County of San Diego
Health and Human Services Agency
Mental Health Services

Mental Health Services Act

Three-Year Program and Expenditures Plan

Community Services and Supports Plan

ADDENDUM

Fiscal Years 2005-06, 2006-07, 2007-08

March 15, 2006

County of San Diego

JEAN M. SHEPARD
DIRECTOR

ALFREDO AGUIRRE
CHILDREN'S MENTAL HEALTH SERVICES
DIRECTOR
ADULT AND OLDER ADULT MENTAL HEALTH SERVICES
ACTING DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY

CHILDREN'S MENTAL HEALTH SERVICES
ADULT/OLDER ADULT MENTAL HEALTH SERVICES
P.O. Box 85524
San Diego, CA 92186-5524
(619) 563-2750/2700 • FAX (619) 563-2775/2705

March 14, 2006

Carol S. Hood, Deputy Director
Systems of Care
California Department of Mental Health
1600 9th Street
Sacramento, CA 95814

Dear Ms. Hood:

I am pleased to submit an addendum to San Diego County's Community Services and Supports (CSS) Three-Year Program and Expenditure plan.

The addendum provides in detail, the additional information and/or revisions requested by the State Department of Mental Health to our original plan which was submitted on December 15, 2005. We have also provided additional information and incorporated into the addendum, comments and suggestions that were given to the Department of Mental Health Review Team both in writing and at the February 15, 2006 meeting.

On Part II Sections I, II, III, V and VI, we have highlighted sections that are new to the original submission. We utilized this method in order to provide context by using narrative from the original submission and making it easier for the reviewers to see the new sections.

Exhibits III, IV and V are new. In Exhibit IV, questions 1-13 have been significantly expanded to give the reader a better understanding of the proposed programs.

It is hoped that the State Department of Mental Health can quickly review this additional material so that we can maintain our projected timeline. I know your staff has been working very hard to get through these reviews and we have appreciated their availability. I look forward to hearing from you.

Sincerely,

ALFREDO AGUIRRE, LCSW
Acting Mental Health Services Director

AA:az

cc: Michael Borunda, Assistant Deputy Director, Systems of Care, DMH
Dave Neilsen, Chief, Child and Family Program Policy
Eddie Gabriel, County Operations Liaison, DMH
Henry Tarke, Assistant Deputy Director, SDMHS

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PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Section I: Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

1) *Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years placing an asterisk (*) next to these issues.*

REQUEST FOR ADDITIONAL INFORMATION: Please provide additional information, as was made available or discussed during the County's planning processes, about specific racial ethnic and gender disparities that are recognized as part of your "community issues" (i.e. over representation within homeless populations, incarcerations, emergency care).

Identified Community Issues

San Diego County identified the major community issues and needs that informed the foundation of the draft CSS Plan through our community planning process. Workgroup members used this information to formulate the program and service recommendations set forth in this document.

San Diego County Community Issues Identified in the Public Planning Process			
Children/Youth	**Transition Age Youth**	**Adults**	**Older Adults**
1. Involvement in child welfare and juvenile justice systems *	1. Homelessness *	1. Homelessness *	1. Frequent hospitalizations *
2. School failure *	2. Frequent Hospitalizations *	2. Institutionalization and Incarceration *	2. Homelessness *
3. Inability to be in a mainstream school environment *	3. Institutionalization and Incarceration *	3. Frequent emergency medical care	3. Isolation *
4. Out-of-home placement *	4. Inability to manage independence*	4. Inability to manage independence *	4. Frequent emergency medical care *
5. Peer and family problems *	5. Inability to work*	5. Inability to work *	5. Inability to manage independence *
6. Access to Care*	6. Access to Care *	6. Access to Care *	6. Access to Care*

2) Please describe what factors or criteria led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were issues prioritized for selection? (If one issue was selected for more then one age group describe the factors that led to including it in each.)

Process for Selection and Prioritization
Multiple steps led to the selection of the community issues as described below. First, community input was aligned with the MHSA by categorizing it according to the recommended priority populations and community and supports strategies described in the DMH guidelines. Second, we used our extensive gap analysis to identify unserved and underserved individuals in our system. Third, the community input was ranked in terms of frequency and the Top Ten recommendations were presented to the MHSA Workgroups for discussion, deliberation and recommendations.

The MHSA Workgroups were also asked to add any other community issues identified in the full list beyond the Top Ten that they believed should be included for deliberation. Lastly, the MHSA Workgroups independently ranked the community issues and forwarded them to the Cross Threading Workgroup for review and final recommendations.

The final recommendations regarding the priority community issues selected by the MHSA Workgroups and Cross Threading Workgroup are noted in the table above.

> *3. Please describe the specific racial, ethnic and gender disparities within the selected community issues for each age group, such as access disparities, disproportionate representation in the homeless population and in county juvenile or criminal justice systems, foster care disparities, access disparities on American Indian rancherias or reservations, school achievement drop-out rates, and other significant issues.*

Racial, Ethnic and Gender Disparities within the Community Issues

Racial/ethnic and gender disparities relevant to the community issues noted in the table above were identified as priorities based on the gap analysis data that was made available to the MHSA Workgroups, as well as community input. The MHSA Workgroups strongly recommended that all programs to be developed through MHSA funding be required to address ethnic/racial and gender disparities. The specific disparities within the selected community issues for each age group are described below.

- **Children/Youth**

1. Involvement in the child welfare and juvenile justice system

The need for additional services for children/youth with seriously emotionally disturbances (SED) and their families who are also involved in the child welfare and juvenile justice systems was the top priority for MHSA Workgroups. As a result, recommendations were made for services addressing the needs of this specific target population. These include: Short-

term mental health intervention for dependents and wards released from Juvenile Court; Mental Health Services for Children and Youth at Juvenile Justice Court and Community Schools; and mental health services to dependent children in out-of-home care at risk for residential and institutional based treatment.

In addition to the need to increase services for all, there are specific ethnic/racial and gender groups for whom there are disparities in services. Our analysis of the service data indicates that for youth receiving service concurrently from both Mental Health (MH) and Child Welfare Services (CWS), African American's are over-represented (22% of CWS population versus 17% of Total MH population) and Latino youth are underrepresented (38% versus 44%), relative to the distributions seen in the overall mental health population. For children served in both Juvenile Justice (JJ) and Mental Health there is a similar over-representation of African American children seen conjointly (20% in JJ versus 17% in MH), and the overall JJ percentage of African American children/youth mirrors that of MH at 17.8%. Asian/Pacific Islander children/youth, while comprising 3% of the MH population, and 2.9% of those receiving conjoint MH and JJ services represent 5% of the total JJ population, indicating a potential ethnic/racial disparity among children/youth within the Juvenile Justice System.

Reports from the National Mental Health Association (NMHA) indicate that adolescent girls, as well as gay and lesbian youth are at risk and may not be receiving needed mental health services. Active participation of the presiding Juvenile Judge and other representatives of the juvenile justice system supported the mental health needs and gaps of these groups. While an overall disparity by gender exists among children/youth seeking MH services (60% male and 40% female), this disparity is reduced among populations conjointly served by MH and CWS (52% are male, 48% female). However, this disparity is heightened among children/youth seen concurrent to MH and JJ (72% male and 28% female). Requirements will be included in the RFPs for these MHSA programs to address racial/ethnic and gender disparities.

2/3. School failure/ Inability to be in a mainstream school environment

Through the community input process and in the Children's MHSA Workgroup, school-based mental health services were identified as a priority to avoid school failure and help students stay and succeed in a mainstream school environment. Providing school-based services was considered a key strategy to increase access to care, increase collaborative relationships with education, and help improve school success.

Services provided through the MHSA will increase access for children's mental health services and reduce behaviors that may interfere with their life domains, including education. All services support children's success in the

mainstream school environments. Currently, access to school-based services is only available to eligible children/youth with Medi-Cal.

The value of expanding school-based services under the MHSA to include indigent (unfunded) children/youth was consistently supported by community input. It was also stressed that services must involve families in the services, including home-based interventions if necessary. Additionally, services to this specific population provide the opportunity to improve access to care for two underserved ethnic groups, Latinos and Asian Pacific Islanders, within a normative environment. Analysis of our service data indicated that Hispanic children seen concurrent to MH and Special Education Services were under-represented (37%) compared to the overall MH population (44%). School based services will also improve access for African American and American Indian children and youth.

For this age group, males have traditionally received more mental health services then females. Our analysis indicated that this gender disparity increased from the 60% male to 40% female ratio in the overall MH population, to 70% male versus 30% female ratio of children/youth concurrently open to MH and Special Education Services. MHSA programs will be required to ensure that mental health assessments are provided for females, who are currently underrepresented, are more likely to have been abused, and may be less likely to be referred for or seek services.

4. Out-of-Home Placement

The MHSA requires Wraparound services. Wraparound services were consistently identified as a priority by the MHSA Children's Workgroup and in particular for the uninsured and underserved. Wraparound services provide an approach that has been demonstrated to be effective in reducing out-of-home placement, returning children/ youth from higher levels of foster/residential care, and helping them stabilize in their living environments.

Due in part to the overrepresentation of African Americans in foster care and in the Juvenile Justice system, they may be at greater risk of Out-Of-Home placement. An additional emphasis in this MHSA program will be placed on reducing disparities in provision of wraparound mental health services.

5. *Peer and Family Problems*

Authentic family/youth involvement at multiple levels of care has been a core value that has been promoted in the current system. Stakeholders recognized the need to fully involve children and their families in mental health services in order to incorporate recovery into family functioning. Services identified through the community forums and the Children's MHSA

Workgroup supported this value of family involvement in the development of treatment plans.

Additionally, the MHSA Workgroup identified two additional services to further support families: 1) information and education related to their child's mental health condition; and 2) support services to families and youth to help ensure linkages to services and resources to help achieve treatment goals. Two programs will address these issues: a Family/Youth Information and Education Program, and Family/Youth Peer Support Partners.

- **Transition Age Youth (TAY)**

1. Homelessness

Supportive housing for TAY who are homeless was ranked among the Top Ten issues identified by community stakeholders for this age group. Only ten percent of the current AB2034/REACH program's clients are TAY who are homeless. It is estimated that more than 750 TAY are homeless and have SMI and a co-occurring disorder in San Diego County. The community identified the county's need to address not only community services and supports, but a continuum to support wellness and recovery in all TAY served in this program.

Although statistics are hard to come by regarding the age, gender, and ethnicity of the homeless population, it is clear that youth who are aging out of the Juvenile Justice and Child Welfare systems are potentially at greater risk for homelessness. Research indicates that African Americans and Latinos are more likely to be involved in the Juvenile Justice and Child Welfare systems. For example, even though African American youth between the ages of 10-17 make up only 15% of the US population, they account for 26% of juvenile arrests, and 32 percent of delinquency referrals to juvenile court. Other studies show that minority youth (including Latinos) comprise 32% of the population in the U.S. ages 10-17, they account for 68% of the detention population, and 68% of those committed to secure institutions. In addition African Americans youth tend to be diagnosed with more severe disorders, and the rate for hospitalization can be two to three times that of Caucasian youth. As these youth turn 18 the mental health system must be prepared to provide appropriate services to minimize further risks.

Another issue that must be addressed is the increasing rate of females being arrested and incarcerated as adolescents. In 1997 females accounted for 26% of juvenile arrests, a rate that has been rising since 1993. The females who are involved in the juvenile justice system exhibit a high rate of mental health problems with some studies showing rates of 60% having anxiety disorders, 59% with mood disorders, and up to 100% with Post Traumatic Stress Disorder. As these young women age out of the Children's Mental

Health system, they will require adequate access to mental health services to address their mental health problems.

This MHSA supportive housing program will be required to address the risk and minimize the disparity by assuring that both African American and American Indian youth are receiving services. In addition, the program will be required to conduct special efforts to outreach to females, with a particular emphasis on single mothers.

2. Frequent hospitalizations

The community planning process identified the need to address the frequent use of acute inpatient care for TAY due to of lack of community-based services. Recommendations included providing community-based intensive services that are age and developmentally appropriate with interventions that include social skills, educational, employment, and housing options and supports.

The risk of increased frequency of hospitalization is potentially higher for youth who are aging out of the Juvenile Justice and Child Welfare systems. As noted above, minority youth, such as Latinos, African Americans, and American Indians are more likely to receive services from Juvenile Justice or Child Welfare, they may also be more likely to have frequent hospitalizations. In addition, TAY females do not access services to the extent that would be expected based on their numbers in the population and predictions for prevalence. Based on these facts, this MHSA intensive case management program will be required to address the risks and minimize the disparities by assuring that minority youth and females are receiving appropriate services.

3. Institutionalization and Incarceration

Community input and our gap analysis suggested that TAY are often found in juvenile institutions and the adult justice system and have received mental health services while in detention. These individuals present with co-occurring (mental health and substance abuse) issues, are isolated, and often have been in the children's system of care, child welfare/foster care system and juvenile justice system.

