heights**

**1. Why isn't New Heights available in Santa Barbara, and what is required to establish a Santa Barbara unit?**

Throughout the original MHSAs Community Services and Supports (CSS) planning process, a variety of stakeholders strongly expressed the concern that of the three major population centers in Santa Barbara County, Lompoc was well below par as to mental health resources. Responding to this major stakeholder concern, two new MHSAs programs, Lompoc ACT (formerly "Vida Nueva") and New Heights were sited in Lompoc. Lompoc is the original site of New Heights and funding limitations have only allowed ADMHS to expand services to Santa Maria. The proposed New Heights program is considered a pilot program, and if funding is available in the future, with the input of stakeholders, ADMHS will consider establishing a similar program in Santa Barbara.

**2. Is the New Heights program being folded into the Recovery Learning Communities?**

No. The New Heights program for transition-age youth is going to expand by being offered in Santa Maria, as well as Lompoc. New Heights will continue to be maintained as a separate program from the Recovery Learning Communities, however, persons served by New Heights are welcome to participate in the Recovery Learning Communities.

**F. Partners in Hope**

**1. What are the specific additional staff resources to help consumers fulfill the goals of employment, increased community involvement and recovery from substance abuse.**

MHSAs-funded Alcohol and Drug Specialists will work with individuals experiencing substance abuse issues. MHSAs-funded Recovery Specialists will assist clients with issues related to community involvement and employment. In addition, the Recovery Learning Communities (RLCs) will support individuals with various aspects of their recovery.

**2. How may an individual with co-occurring conditions access Partners in Hope services?**

Services may be accessed by contacting the Peer Recovery Specialist in your region:

Lompoc Adult Mental Health Clinic, 737-7864  
Santa Maria Adult Mental Health Clinic, 934-6190  
Santa Barbara Adult Mental Health Clinic, 681-5455

**3. What is the timeline for hiring three alcohol/drug treatment specialists and three more recovery staff?**

Hiring will occur once the job duties are modified to ensure that they meet MHSA standards and principles related to a recovery-based service approach. The positions will be also be required to meet all MHSA standards related to cultural competency and outreach to un-served communities.

**4. I understand that the proposed “new” Peer Recovery Staff are actually existing Mental Health Assistants employed at the regional community care teams. Is this supplanting? Why aren’t the additional Partners in Hope Recovery Specialist positions filled by individuals who present as consumers?**

These positions will not be restricted to consumers, although consumer staff may fill those positions. Although previously funded by ADMHS, these positions were limited in their scope of services and did not meet MHSA recovery-oriented standards. Under MHSA funding, these positions are designed to ensure that they meet MHSA standards. Specifically, the positions are now required to employ a recovery-focused approach to working with consumers, which may include resource referrals, assistance in employment, and other recovery-based activities.

**5. Why are family members apparently left out of the Recovery Learning Center (RLC) planning process and why won’t they be recipients of RLC services?**

The charters of the Recovery Learning Communities (RLCs) require representation of both family members and consumers on the Guidance Councils, which will determine the allocation of services. The Recovery Learning Communities included family members in the initial planning discussions. Family members are currently participating in the RLC’s.

**6. How may consumers participate in the RLC’s? How do consumers find out about volunteer and stipend-supported opportunities with the RLCs?**

For more information about opportunities, telephone the RLC in your region:

- Santa Barbara, 884-8440
- Santa Maria, 928-0139
- Lompoc, 736-7611

More than 250 persons are participating in the RLC’s, and many are engaged in more than on activity.

## G. Bridge to Care

**1. Why isn’t Bridge to Care being re-established in Santa Barbara and Santa Maria, and who is providing comparable services in those locales? What is the process for reactivating the program in Santa Barbara and Santa Maria?**

Equivalent services are offered in Santa Maria through a psychiatrist with a community-based organization (CBO). Current Alcohol and Drug Program (ADP) funding challenges prevent the establishment of a Bridge to Care program in Santa Barbara, but we hope to address this need in the future.

## H. Justice Alliance

**1. There is no program description. Please provide it.**

The Justice Alliance program serves adults and older adults the individuals with mental illness or mental illness and co-occurring substance abuse conditions who have had interactions with the legal system. Staff are licensed mental health professionals who provide wellness- and recovery-oriented treatment and linkages to resources.

## I. Other MHSA Funding Components

### **1. How may stakeholders participate in the decisions on which programs and services will be selected for Prevention and Early Intervention (PEI) funding?**

Stakeholders have had or will have the following opportunities to provide input and follow-up:

1. Three community forums in Santa Maria, Lompoc, and Santa Barbara, solicited stakeholder feedback on PEI priority populations and community needs.
2. Stakeholders were invited to suggest specific programs and interventions in a community survey available online and through the distribution of hard copies.
3. As with all new MHSA programs and plan updates, stakeholders will be invited to participate in a public comment and public hearing process.
4. Once PEI programs are operational, the Consumer and Family Member Advisory Committee will have the option of monitoring PEI programs and providing feedback.

### **2. Why is there no description of the PEI Work Plan in the 2009/10 Plan Update? Why is there no Exhibit E4 (PEI)? What funds are available?**

The PEI Work Plan has not been created yet and will be a separate Plan.

### **3. Is there no 2009/10 Workforce Education and Training (WET) funding set aside for training? What about the training modules that consumers had chosen? Where is the budget for this shown?**

All WET components approved for funding in prior years, including training for consumers and family members, will be implemented in FY2009/10. The initial WET budget, which includes funding for this training, was posted to [www.admhs.org](http://www.admhs.org) on July 7, 2008 and remains online. ADMHS is happy to provide hard copies of MHSA plans to stakeholders on request.

### **4. Why is there no Exhibit E3 for Capital Facilities and Technological Needs? Has any of this funding already been used? How much is still available?**

A Capital Facilities and Technological Needs Work Plan has not yet been created yet and will be a separate Plan.

### **5. Why is there no Exhibit E5 (Innovation Funding Request)? Has ADMHS received any Innovation funds, including for planning?**

An Innovation Work Plan has not yet been created yet and will be a separate plan.