Once again it is clear that youth who are aging out of the Juvenile Justice and Child Welfare systems are at risk. The risks for this population are multiplied by the potential of substance abuse and gang involvement. This MHSA intensive case management program will be required to address the risk and minimize the disparities by assuring that Latino, Asian/Pacific Islander, African American and American Indian TAY are receiving case management services. In addition, the program will be required to serve females at a rate

consistent with prevalence reports, with a particular emphasis on young women who have been abused and who demonstrate self-harm behaviors.

4. Inability to work

Community input highly ranked needs for supportive education, supported employment and community living classes, all within the Top Ten issues most frequently cited during the input phase. Education and employment are normalizing activities that will be developed in programs in this Plan. Ethnic/Racial and gender disparities are the same as those noted for homelessness and frequent hospitalizations. Programs will be required to address ethnic/racial and gender disparities that are identified.

5. Inability to manage independence

Community supports and services for TAY with serious mental illness are limited to a few programs. The community affirmed the need to develop services for TAY to assist them in managing their illness, maintaining their independence and achieving goals in the areas of education, employment, housing and personal functioning. Community stakeholders ranked TAY peer-support services as one of the Top Ten recommendations. Support services provided by peers will be provided from a strength-based and wellness philosophy. Ethnic/Racial and gender disparities are the same as those noted for homelessness and frequent hospitalizations. Programs will be required to address ethnic/racial and gender disparities.

- **Adults**

1. Homelessness

It is estimated that approximately 4,000 homeless individuals with serious mental illness reside in San Diego County; over 60 percent of this population may have co-occurring disorders of mental illness and substance abuse. The issues of homelessness and its related consequences and the lack of affordable housing were raised by the community, homeless providers, and other stakeholders. The need for supportive housing was ranked as a primary issue among the Top Ten most frequently cited issues for adults.

Based on statistics taken from the InSyst system, African Americans who are homeless, are overrepresented in mental health services. The MHSA supportive housing program will be required to address this disparity by ensuring that housing services are provided to African Americans.

2. Institutionalization and Incarceration

San Diego's gap analysis demonstrated that an overwhelming number of incarcerated men had not received any mental health services other then those received in jail. The community input echoed this issue, along with the need to provide services and supports to prevent incarceration of the mentally ill and to assist in their re-entry to the community. Very few community-based services exist to address this issue.

The number of African Americans in jail is notably higher then other groups, and the number of African Americans receiving mental health services jail is also higher, yet many of them do not receive mental services when they are released from jail indicating that many of them may be underserved or inappropriately served. The number of females receiving mental health services while in jail is not consistent with predicted prevalence rates indicating that more females may need to assessed for mental illness while in jail, as well as receiving services to assist them with re-entry to the community.

The MHSA intensive case management program will be required to address both of these racial/ethnic and gender disparities.

3. Frequent emergency medical care

The need for integration of primary care and mental health care was a frequent issue noted for adults as they have multiple physical health care needs, and often have co-occurring disorders that include physical health, mental health and substance abuse. Care providers without the expertise to screen and assess these co-morbid conditions are often blind to the full picture of the adult's health.

Two significant disparities can be found in the gap analysis. Currently 51% of MH service are provided to females, but based on the prevalence data the number should be closer to 65%. African Americans are overrepresented in emergency services (14% of those receiving frequent emergency services) compared to the expected prevalence (6%).

MHSA physical health coordination programs will be required to reduce these disparities by ensuring that their services are provided to females at rates more similar to the prevalence projections, and that African Americans have adequate access to care in order to reduce the risk of frequent hospitalization.

4. Inability to manage independence

Clients and family members identified the challenges that seriously mentally ill (SMI) adults face in managing their lives, having meaningful use of time and capabilities, safe and adequate housing and a network of positive relationships to help daily functioning. Safe and affordable housing options,

peer supports, employment supports and family education are services that were recommended by the community input.

5. Inability to work

The inability to work and lack of employment-related supports were frequently mentioned as priorities at the community input forums and in the client survey. This issue was ranked among the Top Ten most frequently cited issues during the community input phase. Employment supports and services were recommended by the community input process.

- **Older Adults**

1. Frequent Hospitalizations and Medical Care

The community input process and gap analysis identified that older adults are using acute inpatient care and emergency mental health services for several reasons. Older adults do not access community-based mental health programs in a timely manner due to the stigma associated with mental illness. Fifty percent of older adults receiving mental health care receive it from primary care physicians. Primary care and mental health providers recognize that there is a need to provide integrated community-based programs and supports to isolated older adults, and that geriatric mental health education for these providers is needed.

2. Homelessness

This issue was identified by the community planning process repeatedly. Older adults who are homeless or near homeless face many challenges, i.e., isolation, co-occurring disorders, disparities issues, lack of several needs, including affordable housing, in-home support services, culturally competent services and transportation. African Americans represent 13% of older adults of those currently receiving mental health services who are homeless. In addition, many Latino, African American and American Indian older adults, especially females, who are living in poverty are at risk for being or becoming homeless. The MHSA programs will be required to address this disparity by ensuring that services are provided to these groups.

3. Isolation

The older adult network repeatedly echoed that many older adults, as a result of the loss of roles in society, diminished functional capacity, limited finances, lack of accessible and affordable-transportation services, tend to become isolated. This, coupled with depression associated with multiple losses, places older adults at high risk. There is a need for mental health and social service supports to address older adult serious mental illness. The community

input also affirmed that outreach and engagement strategies are needed to reach this population and reduce the high rate of untreated mental health illness, the high rate of suicide and the inappropriate use of institutionalized care. Women who are living alone may be particularly at risk. Programs will be required to address racial and ethnic disparities in delivering service, including ensuring that they have the capacity to meet the language needs of older adults, who may be more likely to be monolingual. Languages that must be addressed include the county's threshold languages: Spanish, Vietnamese, Arabic, and one language that will be added soon to the list Tagalog.

4. Frequent Emergency Medical Care

The need for integration of primary care and mental health care was a frequent issue noted for older adults as they have multiple physical health care needs, and often have co-occurring disorders that include physical health, mental health and substance abuse. Care providers without the expertise to screen and assess these co-morbid conditions are often blind to the full picture of the older adult's health.

The MHSA programs will be required to have the capacity to serve diverse groups, including Latinos, African Americans and Asian/Pacific Islanders. In addition, during future MHSA planning SDCMH will consider developing outreach services to ensure that more females are aware of the available services.

5. Inability to Manage Independence

Seriously mentally ill older adults are often unable to manage their independence and self-sufficiency due to undetected mental health issues, lack of community services and supports and attitudinal views about older adults' capacities and abilities. Older adults in these situations are often isolated, their mental illness is undetected and there are not enough professionals with geriatric and mental health expertise to serve them.

4. If you selected any community issues that are not identified in the "Direction" section, please describe why these are more significant for your county and how they are consistent with purpose/intent of MHSA.

Additional Community Issue: Access to Care

In addition to the community issues noted above Workgroups noted that "access to care" is a significant issue that needs to be addressed in San Diego County. San Diego's gap analysis demonstrated that approximately 72,000 individuals of all ages may be in need of mental health services, and the mental health system is currently serving 58,000. San Diego's gap analysis also demonstrated that a significant

number of ethnically/racially diverse individuals are unserved and underserved in the mental health system as noted in the chart below.

	Children		TAY		Adult		Older Adult	
	% Served	% of Poverty Pop	% Served	% of Poverty Pop	% Served	% of Poverty Pop	% Served	% of Poverty Pop
African American	16%	7%	12%	7%	12%	6%	7%	5%
Latino	44%	58%	29%	41%	21%	37%	15%	23%
Asian/Pacific Islanders	3%	7%	5%	10%	5%	8%	7%	10%
American Indians	1.1%	.6%	.6%	1.2%	.6%	.4%	.2%	.4%

Some other notable issues are that African Americans and American Indians are not accessing outpatient services; and women are not accessing services in numbers consistent with predicted levels.

SDMHS recognizes multiple contributing factors to racial/ethnic and gender disparities, including:

- Limited knowledge about mental health services and recognition of mental health issues;
- Stigma associated with seeking mental health services;
- Language and cultural barriers, including lack of bilingual and bicultural professionals and consumer/family providers;
- Lack of transportation and related economic and sociopolitical factors; and

Consistent with the MHSA, DMH guidelines, the gap analysis and community input, San Diego is proposing to improve access to care by integrating primary care and mental health services in multiple community health centers sites. The community health centers will be spread throughout the county and will include Indian Health Centers. This intervention is considered a best practice for ethnically diverse populations. In addition the current program of cultural competence training will be expanded and will support culturally competent clinical practice standards developed by the Cultural Competence Resource Team (CCRT). The training will encompass courses on working with diverse populations, including but not limited to Latinos, African Americans, Asian/Pacific, American Indians, Sexual Orientation, Older Adults, Transitional Age Youth, and gender issues. Finally, consistent with current practice, all new services will be comprehensive, integrated and provide culturally competent services throughout the delivery of services.

Part II, Section II,: Analyzing Mental Health Needs in the Community

Gap Analysis

> *1) Using the information from population data for the County and any available estimates of unserved populations, provide a narrative analysis of the unserved populations in your county by Age Group. Specific attention should be paid to racial ethnic disparities.*
>
> **REQUEST FOR ADDITIONAL INFORMATION: Please provide additional information about primary languages, sexual orientation, and special needs for each age group.**

San Diego County Mental Health Services (SDCMHS) prepared a detailed gap analysis to fully understand the scope of mental health needs among all four target population age groups. San Diego also conducted an in-depth analysis of population subgroups to identify service needs based on diversity and special needs. Data used in the Gap Analysis was derived from the InSyst system, the State Prevalence Report, and San Diego County census data.

A summary of the gap analysis, which included estimates of unserved, underserved, and inappropriately served individuals, and the analysis of Prevalence Data was provided to, reviewed and discussed by the MHSA Workgroups. Please see Attachment 1 for the gap analysis and prevalence data, which was the document used by the workgroups.

Additional groups for whom there is currently a gap in services were identified through community input, the Children's System of Care reports, and through additional research conducted by mental health. Community input lead to the identification of two special needs groups, the deaf and hard of hearing and victims of torture. The additional research demonstrated that in addition to disparities in services for various ethnic/racial groups and by gender, services gaps also exist for persons who are gay, lesbian, bi-sexual and transgender. This was not identifiable in the gap analysis report as the current MIS does not capture data regarding sexual orientation.

In addition to the reports noted above, GIS mapping (Attachment 2) was utilized to compare locations of current services to areas of need based on information on <200% poverty, age, and ethnicity/race.

Unserved Populations in San Diego County

The formula used to determine the number of unserved persons in San Diego County was based on the estimated prevalence of mental health needs among those in poverty, for all age groups, across each ethnic/racial classification, contrasted to the numbers served in the current service system.

In addition, as suggested in the CSS Requirements, SDCMHS included in the estimate of unserved the number of individuals who received inpatient or emergency services and no other specialty mental health services (stated in the DMH CSS requirement as "crisis only services"). Another factor considered was the estimated numbers of homeless. These data were provided by the San Diego Task Force on the Homeless.

As can be seen in the analysis below, significant ethnic/racial disparities exist among numbers of persons who are not being served. Additional needs of the unserved populations include language, sexual orientation, and other special needs. Two "special needs" groups identified by the MHSA Workgroups were Deaf and Hard of Hearing and Trauma Victims. These findings were reaffirmed in the community input provided by family members, providers and other interested community stakeholders.

Estimates for Unserved Populations in San Diego County by Age Group

1. **15,821 Children and Youth**
   - Many of the children who are currently unserved are without insurance – number is estimated to be 15,667 (represents a duplicate count across gender and age)
   - Of these, the ethnic/racial groups that appear to have the largest number of children and youth in need of mental health services are Hispanic (8,805) and Asian Pacific Islander (1,447)
   - Children/youth of all ethnic/racial populations are unserved in the Age ranges of 0-5 (3,697) and ages 6-11 (3,154)
   - Primary language needs of unserved children and youth include Spanish, Tagalog, Vietnamese, and Arabic
   - Females are underrepresented in CMH, 40% females compared to 60% males
   - An estimated 950 of unserved children and youth may be gay or lesbian
   - A number of unserved children may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims

2. **8,900 Transition Age Youth**
   - In San Diego County, the unserved TAY were identified as between 18 and 25 years of age because, based on prevalence data there, is no apparent service gap for 16 and 17 year olds.
     - Of this group, 7773 received no mental health services and 1,127 TAY received only crisis or emergency services
     - The ethnic/racial groups with the largest number of unserved are Latino (2,506) and Asian Pacific Islanders (312).

- Primary language needs of unserved TAY include Spanish, Tagalog, Vietnamese, and Arabic
- Based on the State Prevalence report estimates of gender differences, it is possible that up to 5,000 females in this age group may be unserved.
- Approximately 6-8% of the unserved TAY population may be Gay, Lesbian, Bi-Sexual or Transgender
- A number of TAY may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims

3. 16,007 Adults (25-59)

- 11,392 received no mental health services and 4,615 utilized only emergency or inpatient mental health services,
- Based on projections in the State Prevalence Report large numbers of the county's Latino (9,422) and Asian Pacific Islander (1,970) population are not accessing mental health services at all.
- Of these, it is assumed that a higher percent may be monolingual Spanish, Vietnamese, Tagalog, or other language.
- In addition, although Native Americans and African Americans are accessing mental health services at a rate closer to the number projected by the State Prevalence data they were much more likely to be receiving only emergency, inpatient or jail mental health services.
- Approximately 6-8% of this population may be Gay, Lesbian, Bi-Sexual or Transgender
- A number of adults may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims
- In addition, to the other factors noted it is possible that an estimated 11,000 adults who are unserved are without insurance.
- There are a substantial number of veterans who are seriously mentally ill and are in need of comprehensive mental health services.
- As a result of community input, SDMHS will track service use by Transitional Age Adults ages 50-59 to better understand mental health needs among this population.

4. 4,613 Older Adults (60+)

- 4,035 received no mental health services and 578 Older Adults received only inpatient or emergency services, but were not connected to other MH services.

- A relatively high percent of African Americans and American Indians received only emergency or inpatient mental health services
- It is estimated that 650 Latinos and 250 Asian/Pacific Islanders were unserved
- Many Latino and Asian/Pacific Islander older adults may be monolingual
- Based on estimates of gender differences, it is possible that up to 1,600 females in this age group may be unserved.
- Approximately 6-8% of this population may be Gay, Lesbian, Bi-Sexual or Transgender, indicating a need for training
- There are a substantial number of older adults who are veterans who are seriously mentally ill and are in need of comprehensive mental health services.
- A number of older adults may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims
- Prevalence estimates will be re-evaluated on an on-going basis because the MHSA Older Adult Workgroup felt the prevalence estimates were too low, as stigma and isolation contribute to more underreporting and lack of recognition of mental illness among older adults.

2. Chart A. Service Utilization by Race/Ethnicity

2) Using the format provided in Chart A, indicate the estimated total number of persons needing mental health services who are already receiving services, including those fully served and those underserved/inappropriately served, by age group, race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity (Transition Age youth may b shown in a separate category or as part of Children and Youth or Adults).

The tables below provide estimates of the total number of persons needing MHSA-level mental health services who already are receiving services, including those fully served or underserved/inappropriately served, by age group, race ethnicity, and gender.

Children and Youth 0-17	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	205	106	6,469	6,128	17,716*	94%	310,449	100%	742,584	100%
RACE/ ETHNICITY										
African American	32	17	1,586	1,018	2,653	15%	22,440	7.23%	46,782	6.3%
Asian Pacific Islander	2	1	281	180	464	3%	21,982	7.08%	65,347	8.8%
Latino	55	29	4,292	2,750	7,126	40%	179,692	57.88%	280,697	37.8%
Native American	2	1	94	60	157	1%	1,863	0.6%	3,712	0.5%
White	113	58	3,80	1,984	5,235	30%	70,525	22.72%	304,459	41%
Other	1	0	212	136	882	5%	13,946	4.49%	41,585	5.6%
Missing Data	0	0	731	468	1,199	6%				

Transition Age Youth 18-24	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	5	0	746	574	5409	100%	130,559	100%	337,506	100%
RACE/ETHNICITY										
African American	2	0	102	52	626	11.6%	8935	7%	20,623	6%
Asian Pacific Islander	0	0	35	26	259	4.8%	12660	10%	35,965	11%
Latino	1	0	209	129	1,579	29.2%	53620	41%	122,665	36%
Native American	0	0	9	3	32	.6%	1611	1%	2,147	1%
White	1	0	349	239	2,567	47.5%	48699	37%	143,093	42%
Other (and UK)*	1	0	42	125	346	6.4%	5034	4%	13,013	4%

Adults 25-59	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	261	184	4004	3949	30,776	100%	347,997	100%	1,917,017	100%
RACE/ETHNICITY										
African American	46	39	583	558	3,656	11.9%	19618	6%	78,404	4%
Asian Pacific Islander	10	11	174	190	1,626	5.3%	26,296	8%	164,799	9%
Latino	30	25	748	793	5,993	19.5%	127502	37%	390,659	20%
Native American	0	3	22	33	189	0.6%	1432	0%	7,896	0%
White	166	103	2300	2211	16,549	53.8%	87216	25%	803,549	42%
Other*	9	3	177	164	2,763	9.0%	85531	25%	471,710	25%

Older Adults 60+	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	14	15	175	373	577	100%	96,530	100%	434,147	100%
RACE/ETHNICITY										
African American	2	2	17	40	186	6.7%	4676	5%	14,248	3%
Asian Pacific Islander	0	0	7	16	197	7.1%	9482	10%	40,446	9%
Latino	0	2	29	74	420	15.1%	21908	23%	56,392	13%
Native American	0	0	1	0	7	0.3%	414	0%	1,856	0%
White	12	10	107	226	1,571	56.6%	58922	61%	314,353	72%
Other*	1	1	14	17	393	14.2%	1530	2%	6852	2%

** Other includes other, unknown and 2 or more races*
*** County poverty population is based on prevalence data and the percentages are estimated based on percentages for Ages 18+*
**** Fully served are those receiving Wraparound or AB2034 services according to DMH guidelines.*

3. Analysis of Ethnic Disparities in Fully Served, Underserved or Inappropriately Served Populations in San Diego County

3. Provide a narrative discussion/analysis of the ethnic disparities in the fully served, underserved and inappropriately served populations in your county by age group as identified in Chart A above. Include any available information about their age and situational characteristics as well as race ethnicity, gender, primary language, sexual orientation, and special needs.

In order to complete the gap analysis, County staff estimated the needs related to the fully served, underserved or inappropriately served for all age and ethnic groups.

The methodology used to determine the number of fully served for the purpose of this analysis was the include only those children and youth currently receiving Wraparound Services and only those TAY, Adults and Older Adults receiving services in Intensive Case Management or AB2034 programs.

The methodology used to determine the number of persons underserved or inappropriately served was to analyze the use of inpatient, emergency, and jail services, as well as analyzing the utilization of those services based on demographics of the client population. This comprehensive analysis was conducted by Children and Adolescent Services Research Center (CASRC) for data regarding children and adolescents and by Dr. Todd Gilmer of UCSD Department of Family and Preventive Medicine for data regarding transitional age youth (TAY), adults, and older adults. Data used for this analysis was from the InSyst system, the management information system used to record services in San Diego County, and from published census data. Please see Attachment 1

for the summary of the gap analysis data, which was the document used by the workgroups.

Children & Youth

Fully Served:

- 311 children and youth currently are fully served in the Children's System of Care/Wraparound Services programs.
- Females are under-represented, seen as 33% of the fully served population
- Latinos (25% of fully serviced compared to 44% in the overall MH population) and Asian/Pacific Islander (1% in full served population versus 3% overall MH) are underrepresented

Underserved or inappropriately served:

- Potentially 6,106 adolescents may have underserved mental health needs related to a co-occurring substance use disorder.
- Potentially 2,024 children without health insurance leave the juvenile justice system without adequate continued mental health services.
- There is a notable disparity in the number of females compared to males being fully served in the Juvenile justice system

Transition Age Youth

Fully Served:

- Currently only 5 TAY are being fully served
- All racial/ethnic groups are underrepresented
- Both genders are underrepresented

Underserved or Inappropriately Served:

- 154 youth who receive limited outpatient and/or case management services, and 516 who receive more than seven of these services a year and yet they still use emergency services
- 774 who receive only medication management services
- 1,949 youth who receive jail mental health services
- A larger percent of TAY are Latino than is predicted by the percent of this ethnic group in the general population.
- African American TAY receive a higher rate of mental health services while in jail.

Adults

Fully Served:

- 445 adults are currently being fully served
- All racial/ethnic groups are underrepresented

- Females are underrepresented

Underserved and Inappropriately Served:

- 613 who received very limited (1 to 3) outpatient or case management services
- 3,093 who received more than seven outpatient services, but also had multiple needs for crisis or emergency services;
- 4,824 adults with a diagnosis of schizophrenia, bipolar, major depression and other psychosis who only received medication management services.
- An estimated 2,765 adults with serious mental illness may have been homeless.
- In addition, almost 9,000 adults were dually diagnosed and are therefore at risk for hospitalization, incarceration and homelessness.
- African Americans were more likely to receive a diagnosis of schizophrenia than other groups, compared to their prevalence in the population.
- In addition, African Americans receive a higher rate of mental health services in jail, and receive fewer outpatient services in several regions, than is predicted by the percent of this racial group in the general population.
- The number of Latino and Asian/Pacific Islanders with Medi-Cal who are accessing services is lower then expected.
- Spanish speaking clients compared to English speaking clients are diagnosed less frequently with bi-polar disorder, and more frequently with depression.
- There is a notable disparity in the number of females compared to males

Older Adults

Fully Served:

- Only 29 older adults are currently being fully served so older adults in general are underrepresented in FSP
  There are currently no older adult Asian/Pacific Islanders or American Indians being fully served

Underserved and Inappropriately Served:

- An estimated 1,539 older adults potentially underserved.
- A smaller number, 213 and 140 respectively, were either dually diagnosed or were in jail at some time during the year.
- 476 received very limited (1 to 3) outpatient or case management services
- 128 who received more than seven outpatient services, but also had multiple needs for crisis or emergency services

    - 357 older adults with a diagnosis of schizophrenia, bipolar, major depression and other psychosis who only received medication management services
  - A relatively high percent of African American older adults received mental health services while in jail, 12.9% compared to 6.7% receiving mental services.
- Of those Older Adults receiving more then 7 specialty mental health services, 19.8% were Latino which was much higher then any other group except Caucasian.
- Latinos and Asian/Pacific Islanders appear to be under-served in Case Management services.
- Females are notably underserved or inappropriately served.

These figures were used by each population workgroup to hone in on priorities for MHSA funded services. By focusing on these populations, we can reduce negative consequences of institutionalization and homelessness among those groups needing more mental health services.

4. Objectives for the Provision of Culturally and Linguistically Competent Services to Address Disparities in Access to Care

> *4. Identify objectives related to the need for and provision of culturally and linguistically competent services based on the population assessment, the county's threshold languages and the disparities or discrepancies in access and service delivery that will be addressed in this Plan.*

Based on the evident disparities in access to care for the ethnically diverse groups mentioned above, SDMHS is committed to continuing expansion of its culturally competent capacity in the proposed MHSA-funded programs described in this plan. The following objectives include specific strategies and interventions to address access to care disparities. Objectives to increase access to care and reduce health care disparities countywide include:

- Conduct outreach to engage and increase access to care for Latinos, Asian/Pacific Islanders, African Americans, and American Indians in the mental health system

- Increase penetration and rates of client retention for all ethnic/racial groups and for females

- Provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them, such as primary care clinics and school-based programs

- Provide culturally competent mental health services in all proposed MHSA programs by educating and training providers on evidence-based and promising clinical practices, interventions and skill sets, including coordination and integration of mental health and primary care, clinical practice guidelines, screening/assessment protocols, chronic disease management and cultural competence

- Include training on working with translators, the deaf and hear of hearing, victims of trauma, and gender and sexual orientation issues in the plan for cultural competence training

- Require enhancement of the bilingual and bicultural capacity in all programs by recruiting, hiring, retaining and retraining culturally competent staff

- Address disparities in services for females in all age groups by requiring MHSA programs to ensure females are assessed for mental illness

- Increase access to services for all ethnic/racial groups and females by implementing the MHSA program to provide more mental services in community clinics

- Establish relationships with tribal communities for as many of the 17 American Indian who have reservations in San Diego County as possible

- Implement a Breaking the Barriers program, designed to evaluate how to address stigma and increase access for selected underserved communities

Part II, Section III. Identifying Initial Populations for Full Service Partnerships

1. From your analysis of community issues and mental health needs in the community, identify which initial populations will be fully served in the first three years. Please describe population each in terms of age, situational characteristics described above (e.g. youth in the juvenile system, transition-age youth exiting foster care, homeless adults, older adults at risk of institutionalization, etc.) If all age groups are not included in the Full Services Partnerships during the three-year plan period, please provide an explanation specifying why this was not feasible and describe the county's plan to address these age groups in the subsequent plans.

REQUEST FOR MORE INFORMATION: **Please provide a copy of the data that was made available to stakeholders as part of the process to identify initial populations for FSP, including specific data on gender.**

Data regarding ethnic/racial and gender disparities were made available to the stakeholders as part of the process to identify initial populations. This data was included in the gap analysis, Children's System of Care annual report, and the Prevalence report.

Children and Youth

Full Service Partnerships (FSP) for Children and Youth include those with severe emotional disturbances who are uninsured, unserved and underserved. FSP programs will be structured to provide countywide service with regional capacity. Assuming stable funding in the next two fiscal years (2006-07 and 2007-08) results in FSP annual projections for 267 children and youth. The children and youth targeted for FSP services will include an emphasis on females who are currently underrepresented (40% of MH population compared to an estimated 50% of all children in need of services) and will have one of more of the following situational characteristics:

- Be dependents and wards; at risk of residential treatment or stepping down from residential treatment
- Be currently homeless or at risk of homelessness
- Be high level service users
- At least half, as per the population prevalence, are Latino and Asian Pacific Islanders
- Have co-occurring disorders of severe emotional disturbance and substance abuse

Additional situational characteristics include exposure to domestic violence, educational failure, substance abuse in the family, and access to care barriers.

FSP services will incorporate practices that are culturally competent and linguistically appropriate.

Transition Age Youth (TAY)

FSP services will be primarily targeted for currently unserved/underserved TAY who are between ages 18 and 25 years old, as in San Diego the gap analysis demonstrated that 16-17 year olds do not appear to be unserved. The planning assumption for stable funding in the next two fiscal years (2006-07 and 2007-08) results in FSP annual projections for 192 TAY, who will have one or more of the following situational characteristics:

- Have a serious mental illness;
- Involvement in the justice system;
- Be currently homeless or at imminent risk of homelessness; and
- At risk of involuntary hospitalization or institutionalization.

The FSP program TAY 1 will use the Assertive Community Treatment (ACT) team model, a well-researched evidence-based practice that addresses the high needs of these individuals. We anticipate that approximately 100 housing units will be needed to decrease homelessness for this population, as 36 TAY will be in a dual diagnosis residential program (TAY 3). Rehabilitation and recovery services that are age-specific will be included in the service array.

Community input noted that co-occurring disorders are significant issues for TAY. Given estimates that co-occurring disorders exist in over 60 percent of persons who have a serious mental illness, all services will be delivered in a dually diagnosed capable manner, using the Comprehensive, Continuous Integrated System of Care (CCISC) model. San Diego has invested in CCISC capability over the past three years; this model is considered a best practice in the field of co-occurring disorders.

In addition, programs will be required to reduce the disparity for females who have been underrepresented in FSP.

Adults

Services for persons with serious mental illness who are homeless will be provided in the Central/North Central and North County regions of San Diego County. The planning assumption for stable funding for FSP services for adults ages 25 to 59 years of age in the next two fiscal years (06-07, 07-08) results in FSP annual projections for 435 adults.

First priority will be given to unserved adults with SMI with the below situational characteristics, then to adults so underserved that they are at risk of the below situational characteristics:

- Serious mental illness;
- Co-occurring disorders;
- Homelessness; note that priority is given to persons who are actually homeless compared to those at risk of homelessness;
- High utilization of acute inpatient care; and/or
- Local criminal justice system involvement, including child protective services involvement.
- In addition, programs will be required to reduce the disparity in services for females who have been underrepresented in FSP.

This group includes persons with co-occurring substance abuse disorders and/or health conditions, along with transitional age older adults, ages 50-59, who are aging out of the adult mental health system and at risk of any of the above conditions or situational characteristics. Close coordination will occur with the Older Adult system of care for these transition age adults.

San Diego will use the integrated service modality of Assertive Community Treatment (ACT) that has demonstrated positive outcomes with high need individuals. Rehabilitation and recovery services will be included in the array of services provided by the ACT teams. Housing options will also be provided to homeless and at risk of homelessness individuals. We anticipate that approximately 435 housing units, in a full fiscal year period, will be needed to decrease homelessness for this population.

Older Adults

The planning assumption for stable funding in FSP services for older adults, ages 60 in fiscal years 06-07, 07-08 is for 83 older adults. Situational characteristics of this group will include those:

- Serious mental illness;
- Co-occurring disorders;
- Frequent users of hospital and emergency room services;
- Reduced personal and/or community functioning due to physical or health problems;
- Homelessness and/or at risk of homelessness; and
- At risk of institutionalization or nursing home placement.
- In addition, programs will be required to reduce the disparity for females who have been underrepresented in FSP.

The integrated service modality of Assertive Community Treatment (ACT), which has demonstrated positive outcomes with high need clients, will be used for this population. Rehabilitation and recovery services that are age-specific will be

integrated in the service delivery. We anticipate that approximately eighty-three housing units will be needed for this population.

2. Factors Leading Selection of Initial Populations

2. Please describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years. (Distinguish between criteria used for each age group if applicable.)

In making selections, factors considered included (1) priority population criteria that were identified in the MHSA and the DMH final guidelines for the CSS plan; and (2) San Diego's community input process, during which these populations were consistently affirmed and prioritized and (3) San Diego's gap analysis which identified ethnic/racial and gender disparities for each age group.

3. Reductions in Ethnic Disparities

3. Please discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

As described in Section II in both chart and narrative form, the proposed Community Services and Supports Plan services will increase access to community mental health and rehabilitation and recovery-based services for the priority populations by expanding service locations and providing new services and outreach activities. By focusing on individuals with the highest needs and those from underrepresented racial/ethnic groups, we will reduce ethnic disparities particularly for Latinos, Asian Pacific Islanders, African Americans and American Indians. Additionally, for these groups we can reduce the long-term effects of untreated mental illness, homelessness, and inappropriate treatment of individuals in the justice system in acute care and long term care institutions.

SECTION V: ASSESSING CAPACITY

1) Provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county. Must address the bilingual staff proficiency for threshold languages.

1) Analysis of Organizational and Service Provider Strengths and Limitations

San Diego County, like other parts of California, is home to rapidly changing demographics. SDMHS is committed to serve the culturally, linguistically and ethnically diverse populations throughout San Diego. These populations are described in Part II, Section II.

SDMHS's strengths include a systematic approach to integrating cultural competence in our mental health delivery system. This integration is met through a comprehensive approach that continuously examines and improves standards in the following areas:

- Clinical Practice Standards
- Human Resources
- Evaluation and Research
- Policy
- Culturally Competent Policies and Training

SDMHS evaluates and monitors the ability and capacity of both County staff and contract providers to provide culturally competent mental health services. SDMHS has established a number of specialty provider programs to meet the unique needs of culturally and ethnically diverse populations such as Union of Pan Asian Communities (UPAC) providing services to Asian Pacific Islander populations, María Sardiñas Center providing services to Spanish-speaking Latino population, and Project Enable providing services to the African American population.

SDMHS was one of two counties in California that scored 100 points out of 100 possible points in its most recent Cultural Competence Plan. The MHSA project lead, Piedad Garcia, Ed.D., LCSW, is also the Ethnic Services Manager for SDMHS; together with the Cultural Competence Resource team (CCRT) and the Quality Improvement Unit, she oversees and monitors the integration and application of the SDMHS cultural competence standards.

Our cultural competence plan provides for continuous improvement through ongoing tracking and review processes, annual objectives for training, use of interpreters, monitoring of providers' linguistic capacity, and ongoing objectives to

increase access to mental health services to the Latino community. The Performance Improvement Project (PIP) to improve Latino access to mental health care is one example.

2) Compare and include an assessment of the percentages of culturally, ethnically and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county and the total population currently served in the county.

Comparisons of Direct Service Providers to Populations in Need

SDMHS has greater needs for diverse staffing than is currently available in the array of County, contractor and fee-for-service providers. This gap is apparent in the table below that compares the ethnicity breakdown for the county population who may need services (individuals below 200% poverty), and clients that are currently served with direct service providers.

	Population needing services*	Population Currently Served	Direct Service Providers**
African American	7%	9%	16%
American Indian	1%	1%	<1%
Asian Pacific Islander	8%	5%	8%
Latinos	47%	29%	17%
White	34%	49%	57%
Other	3%	7%	1%

Data from Prevalence Data, InSyst Service data, Bi-Annual Program Status report

** Based on prevalence data regarding <200% poverty population*
*** Based on bi-annual report sent by County and Contracted organizational providers for Adult and Children's System of Care, 2004/2005.*

Ethnicity of direct service practitioners, according to this data, is underrepresented for:

- *Latinos:* Only 17 percent of service providers are Latino compared to 47 percent of the target population;
- *Asian Pacific Islanders*: 8 percent of service providers are of Asian Pacific Islander descent compared to 8.4 percent in the target population; this group includes both Vietnamese and Filipino; and
- *African-Americans*: Well represented with 16 percent of service providers compared to 6.4 percent in the target population.
- *American Indians*: Underrepresented with less then 1% of direct service providers

Language Capacity among service providers in itself does not appear to be a major barrier to service:

- *Spanish:* 44 percent of providers speak Spanish;
- *Asian Pacific Islanders cluster*: 28 percent of service providers speak at least one of the Asian Pacific Islander languages. This includes 1 percent in Vietnamese, reflecting some language capacity needs, and 20 percent in Tagalog; and
- *Arabic:* Data are not available on this group, but community input and limited staff linguistic proficiency indicates a need for expanded capacity.

3) Provide an analysis and include a discussion of the possible barriers your system will encounter in implementing the programs for which funding is requested in this Plan and how you will address and overcome these barriers and challenges.

Barriers to Hiring Clients and Family Members

SDMHS has experienced challenges in hiring clients and family members. SDMHS Administration successfully overcame internal administrative barriers in order to hire consumer and family members to assist with MHSA planning. This positive experience set important precedence to expand client and family member capacity in the forth-coming MHSA programs and services.

Strategies to address the barriers to hiring clients and family members:

- The majority of new programs will have requirements to hire clients;
- Proposing new programs that are client and/or family-run
- Increasing vocational and employment services and opportunities for clients.

REQUEST FOR MORE INFORMATION: Please provide a brief summary of the SDMHS "barriers and challenges" for working with the Native American populations.

Barriers Related to Staffing Shortages

SDMHS faces difficulty in recruiting and hiring culturally and linguistically diverse staff due to human resource shortages in the field and strong competition for culturally and linguistically diverse professionals and Consumer/Family Providers. In Southern California, and particularly throughout San Diego County, there is heavy competition for Spanish-speaking professionals. In general, mental health field salaries are lower than other professions, so the field faces competition from other sectors. Adding to this challenge, San Diego County is less competitive for two important reasons:

- High cost of housing in San Diego

- Other costs of living are higher than in other counties

These factors negatively affect our ability to hire culturally competent clinicians in both County and contract operated programs and, in particular, in children's programs.

With Spanish-speaking Medi-Cal beneficiaries making up 28 percent of the County Medi-Cal population, there is a shortage of bicultural, Spanish-speaking clinicians in every region of the County with the most severe shortage occurring in the South region where 71percent of the clients are of Hispanic origin.

There is a lack of Vietnamese clinical staff serving both children and adults. The number of Vietnamese and other Asian/Pacific Islander direct service providers is less than is needed to meet the demand. Efforts to recruit Fee-For-Service Vietnamese-speaking clinicians and psychiatrists have yielded several recruits.

There are also several barriers to hiring staff who are Native Americans. Currently there are fewer then 1% of direct service providers who are American Indian. The barriers to hiring include strong competition for eligible candidates, and fewer candidates available overall.

Strategies to Address Barriers

To adequately serve the additional MHSA target populations, we have to build on the strengths of the system and ensure that services features include:

- Services will be provided in the languages of the specific community to be served;
- Selected interventions have demonstrated efficacy with population served in appropriate settings and locations also; and
- Services providers will possess cultural awareness, knowledge and skills/training necessary to provide competent services.
- Placement of services within schools and in geographic locations identified through ethnic population mapping as having a higher density of Hispanic and Asian/Pacific Islanders utilizing services.

The following are methods that SDMHS plans to utilize to achieve these goals:

- Provide adequate funding level for programs to allow for competitive salaries and pay differentials for staff who are bilingual/bicultural or who have other special skills;
- Continue to utilize interpreters to supplement staff with bilingual skills; and
- Continue to enhance the systematic approach to integrating cultural competence standards in our mental health delivery system as discussed below:

- Implement Best Practices or Proven Practices that are appropriate for various ethnic/racial groups
- Develop more coordination with Physical Healthcare services to increase access for Latino, Asian, American Indians, African Americans, as well as adolescent and TAY females, including services to be provided at Indian Health Centers
- Work with local tribal communities to improve relationships and increase cultural understanding by providers regarding barriers limiting the Native American population from accessing mental health services; including the heightened stigma against mental health and treatment, relative geographic isolation, culturally specific alternative forms of treatment, reduced incentive to participate in treatment.
    - Providers will be encouraged to target Native Americans in their employment recruitment
    - Providers will be required to form collaborative relationships with Tribal communities for continued outreach and education for clients, families, and provider staff.

Enhancing Cultural Competence

Our systematic approach includes goals for recruiting, hiring and retaining linguistically and ethnically diverse professionals and Consumer/Family Providers. More detailed discussion below addresses how SDMHS will address this and other challenges.

Clinical Practice Standards: Additional measurable objectives, specific to the Mental Health Services Act, will be developed and added to the current annual review process. Best Practices and Proven Practices will be implemented across the system.

Monitoring: SDMHS will continue to monitor provider cultural and linguistic capacity, as well as client outcomes, client satisfaction with services, and impact on penetration and retention for all diverse populations.

Human Resources: Our Cultural Competence Plan requires a continuous tracking and review process, along with annual objectives for training, use of interpreters, and monitoring of provider linguistic capacity. SDMHS will require a human resource plan from MHSA providers that goes beyond business-as-usual in the recruitment, hiring and retention of linguistically and ethnically diverse providers.

Evaluation and Research: SDMHS gathers the most recent information and data regarding the diverse populations within San Diego County. These findings will be used for our on-going MHSA planning efforts. In addition, implementation of best practices, evidence-based practices and client outcomes will be evaluated for all the MHSA programs and services recommended. The County will be

vigilant in identifying any disparities of outcomes concerning ethnic and racial groups served. We will collaborate with local research entities to conduct program evaluation and research that is specific to ethnically diverse populations.

Policy and Administration: SDMHS has developed system-wide policies to institutionalize the approaches, behaviors, and practices that guide the system towards cultural competence. Additional policies will be developed that focus specifically on the enhanced services to be provided under the MHSA and which address the diverse groups targeted under the CSS Plan.

Training Plan: On-going cultural competency training is required of all County and contracted staff. This includes consumers/family member staff, administrative, clerical support staff, and clinical staff. A system-wide assessment of cultural competency training needs was completed in 2003 and the findings have been incorporated into the County of San Diego's Cultural Competence Plans since that time. As a result of this assessment, trainings provided on Awareness and Knowledge have been augmented, and current plans call for an evaluation of skill-based training for clinicians, with an initial focus on improving culturally competent assessment skills.

Currently training is offered on services for Latinos, Asian/Pacific Islanders, African Americans, American Indians, Older Adults, and Gay and Lesbians. Existing curricula will be evaluated and augmented to ensure that training addresses relevant cultural issues, such as services for the deaf and hard-of-hearing community, the Arabic/Chaldean community, victims of torture, veterans and transition age youth. These training curriculums will focus specifically on issues identified in our extensive Community Program Planning process. SDMHS is proposing that a portion of one-time money will be specifically allotted to use for system-wide cultural competence training.

Section VI: Developing Workplans with Timeframes and Budgets/Staffing

- *The SDMHS submission includes an expansion of an existing SB 163 program within the county for a probation focused population. The CSS requirements for this section, Page 40 of the DMH CSS document, remind counties of the MHSA requirement. Please describe in greater detail the existing SB 163 program within San Diego County, the number of current slots, populations served, and any inter-departmental funding arrangements regarding the local matching requirements. It was noted in the review of the SDMHS workplan CY-7 that there was not clear information regarding the County's social services department willingness to participate in the proposed expansion of services under this program.*

SB163 Services

The County of San Diego currently operates through contract a program that utilizes SB163 funding. The program is known as Families Forward. Families Forward is a Wraparound Program that services a prominent role in the Children's Mental Health Services (CMHS) System of Care and offers a variety of services to both families and the community with a total budget of 5.576 million dollars. Services are provided to children and youth who are at imminent risk of high-level residential placement. Children served come from the Child Welfare and Probation system. The program is designed with a capacity to serve 240 clients (twenty-two slots are provided for SB163 eligible clients). The following services are available for severely emotionally disturbed (SED) children and youth ages 6-18 and their families: crisis intervention, case management, medication management, mental health services (individual, family and group therapy), Wraparound facilitation, Family to Family/Peer to Peer support and Education. Families Forward currently serves families through five satellite offices located throughout the county. Children and youth are referred through the Probation Department, Child Welfare Services, and Children's Mental Health Services with the objective of maintaining children in their home or homelike setting and preventing transition to a higher level of care. Family Service Teams consist of a Family Service Coordinator and may include a Counselor, Family Support Partner and/or Youth Support Partner to assist families and to provide coordination of services that are culturally relevant and strength-based within the family's neighborhood. The aspects that are unique to the program and set Families Forward apart from other programs that serve high risk youth include a substantial Family Support Partner Program, the Wrap Assessment Team (W.A.T.) and "No Wrong Door" linkage service through an Information and Referral Line.

Families Forward has thirteen (13) family support partners and the capacity for four (4) youth support partners. These partners are individuals who offer support and their personal experience in the System to provide a sense of normalization and to build trust and rapport with families.

The Wrap Assessment Team (W.A.T.) is comprised of a clinician (Family Service Coordinator) and Family Support Partner who completes the intake assessment process to individually determine service intensity and identify the appropriate Wrap Team with the family. This process helps expedite service delivery and allows for crisis needs to be attended to immediately.

For families that do not meet eligibility criteria, a "No Wrong Door" system allows the Information and Referral Line to provide up to 10 hours of linkage and referral services to families including follow-up calls to ensure that contact was made with the appropriate resource in their community.

Families Forward plays a prominent role in enhancing the System Of Care in collaboration with community partners. This is evidenced by the following: Representation at the Collaboratives throughout San Diego; establishment of an Information & Referral Line (with over 3,000 resources throughout San Diego County); Monthly educational workshops; Outreach to neighborhoods; a Community Advisory Board made up of representatives from the arts, business, faith-based community, technology, military and law enforcement to enhance community awareness of Children's Mental Health needs; coordinating The Annual Children's System of Care Conference; Wraparound trainings to the community; and Mental Health Systems, Inc. Conferences. The program is represented on various committees to enhance the System of Care including the Children's System Of Care (CSOC) Council, the Wraparound Training Academy Oversight Committee, the Super Outcomes Committee, the Dual Diagnosis Cadre, the Initiative Oversight Committee, the Strategic Planning Committee, the Academy Supervisor's Task Force, Training For Trainers Group, and the CSOC Curriculum Development Task Force.

Current funding for the program is as follows:

Total Medi-Cal:	$4,043,844 (This includes FFP, realignment for base Medi-Cal and State EPSDT)
Total SB163 related funding:	$1,471,998
State 163	$588,799
County Match	$883,199 (Match is a combination of MH realignment and tobacco funds)
Additional realignment for Wrap flex funds:	$61,072
Total current program:	$5,576,914

The proposed Wraparound Mental Health Services Act program will be a separate and distinct program. The new program will have most of the elements above. However, it will be distinct in that it will be jointly monitored by Child Welfare and Children's Mental Health and will target children and youth already in residential care with a goal of returning them back to the community.

EXHIBIT 3: FULL SERVICE PARTNERSHIP OVERVIEW

Number of individuals to be fully served:

FY 2005-06: Children and Youth: 0 Transition Age Youth: 0 Adult: 0 Older Adult: 0 TOTAL: 0
FY 2006-07: Children and Youth: 267 Transition Age Youth: 192 Adult: 435 Older Adult: 83 TOTAL: 977
FY 2007-08: Children and Youth: 267 Transition Age Youth: 192 Adult: 435 Older Adult: 83 TOTAL: 977

PERCENT OF INDIVIDUALS TO BE FULLY SERVED

Race/Ethnicity									% TOTAL
	% Male		% Female		% Male		% Female		
	% Total	% Non-English Speaking	% Total	% Non-English Speaking	% Total	% Non-English Speaking	% Total	% Non-English Speaking	
% African American									
% Asian/ Pacific Islander									
% Latino									
% American Indian									
% White									
% Other									
Total Population									
% African American	2%	NA	3%	NA	2%	NA	2%	NA	9%
% Asian/ Pacific Islander	2%	10%	2%	10%	1.5%	10%	1.5%	10%	7%
% Latino	9%	10%	10%	10%	6%	10%	7%	10%	32%
% American Indian	.5%	NA	.5%	NA	.5%	NA	.5%	NA	2%
% White	13%	10%	13%	10%	8%	10%	9%	10%	43%
% Other	2%	10%	2%	10%	1%	10%	2%	10%	7%
Total Population	28.5%	10%	30.5%	10%	19%	10%	22%	10%	100%
% African American	3%	NA	3%	NA	2%	NA	2%	NA	10%
% Asian/ Pacific Islander	3%	15%	3%	15%	2%	15%	2%	15%	10%
% Latino	10%	15%	11%	15%	7%	15%	7%	15%	35%
% American Indian	.5%	NA	.5%	NA	.5%	NA	.5%	NA	2%
% White	11%	15%	12%	15%	7%	15%	7%	15%	37%
% Other	1%	15%	2%	15%	1%	15%	2%	15%	6%
Total Population	28.5%	15%	31.5%	15%	19.5%	15%	20.5%	15%	100%

*As services will most likely not be implemented until the middle or end of FY 05-06, planning for percent of services by ethnicity this FY will not be applicable.

- Analysis includes children, TAY, adults, older adults
- Based on gap analysis and reflects the needs of various ethnic groups in San Diego County
- Services will be developed to meet needs of target population by improving capacity or access

LISTING OF SAN DIEGO COUNTY'S MHSA WORK PLANS

Number	Program Name	Funding	Target Age	Linkages
CY-1	School and Home Based Services	OE	Children	
CY-2.1	Family and Youth Information/Education Program	SD	Children	TAY-1, CY5.1, CY 2.2
CY-2.2	Family/Youth Peer Support Services	FSP	Children	CY-5.3, CY-7
CY-3	Cultural/Language Specific Outpatient	FSP	Children	
CY-4.1	Mental Health and Primary Care Services Integration	OE	Children	A-7, OA-3
CY-4.2	Mobile Psychiatric Emergency Response	SD	Children	ALL-3
CY-5.1	Medication Support For Dependents and Wards	SD	Children	CY-2.1
CY-5.2	Outpatient Court Schools and Outreach	OE	Children	CY-2.2
CY-5.3	Homeless and Runaways	FSP	Children	CY-2.2
CY-6	Early Childhood Mental Health Services	SD	Children (0-5)	
CY-7	Wraparound Services	FSP	Children	CY-2.2
CY-8	Mental Health Services to Children/Youth in Placement	SD	Children	
TAY-1	Integrated Services and Supported Housing	FSP	Transition Aged Youth (TAY)	TAY-3, TAY-2, A-A-1, A-2, OA-1
TAY-2	Clubhouse and Peer Support Services	SD	TAY	TAY-1, TAY-3
TAY-3	Dual Diagnosis Residential Treatment Program	FSP	TAY	TAY-1, TAY-2,
TAY-4	Enhanced Outpatient Mental Health Services	SD	TAY	TAY-1, A-5
A-1	Homeless Integrated Services and Supported Housing	FSP	Adult	A-2, TAY-1, TAY-3, OA-1
A-2	Justice Integrated Services and Supported Housing	FSP	Adult	A-1, TAY-1, TAY-3, OA-1
A-3	Client-Operated Peer Support Services	SD	Adult	A-5
A-4	Family Education Services	SD	Adult	A-5
A-5	Clubhouse Enhance and Expand with Employment	SD	Adult	A-1, A-2, A-3, A-4, A-8, TAY-1
A-6	Supported Employment Services	SD	Adult	A-5
A-7	Mental Health Services and Primary Care Services Integration	OE	Adult	CY-4.1, OA-3
A-8	Enhanced Outpatient Mental Health Services	SD	Adult	
OA-1	High Utilizer Integrated Services and Supported Housing	FSP	Older Adult	OA-2
OA-2	Mobile Outreach at Home and Community	SD	Older Adult	OA-1

OA-3	Mental Health Services and Primary Care Services Integration	OE	Older Adult	CY-4.1, A-7
ALL-1	Services for Deaf and Hard of Hearing	OE	All Ages- (Children, TAY, Adult, and Older Adults)	
ALL-2	Services for Victims of Trauma and Torture	OE	All Ages	
ALL-3	Walk-in Assessment Center, North County	SD	All Ages	CY 4.2
OTO-1	System-Wide Community Education, Training and Technical Enhancements	SD	All Ages	System-wide
OTO-2	System-Wide Outreach One Time Funding	OE	All Ages	System-wide

FSP- Full Service Partnership
OE- Outreach and Engagement
SD- System Development

CHILDREN'S MENTAL HEALTH
COMMUNITY SERVICES AND SUPPORTS EXHIBIT 4 OVERVIEW

Children's Mental Health Services in San Diego have been in the process of transforming for the past eight years. This transformation has been possible by an unprecedented growth allowing for implementing services that are family centered, culturally competent and culturally based. In 1997-98, the budget for Children's Mental Health in San Diego County was 24.4 million. In 2005-06, the budget was 84.9 million (these dollar amounts do not include MHSA funding). This phenomenal growth fueled by EPSDT, tobacco dollars and realignment was largely due to support and direction by the Board of Supervisors an inclusionary planning process with multiple stakeholder participation, in particular families and dedicated county and contract staff. Examples of the transformation which has already occurred include:

- In 1997 we were in 7 schools; today we are in over 300 schools.
- In 1997 we spent $5.6 million in outpatient and school based services; today we spend $36.1 million.
- In 1997 32% of the Children's budget was spent on inpatient services. Today 8% goes for inpatient services.
- No children have been hospitalized in State hospitals for the past 5 years. San Diego County does not hospitalize for acute care in out of county hospitals.
- We used to not have consumers and family members at the table and we did not listen. We do a much better job at listening.
- We used to blame families and now we actively seek family input and advice.
- Wait times for routine appointments used to run 28 days; they now run under 3 days.
- We used to make decisions that would keep people in the criminal justice system because we assumed that those people did not belong in our system. We have gotten better in that area both from the services we provide and in our attitudes.
- We used to not ask questions around substance abuse. We now have entire pages on the clinical assessments on substance abuse.
- We used to not ask questions about domestic violence and child abuse; we do now.
- We have grown in terms of delivering more and better services. Along the way, we have matured as County staff. We are more transparent, inclusionary and work much better with stakeholders.

The Mental Health Services Act provides a tremendous opportunity for San Diego County to continue its transformation.

- First, through MHSA we are proposing to significantly expand school based services to low income children and youth who do not qualify for EPSDT.

- Second, we will expand services to children who are primarily the County's responsibility - wards and dependents. Rather than merely expanding services, programs that are being funded for this population will be transformative in that they will be linked to family/youth support services, will step down children and youth from Residential Services and will actively involve Child Welfare and Probation Administration in decision making and support.

- Third, family/youth peer support services will be developed which will hire consumers and family members to provide support to families. These services will be closely linked to other services funded through the MHSA.

- Fourth, San Diego County proposes to access low income children/youth by developing mental health resources to 27 community based clinics. These services will transform the clinics as they currently are unable to provide mental health services to non Medi-Cal children and youth. Additionally, because these clinics are located in largely low income areas, these services represent a targeted opportunity to provide mental health services to minority populations including Asians, Latinos, African Americans, and Native Americans.

- Fifth, the very early childhood population has limited mental health resources. The proposed early childhood program will represent a marked change in doing business where we will be able to "catch" those young children much earlier and prevent them from needing special education mental health services or getting into trouble which may lead them into the Juvenile Justice System.

Finally, in cooperation with the Adult System, new and innovative programs are being developed such as homeless services for homeless children/youth, victims of torture and trauma and children/youth who are hard of hearing. These new programs will tie into the system and fix those current voids in the system.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year**: 2005-06, 2006-07, 2007-08	**Program Work Plan Name**: School and Home Based Outpatient Services for Uninsured Children/Youth with Serious Emotional Disturbance.
Program Work Plan: CY-1		**Estimated Start Date:** April 1, 2006

Program Description:

1a) 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. In a series of focus groups where consumers were asked for input on service priorities for the Mental Health Services Act, expanding school based services was given the highest priority. Through the Mental Health Services Act, this program will be able to expand services to another 605 children and youth (to age 18) with Serious Emotional Disturbance (SED) per year who are unfunded and 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.

Originally, Children's Mental Health services (CMHS) were primarily clinic based. Due to the expansion of EPSDT which began in 1997, CMHS was able to provide school based services to Medi-Cal eligible youth and has expanded from serving 7 school sites in 1997 to currently serving 300 school sites. MHSA funding will allow these programs to begin serving uninsured, low income, non-Medi-cal eligible children and youth who are Seriously Emotionally Disturbed.

Priority Population: 1b) School age children/youth up to age 18 with SED who are non Medi-Cal, indigent unserved/uninsured).

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Provide outreach and treatment to indigent, unserved, uninsured populations noted in gap analysis. The gap analysis indicated that approximately 1,896 children/youth in San Diego County with mental health issues are unfunded/unserved; ✓ Provide comprehensive school-based, individualized, culturally competent,	☐	☐	☒	☒	☐	☐	☐

and strength based mental health services that support recovery and resilience with a focus on achieving self-sufficiency; ✓ Intervene early to increase chances of positive outcomes; ✓ Involve children, youth, and families in the development of individualized, culturally competent, comprehensive assessments and service plans; ✓ Encourage family participation in identifying service locations which may include school, clinic, or home based locations. Families have opportunities to be in positive environments that encourage successful relationships and foster belief in the resiliency of the child; ✓ Increase array of community service options for children and youth diagnosed with SED and their families; ✓ Offer services in the least restrictive setting which may deter need for higher level of care and may help prevent unnecessary institutionalization and out of home placements; ✓ Coordinate and provide linkage with educational partners to improve continuity of care in a normative setting and support development of healthy coping and problem solving skills that lead to recovery; ✓ Provide referrals to help clients apply for Medi-Cal and Healthy Families insurance coverage; ✓ Screen for domestic violence issues and co-occurring disorders and provide referrals as needed; ✓ Train clinical staff on wraparound principles and approach, domestic violence, and co-occurring disorders. Training may be open to pertinent educational staff; ✓ Provide dual diagnosis capable services by applying the Continuous Comprehensive Integrated System of Care (CCISC) model that include, at a minimum, screening, assessment and referral;							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

This program will build on existing outpatient treatment services provided on over 300 school sites within San Diego County by 39 outpatient programs. In the past several years, CMHS has significantly expanded services outside of clinic settings for Medi-Cal beneficiaries who require medically necessary specialty mental health services. School based services have greatly increased access for Medi-Cal children and families who might not seek help through a clinic because of the stigma associated with mental illness. Mental health school outreach efforts have been primarily targeted to school sites with the highest rates of poverty and children and youth from racially and ethnically diverse backgrounds. These culturally sensitive services have increased access to mental health care for this population, specifically the Latino and Asian populations. In determining where school site services would be provided, CMHS went through a process with each school district to determine which school sites had the highest level of poverty/Medi-Cal beneficiaries and districts were given choice in selecting mental health providers who would provide services.

CMHS is a system of care County and is committed to system of care values and principles in providing client and family driven, strength-based, culturally competent, community based services that are outcome driven. Services provided are developmentally appropriate and are designed to accomplish the following goals:

- Children are living at home or home-like settings
- Children are staying out of trouble
- Children are successful in school
- Children are safe
- Children are physically and emotionally stable
- Clients are satisfied

The purpose of this program will be to provide outpatient mental health services to 605 additional SED children and youth annually. Currently, there are limited services available to children who have no Medi-Cal or other insurance. Expanding the existing school based services through the MHSA allows unserved/uninsured children/youth and their families to access services within the normative environment of school and home settings. According to the children's gap analysis, there are at least 1896 children (number adjusted for age and ethnicity/race) who are unfunded and have difficulty accessing services. Services are

provided on elementary, middle school, and high school campuses in all six health and Human Services regions of San Diego County.

Referrals for the program will come primarily from school personnel; however, in CMHS families can self-refer to any program through the “No Wrong Door” access policy. Other providers, child welfare or probation may request that a child/youth be seen at a school site.

School partners contact the parents for consent to refer a child for mental health assessment, and the contract provider then proceeds to contact the family and provide services. Services available through this program to children, youth and families include assessment, individual, group and family therapy, medication management, and case management/ linkage. Services are provided using a strength based and resiliency based model which will be continued in the proposed expansion. School based providers are fully committed to supporting the child and family’s goals through strengthening relationships within the family, assisting members in developing strong social bonds in the community, helping parents to set expectations, and giving the child a meaningful role in the family. Families are involved in developing plans which will improve their ability to cope with the challenges of daily life and to support the child’s ability to become self-sufficient over time. School personnel are encouraged to support the child by encouraging creativity and focusing on strengths and positive behaviors. With services provided on school campuses during school hours, there is frequent communication between teachers and clinical staff working with the client. Clinicians attend school meetings such as Individual Educational Planning meetings and may assist families in navigating educational and other systems to advocate for their children.

School based service providers offer services during school and after school hours. During school hours, services are provided on the school campus. After school hours and during school holidays and vacation closures, services are provided in the client’s home or at the provider’s office based on client/family preferences. All programs offer evening appointments to families and are flexible in providing services based upon the family’s scheduling needs. Providers offer families information about how to access help after hours. All outpatient providers develop a crisis prevention plan with the client/family that identifies behavior triggers, strategies to handle them, and crisis numbers if a crisis situation does not diffuse based upon the developed strategies.

Existing school based providers will expand staffing including licensed and license eligible clinicians and extend psychiatric hours. All programs have capacity for psychiatric consultation and medication management as needed. Each program will expand staffing by increasing hours or hiring new staff based upon the amount of their MHSA allocation and the number of MHSA clients they are expected to see. Program Management and clerical staff from the current program will be utilized for MHSA so programs will not need to hire new administrative personnel.

This program addresses MHSA goals for system transformation by increasing timely access to care for indigent children and youth who would otherwise remain unserved, and by providing client and family-driven, strength-based, culturally competent, and recovery oriented services in school and community based settings. All children referred are assessed to determine if they are seriously emotionally disturbed and are evaluated for domestic violence issues and co-occurring disorders using the CRAFFT, a brief screening tool for adolescents. Additionally, families have access to family/youth information programs currently funded through CMHS such as Family Roundtable.

San Diego Mental Health services has implemented the Continuous Comprehensive Integrated System of Care (CCISC) consensus best based practice model in our system of care for individuals with co-occurring psychiatric and substance disorders. The CCISC model has these four basic characteristics: system level change, efficient use of existing resources, incorporation of best practices, and an integrated treatment philosophy. The program staff shall be trained to, at a minimum, be capable of providing screening, assessment, and referral for dually diagnosed children and youth.

Outcomes are an essential element of CMHS system of care. All providers, including school based providers, implement outcome measures including the Child and Adolescent Measurement Scale (CAMS) and client satisfaction surveys with children and families at intake, six month intervals and discharge. CMHS also uses a quadrant model developed by CMHS to assess severity of client impairment in eight areas and these quadrant ratings correspond to CMHS system of care goals as outlined above. Quadrant measures of severity provide additional program and system outcomes beyond the standardized measurement tools. The following outcome measures are required of all school based programs:

- For 80% of discharged clients whose episode lasted 6 months or longer, Child and Adolescent Measurement System (CAMS) total score at discharge shall show clinically significant improvement compared to the client's intake score. The CAMS is an assessment of youth well-being and has five subscales: acuity, social competence, and hopefulness, internalizing and externalizing problems and victimization.
- For 80% of discharged clients whose episode lasted 6 months or longer, the Client Functioning Quadrant (CFQ) that contains at least one of the targeted treatment goals shall be at least one level higher (improvement) at discharge than at admission.
- For 80% of those clients who remain in the program for 6 months or longer, the discharge summary shall reflect no increased impairment resulting from substance use, as measured by the Client Functioning Quadrants rating for substance use.

- Scores on the Family Centered Behavior Scale (FCBS) shall average 80% or higher across questions/test items. The FCBS is used to assess the presence of family centered qualities, such as clinician responsiveness to family, in mental health services.

In addition, all programs must achieve the following process objectives:

- All clients are assessed for substance use
- All clients, ages 16 and older, are assessed for transitional service needs
- All clients are assessed for domestic violence issues
- All clients are assessed to determine the need for referral to a primary care physician
- Client satisfaction surveys are completed in accordance with CMHS requirements

Dependent upon each individualized Service Plan, children, youth and families may be linked to other resources in the community, including but not limited to primary health care providers, family support services, alcohol and drug programs, regional Family Resource Centers, and mentorship programs.

3) Describe any housing or employment services to be provided.

The program will provide referrals to housing and employment services, regional Family Resource Centers, and community collaboratives, as needed. School personnel assist in identifying children and families with housing needs and work with providers to link the clients with services. Housing referrals may include community shelters which are located throughout the County or housing resources such as San Diego Housing Commission or other public housing agency or Section 8 providers. Employment service referrals may include CalWORKS for parents or education and vocational training through collaboration with school personnel.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A – This service is not funded through a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

School based services are uniquely situated to increase access to services for unfunded SED children, youth and families since they provide services in a normalized setting that is already present in the lives of these children and families. In this setting, the rights, privacy, needs and desires of each child can be fostered without the stigma associated with a traditional mental health clinic. As children and their families become partners in their care, they are empowered to realize their full potential. One strategy that will be utilized is to connect the youth to as many social supports as possible. These may include culturally appropriate groups in the community. Treatment utilized by these programs provides intervention across multiple life domains and is particularly suitable for SED children, whose challenges occur in many settings. The intent of this program is to assist children/youth and their families to realize their goals by utilizing an individualized approach which includes skill building to foster resiliency. The key to the success of the recovery process is the client plan. Clinical staff is key in helping the individual client by engaging the family in a team effort, helping the client and family define their goals and expectations, planning and implementing multi-layered interventions that become part of the client plan. Effectiveness and necessity of treatment is established through a Utilization Review Committee that reviews the treatment of each client at no more than six month intervals to insure that clients are making progress or that alternate treatment goals are established. Program management meets regularly (usually monthly) with school administrators with the goal of problem solving and strengthening collaboration.

Programs have contractual requirements such as the program outcomes described in the program description above. Each program is required to submit a monthly status report to the County Program Monitor in which they report program activities, outcomes, quality assurance activities, staffing, cultural and language capacity, and staff training. The school based Program Monitor conducts monthly regional meetings with providers and obtains verbal program reports. Program Monitor site visits are conducted at least bi-annually to ensure program compliance with contract requirements. Medical record reviews are conducted at least annually by the County Quality Improvement department. In addition, the Program Monitor meets intermittently with school district administrative personnel and providers to obtain feedback about program performance.

CMHS is committed to a culturally competent system. Cultural competence is a principle embedded throughout service delivery. For example, school based programs have recruited and hired a large number of bilingual, multi-cultural, diverse staff which increases and broadens access for diverse individuals.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Current school based programs are able to serve only Medi-Cal eligible children, youth and their families. Augmentation of existing services will allow current EPSDT-only providers to serve uninsured SED children/youth and families. This program will expand services by augmenting thirty-nine (39) contract programs who offer services at over 300 schools throughout all regions of San Diego County. A major advantage of this service augmentation is that mental health providers will now have capacity to serve unfunded children and youth at school sites. School partners are pleased that providers will now be able to serve indigent SED children and youth who present the most challenges to the school, and who have not had access to mental health services previously.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

CMHS financially supports the Family Roundtable, a formal family and youth led organization which serves as a coordinating hub for families and youth involved in public child and family serving systems. Consumer run services offer peer support and training on a wide range of topics that help family members develop skills in supporting their children.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

There is strong collaboration with Educational Partners through existing school-based outpatient programs and this will be further strengthened as a result of MHSA augmented services. School partners include school nurses, school psychologists, counselors, and teachers. Collaboration with primary care providers and child serving agencies such as Child Welfare Services and Juvenile Probation will continue.

As indicated, school based providers convene regular meetings with personnel from the schools they serve. Included in the meetings are program managers, clinical staff, school administrators and the person the school has identified as a liaison for referral or problem solving. Generally these meetings occur monthly.

Monthly regional provider meetings that include all outpatient providers in each region provide an opportunity to share information, changes in service provisions, coordination of referrals and other system-wide issues.

With the implementation of the County Behavioral Health Initiative, Adult and Older Adult mental health service providers, CMHS providers and Alcohol and Drug providers have begun quarterly regional meetings in each region to improve service integration across behavioral health programs. Trainings are scheduled to occur during 2006 on common screening tools and an integrated resource manual to assist with referrals among the three sectors.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs

This program will adhere to the expectations for all CMHS programs as defined in the Mental Health Cultural Competency Plan which includes hiring multi-cultural/bilingual staff, ensuring all staff receive at least 4 hours per year of cultural competence training, and have access to interpreter services as needed (for language and deaf/hard of hearing needs). San Diego County has written material available in the four designated threshold languages (English, Spanish, Vietnamese, and Arabic). New contracts require providers to develop a human resource plan and to demonstrate how they will determine language proficiency within the program.

Specific outreach and engagement is promoted with unserved/underserved children, youth and families including minority groups (particularly Latino and Asian/Pacific Islander). Although continued expansion is planned, school based services have been able to broaden access to diverse populations including Native Americans, Latinos, and Asian Pacific Islanders. Several school based providers in the north and rural east region serve schools attended by Native American children and youth. Another school based provider offers services in the San Diego Unified school district's Deaf and Hard of Hearing classrooms for elementary and middle school youth.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Sensitivity to gender and sexual orientation is part of the cultural competence expectations for the county. 60% of CMHS clients are male, 40% female. Typically, school personnel refer those children/youth who are the most disruptive in the school setting.

These children/youth are more often males. Female children/youth more often internalize problems and are under identified. Providers will further educate school personnel in identifying mental health needs of females.

Staff are trained on gender differences as well as lesbian, gay, bisexual, and transgender (LGBT) issues as part of the Cultural Competence Plan. For children/youth in middle and high school, identification of gender issues and sexual orientation issues are particularly crucial to client outcomes. Their issues will be addressed in the assessment and treatment and/or the children and youth will be referred to an appropriate treatment program.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

School based services are available to children and youth transitioning back from out-of county placement.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisor approval of MHSA Plan	12/13/05
Notify contractors of augmentation amounts and client expectations	12/16/05
Contractors develop new budgets and submit for review	by 01/18/06
Revise Statements of Work to include MHSA and negotiate contractor budgets	by 02/28/06
Process and execute contract augmentations	by 03/15/06
Programs add additional hours to current staff schedules or hire new staff	by 04/01/06
MHSA program start date	04/01/06
Program staff orientation and training	by 04/07/06
Program staff work with schools to identify unfunded SED children, start seeing clients	by 04/15/06

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year:** 2005-06, 2006-07, 2007-08	**Program Work Plan Name:** Family and Youth Information/Education Program
Program Work Plan: CY-2.1		**Estimated Start Date:** July 1, 2006

1a) Program Description: Family and Youth Information/Education Program will provide countywide information and education to children/youth with serious emotional disturbance (SED) and their families. Regional educational forums will focus on MHSA, education and information on mental illness de-stigmatization of mental illness and the use of psychotropic medications to at least 485 participants. Two forums will take place in all six HHSA regions of the County for a total of 12 forums with approximately 30 participants per forum. The program will also provide a family and youth leadership training for about 25 participants. Additionally, the program will conduct two community health fairs for about 100 participants. Staff will be comprised of family/youth educators. Hours of operation will include evenings and weekends to accommodate families and regional needs.

1b) Priority Population: Children and youth with SED (0-18 years old) and their families, with special outreach to unserved/underserved, ethnically diverse populations as per gap analysis (Latino and Asian/Pacific Islanders).

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Development of families and youth in leadership roles to provide information and education to children/youth with SED and their families; ✓ De-stigmatize mental illness and serious emotional disturbances in children and youth; ✓ Family and youth educators will provide information/education regarding mental illness; ✓ Develop Training Plan to be incorporated with Children's System of Care Academy training plan to include: MHSA, de-stigmatization of mental illness. ✓ Outreach and training plan will include special effort to reach Latino and Asian/ Pacific Islanders as per need noted in the gap analysis and to reduce racial disparity; ✓ Family and youth educators will be reflective of the diverse ethnic	☐	☒	☐	☒	☐	☐	☐

population in the County; ✓ Family and youth hired will become members of the existing Children's System of Care Training Academy to support integration and a seamless approach to service delivery; ✓ Orientation and training to family/youth educators will include MHSA: mental health, conflict resolution, dual diagnosis, domestic violence and cultural competence.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

San Diego County will contract with a community-based organization to provide Countywide Family/Youth Information and Education, with specific outreach to Latino and Asian/Pacific Islander populations. The program will provide information and coordinate education to the target population of children/youth with SED and their families. The program will train family/youth in leadership. Hours of operation will include evenings and weekends to accommodate families and regional needs. Forums will take place in all six HHSA regions of the County.

The program supports the principle of authentic consumer and family/youth participation by hiring family partners who will provide training. Family/youth partners, who have experience with the mental health system, will serve as role models, leaders and trainers. This enables the community to experience a positive perception of family/youth with mental health issues. Receiving education from family members has been extremely well received in our community. Providing family-to- family training is one component in the transformation of the mental health system. These trainings will be conducted in regional forums for families. The content will include, but is not limited to, understanding mental disorders of children and the use of psychotropic medications.

The following goals are designed to advance the mental health system transformation:

1) The target population will gain increased knowledge of mental illness and SED disturbances to de-stigmatize mental illness and to improve their ability to benefit from services. Information will include resources and how to access Children's Mental Health Services which will assist in minimizing barriers to access services.

2) Children/youth with SED and their families with experience as clients in Children's System of Care will be trained in leadership roles to provide education and information to the target population.

3) Children/youth with SED and their families of Latino and Asian/Pacific Islander population will receive special outreach to participate in educational forums. These forums will be conducted in Spanish, Vietnamese and other languages as needed. Interpreter services will be available. The selected provider will submit to San Diego County Mental Health their proposed outreach strategies to these groups.

4) Greater client family participation will be achieved by hiring family members to provide education to the community.

5) By hiring family members to function as trainers/educators, the family members serves as members of the mental health provider system thereby serving as role models. These interactions serve to de-stigmatize mental illness for the general public.

3) Describe any housing or employment services to be provided.

Program staff will be familiar with housing/homeless/employment resources and programs in San Diego County.

Program staff will include housing resources as part of their educational forums including information about the Family Resource Centers which provide employment services and housing referrals to clients on public assistance. Program staff will offer information on shelters and transitional housing facilities in the area. The clients may be given information on the San Diego County and City Departments of Housing Authority and Community Development for eligibility to the Section 8 Housing Program, or rental assistance. For transition age youth in need of housing, the program will provide information on the existing transition age youth Young Adult Supportive Housing Initiative (YASHI). This program will assist in obtaining housing and provides vouchers for the deposit on apartments. Information will be provided to families on Housing programs that are being developed through the Mental Health Services Act: TAY-1 Integrated Services and Supportive Housing; A-1 Homeless Integrated Services and Supported Housing; A-2 Justice Integrated Services and Supported Housing.

Employment assistance will be made through the Regional Occupational Program and other employment agencies in San Diego County. An MHSA funded program, A-6, Supported Employment Services will provide an array of job opportunities and supports to help adult family members with serious mental illness obtain employment.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A – This program is not funded as a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The program will plan and provide services in a manner consistent with the Children's System of Care principles. The program staff will ensure that System of Care principles are incorporated into all educational/regional forums and leadership curriculum. Family education promotes recovery and resiliency for child/youth and families through presentations to the target population about the following: Understanding serious emotional disturbances in children/youth, de-stigmatizing mental illness, and understanding use of psychotropic medications. The contractor will hire family and youth partners to act as educators for these educational/regional forums. The program shall be required to comply with the program requirements of the Statement of Work as contained in the Request for Proposal which are:

- Contractor shall hire family partners to meet the requirements of this contract. Contractor shall hire family and youth educators who will be reflective of the diverse ethnic population of the County.
- Contractor shall provide orientation and training to family/youth educators which shall include, but is not limited to: MHSA, mental health issues, conflict resolution, dual diagnosis, domestic violence, cultural competence, transition age youth.
- Contractor shall ensure that System of Care principles are incorporated into all educational/regional forums and leadership curriculum.
- Contractor shall develop families and youth in leadership roles by providing information and education to children/youth with SED and their families.
- Contractor shall develop a family/youth regional educational forum curriculum and leadership curriculum, to be approved by the Contract Monitor.
- Contractor shall develop training plan to be incorporated with Children's System of Care Training Academy training plan.
- Contractor shall provide educational forums to the target population, youth with SED and families of children/youth with SED (0-18 years old) with special outreach to unserved/underserved, ethnically diverse populations as per gap analysis (Latino and Asian/Pacific Islanders). The forums shall include, but are not limited to: understanding serious emotional disturbances in children/youth, de-stigmatizing mental illness and the use of psychotropic medications.

- Contractor shall develop evaluations forms for the family/youth regional educational forums and the leadership training.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new Countywide program. The contractor will be determined by a competitive RFP process. This program compliments existing mental health programs by educating family and youth receiving services in the mental health system of care. The program also advances family and youth partnership and leadership by directly hiring family and youth with experience in the mental health system to provide direct service.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Family members/youth are to be hired and paid to provide education as Family/Youth Educators. Family and youth will train other family and youth mental health issues and on leadership. Family and youth hired will become members of the existing Children's System of Care Training Academy to support integration and a seamless approach service delivery. The Training Academy services as one of San Diego's system of Care sustainability strategies and has been instrumental in training and mentoring families receiving services and family partners to promote authentic family partnerships.

Family and youth will participate on an advisory group, which meets on a regular basis, to advise on the contractor's implementation and provision of services. The advisory group shall include at least 51% family and youth consumers and community members who reflect the cultures of the client population.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Collaboration, in the ongoing effort to transform mental health services, will be made with all System of Care Partners (Education, Child Welfare, Probation, Mental Health Providers, Alcohol and Drug, community and others). In addition, an integrated training effort will be made through the collaboration with the Children's System of Care Training Academy. The program will participate on the Children's System of Care Training Academy Oversight Committee (operations committee for the Training Academy) to ensue collaborative partnership with existing training efforts. The program will coordinate with Health and

Human Services Agency Regional Manager or designee to ensure collaboration on delivering the regional educational forums. The program will collaborate with agencies that serve the target population including but not limited to: Latino and Asian/Pacific Islanders, to ensure effective outreach and participation in the educational forums. The program will collaborate with existing mental health services agencies to identify families and youth to participate in the leadership training. The proposed contractor will submit their collaborative strategies in the competitive request for Proposal process.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The Family/Youth Information Education Program will implement a special outreach effort to Latino and Asian/ Pacific Islanders as per need, noted in the gap analysis undertaken during the preparation of the CSS Plan. The gap analysis determined the Latino and Asian/Pacific Islander populations are underserved in San Diego County. The program will collaborate with agencies that serve Latino and Asian/Pacific Islanders to ensure effective outreach and participation in the educational forums. County of San Diego, Mental Health Services is requiring the proposed contractor to submit their outreach strategies as part of the competitive RFP process. The RFP requires the Family and Youth Educators shall be reflective of the diverse ethnic population in the County.

The staff of the program will be required to attend four hours per year of cultural competence training including but not limited to: ethnic populations (e.g. Native Americans, African-American, Iraqi, Southeast Asian), gay, lesbian and transgender populations, and cultural supervision. The County of San Diego conducts cultural diversity classes regularly. The County of San Diego, Mental Health Services has a Cultural Competence Plan that contains principles and practice standards to effectively provide cultural competency services to a culturally and linguistically diverse population of the County. Private providers and County clinics are required to submit a cultural competence report twice a year, listing the staff and the classes taken. If interpreter services are needed beyond the capability of the program staff, providers may request such services from Interpreters Unlimited, a current provider for the County.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

This program will be expected to follow the Cultural Competence standards for all County services, including sensitivity to gender and sexual orientation. Clinical or staff in direct contact with clients are required to attend four hours of Cultural Competence Training to include “Gay, Lesbian and Transgender Populations”. Sensitivity to gender and sexual orientation is part of the cultural competency expectations for the county. The gender differences will be incorporated into all of the regional educational forums.

Program staff will be trained on issues related to Lesbian, Gay, Bisexual, and Transsexual (LGBT) youth and will provide linkage to LGBT peer support. The Family and Youth Educators will inform the community that children and youth who are Lesbian, Gay, Bisexual, or Transsexual (LGBT) often face rejection from family members which leads to a higher rate of homelessness among these youth. A study by Remafedi in 1987 showed 50% of lesbian and gay youth interviewed report that their parents rejected them due to their sexual orientation and as many as 26% of gay youth are forced to leave home because of conflicts with their families over their sexual identity. This study will be incorporated into the regional educational forums.

Clinical or staff in direct contact with clients are required to attend four hours of Cultural Competence Training to include “Gay, Lesbian and Transgender Populations”. Private providers and County clinics are required to submit a cultural competence report twice a year, listing the staff and the classes taken.

The Family and Youth Educational program will provide specific outreach and engagement with the unserved/underserved groups of consumers who are Latino or Asian/Pacific Islander. The contractor will submit their out reach and engagement strategies in the competitive request for proposal process. .

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide services for in-county residents.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Design program, budget and staffing	October-November 2005
Board of Supervisors approval	December 2005
Draft and finalize Request for Proposal (RFP)	January-February 2006
Release RFP	March 2006
Proposals due	April 2006
Award / negotiate contract	May-June 2006
Contractor interviews staff	May-June 2006
Secure facility	May-June 2006
Contract executed	July 1, 2006
Services begin	July 2006
Hold two forums in each region	July 2006-June 2007
Hold two health fairs	One in Fall 06 and one in Spring 07
Identify participants for youth leadership training	Training to be held in October 2006 after programs begin

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year**: 2005-06, 2006-07, 2007-08	**Program Work Plan Name:** Family/Youth Support Partner Services
Program Work Plan: CY-2.2		**Estimated Start Date:** July 1, 2006

1a) Program Description: This is a county-wide family and youth support partner program to assist children/youth with severe emotional disturbances (SED as defined by the Welfare and Institutions Code 5600.3) and their families who are receiving services from the Children's Mental Health System of Care. Children youth and families receiving services from the MHSA funded program CY-5.3 Services for Homeless and Runaways (a full service partnership) will have priority access to this family/youth support partner program. Contractor shall provide services to a minimum average of 45 youth/families per month. If additional resources permit, children and youth currently receiving mental health services in the Children's Mental Health System of Care can access the family/youth support partner program. The target population is those SED children/youth and their families who need additional support and linkage to other services and community resources in order to meet their treatment plan goals. This program will hire family members to serve as Family/Youth Support Partners; paying for family/youth support serves as a cornerstone of San Diego's transformation of mental health services. This program is a full service partnership, is county wide, and will be available to provide services during business hours, evenings, and weekends as needed by families.

1b) Priority Population: Contractor shall provide services to children/youth with SED and their families receiving mental health services that may require additional support to access services to achieve treatment plan goals. The children/youth and their families served in program CY-5.3 Services for Homeless and Runaways will receive priority for accessing family/youth support partner services. If resources permit, all other clients receiving mental health services in the Children's System of Care may access family/youth support partner services.

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Family/Youth Support Partners as members of the treatment teams to provide additional support to families receiving mental health services in San Diego's Children's System of Care. Clients receiving services in program CY-5.3, Services to Homeless and Runaways, will receive priority	☒	☐	☐	☒	☐	☐	☐

access. ✓ Community collaboration to assist families in linking with multiple formal and informal resources; ✓ Assist children/youth and their families to support continuity of mental health treatment; ✓ Family/Youth Support Partners will be reflective of the diverse ethnic population in the County. ✓ Orientation and training on dual diagnosis, resilience focus treatment, conflict resolution, domestic violence, and cultural competence. ✓ Training from the existing Children's System of Care Training Academy will be provided to Family/Youth Support Partners to include topics such as principles of wraparound, wraparound from a family perspective and family leadership. All services shall be planned and delivered consistent with wraparound principles. To the maximum extend possible, services are to be community-based and emphasize the strengths of the child and family.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

County-wide program to assist children/youth with severe emotional disturbances (SED as defined by the Welfare and Institutions Code 5600.3) and their families who are currently receiving mental health treatment in San Diego's Children's System of Care. Priority access will be given to those clients receiving services in MHSA funded program CY5.3 (Services to Homeless and Runaways).

The Family/Youth Support Partners will provide support, education, linkages to informal and formal services, and advocacy with the goal of achieving an integrated service experience for the family and youth. Potential activities include: treatment meetings, care planning, wraparound meetings, intake and assessments, case management, and home visits.

The program will strive to hire ethnic diverse staff that are reflective of the County's population. Family/Youth Support Partners will offer services in San Diego's four threshold languages through the use of interpreter services, as needed. These interpreter services are available through an existing CMHS contract.

This program is a core component of the transformation of the mental health system and advances the MHSA by:

- Increasing greater client/family participation by hiring family members to provide direct service and family/youth support to the target population.
- Serving more clients through offering a broader array of services, i.e. family/youth support partner services
- Decreasing stigmatization by hiring Family/Youth Support Partners who function as members of the mental health provider system and thereby serving as role models. These interactions serve to de-stigmatize mental illness for the general public, as well.
- Minimizing barriers for children, youth and families so they can access services by linking to formal and informal supports and resources.
- Striving for an integrated service experience for children, youth and families receiving services by ensuring coordination and collaboration of informal and formal supports.

3) Describe any housing or employment services to be provided.

Affordable housing is a major concern for San Diego residents. For this specific target population, homeless and runaways, housing will be a primary need and therefore a focus for this program. Housing strategies may vary over the course of services; transitional or respite housing may be indicated early on, whereas permanent support or independent housing could be the long-term goal. The Family/Youth Support Partners will be familiar with housing/homeless resources and programs in San Diego County. Program staff will be familiar with specific programs targeting homeless and runaways.

Reunifying youth with their families or relatives as part of a stabilization plan, when appropriate, is a primary goal of this program. One of the key factors of resiliency is developing meaningful opportunities and strengthening support systems for the client. Setting goals for obtaining stable housing or employment can be an effective means of assisting the client to become more self-sufficient.

The Family/Youth Support Partners will work with the client and their treatment to identify housing and employment goals. Program staff will refer families, as appropriate, to Family Resource Centers (FRC) who provide employment services and housing referrals to clients on public assistance. Family/Youth Support Partners will refer clients to shelters and transitional housing facilities in the area. The clients may be referred to the San Diego County and City Departments of Housing Authority and Community Development for eligibility to the Section 8 Housing Program, or rental assistance. For transition age youth in need of housing, the contractor will refer to existing programs through Mental Health Services. The existing Transition Age

Youth Young Adult Supportive Housing Initiative (YASHI) assists youth in obtaining and maintaining housing. Families will be referred to housing programs that are being developed through the Mental Health Services Act: TAY-1 Integrated Services and Supportive Housing; A-1 Homeless Integrated Services and Supported Housing; A-2 Justice Integrated Services and Supported Housing.

Employment assistance will be made through the Regional Occupational Program and other employment agencies in San Diego County. An MHSA funded program, A-6, Supported Employment Services, will provide an array of job opportunities and supports to help adult family members with serious mental illness obtain employment.

Contractor will submit their strategies on how they will link clients to necessary resources in the competitive Request for Proposal process.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This is a full service partnership program and the average cost for each participant per year is $7,000. The Family/Youth Support Partner Program, as an FSP, will operationalize San Diego County's Children's System of Care Principles which are: collaboration of four sectors, integrated, child/youth focus, family centered, individualized, strength-based, community-based, outcome driven, culturally competent. The implementation of these principles advances the goal of providing an integrated service experience for clients and families and supports recovery/resiliency.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Family/Youth Support Partners are a key component in promoting recovery and resiliency for child/youth and families through active linkage to resources, strength-based orientation, peer modeling of management of mental illness. San Diego County Mental Health Services will contract with a provider who will operate a program that will hire Family/Youth Support Partners to serve the target population. The program will plan and provide services in a manner consistent with the Children's System of Care principles, thereby supporting the values of recovery/resiliency.

The Family/Youth Support Partner will provide coordinated and supportive services which may include but are not limited to: education regarding mental health services, linkage and referral services, advocacy, and other supportive services to assist clients in meeting their treatment goals.

Contractor shall submit their strategies for serving the priority population of homeless and runaways in the competitive Request for Proposal (RFP) process.

The program will be required to comply with the program requirements of the Statement of Work as contained in the Request for Proposal process which are:

- Program staff shall participate in treatment planning with the referring programs.
  - Meetings may include the psychiatrist, individual and family therapist, and the mental health case manager. Families and youth shall be invited to treatment reviews where clinically indicated. Other participants may extend to family members, the school district(s) representatives, and/or other system personnel such as a Probation Officer or Child Welfare Services Social Worker.
  - Participation is designed to provide additional support to families and to ensure that the treatment planning is strength-based and contains measurable objectives for each family/youth receiving services.
- Program shall educate families/youth regarding mental illness and seriously emotional disturbances and available mental health services.
- Program shall:
  - Assist families/youth with linkage to community resources as needed to achieve their treatment goals.
  - Assist families/youth with housing resources targeting runaways.
  - Assist the referring program to transition the child/youth from program to program if needed.
  - Assist the referring program to transition the child/youth from program to community resources if needed.
- Program shall provide advocacy for families/youth as needed. Advocacy shall include, but is not limited to, assistance with education, patient rights and Children's System of Care services.
- Program shall collaborate with the community to assist families/youth in linking with multiple formal and informal supports
- Program shall provide one-to-one assistance in understanding and accessing resources.
- Program shall assist in accessing transportation as needed.

- Program shall assist in accessing housing and employment referrals as needed. Provider shall be familiar with housing resources and programs targeting runaways.
- Program shall develop brochures describing the program in threshold languages.
- Program shall demonstrate organizational advancement of family/youth partnership in the areas of program design, development, and policies and procedures. Such efforts shall be reported to the County contract monitor.
- Program shall offer services in the client's preferred language. When this is not possible, Contractor shall arrange for appropriate interpretation services, which are available through a County contract
- Program shall develop, within 60 days of contract execution, a provider satisfaction survey, given to the other programs that will be referring clients to the Family/Youth Support Partner program. The survey shall be submitted and approved by the County Contract Monitor. The survey shall be administered twice a year to the referring programs.
- Program shall develop, within 60 days of contract execution, a client satisfaction survey, which will be approved by the County Contract Monitor. The survey shall be administered to all families and youth served by the program. The survey shall be available in all threshold languages.
- Program shall ensure, whenever possible, continuity of care by minimizing changes to the Family/Youth Support Partner assigned to work with the client. When a change of Family/Youth Support Partner is necessary, Contractor shall follow the guidelines included in the Children's Mental Health Services Organizational Provider Handbook to ensure a smooth transition of care.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new County-wide program. The contractor will be determined by a competitive Request for Proposal process. This program compliments the MHSA funded CY-5.3 program as well as existing programs by providing Family/Youth Support Partners. The program transforms the mental health system and advances family partnership by directly hiring family and youth with experience in the mental health system to provide direct service to any client in the mental health system needing additional support.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Family members/youth are to be hired and paid to provide family/youth support services as Family/Youth Support Partners. Family and youth hired will become members of the existing San Diego Children's System of Care Training Academy by participating on the Oversight Committee (operations committee for the Training Academy) to support integration and a seamless approach to a service delivery. The Academy serves as one of San Diego's System of Care sustainability strategies and has been instrumental in training and mentoring families and Family/Youth Support Partners to promote authentic family partnership.

Youth and family members will participate on the Contractor's advisory group, which will meet on a regular basis, to advise on the contractor's implementation and provision of services. The advisory group shall include at least 51% family and youth consumers and community members who reflect the cultures of the client population.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Family/Youth Support Partner program will collaborate, in the ongoing effort to transform mental health services, with all System of Care Partners (Education, Child Welfare, Probation, Mental Health, Providers, Alcohol and Drug, community and others).

Collaboration will be demonstrated by, but not limited to, the following:

- meeting monthly with referring programs, with an emphasis in decreasing gender disparity in clients served
- reporting to referring program the status of the referred child/youth and family within 3 working days.
- participating on the San Diego's Children's System of Care Training Academy Oversight Committee (an existing interagency collaborative) to ensue collaborative partnerships
- linking clients to housing and employment resources identified in Section 3
- linking clients to formal and informal community resources to meet individual needs
- linking clients to cultural and linguistic services as needed

Contractor shall submit strategies on how the contractor will collaborate with System of Care partners in the competitive Request

for Proposal process.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies will be used to meet their needs.

The Contractor will be required to hire ethnically diverse staff to reflect the cultural diversity of San Diego County population. Written materials will be required in all threshold languages. Services will be offered in the clients preferred language, with use of interpreters, as needed. Providers may request such services from Interpreters Unlimited, a current provider for the County.

The Family/Youth Support Partner program will address the many aspects of culture including, but not limited to, ethnicity, language, religion, values, and acculturation. In adherence with the Children's System of Care Principles, the Family/Youth Support Partners will assess each clients' and families' individual cultural needs, which will then be reflected in the treatment plan.

Program staff will be required to attend four hours per year of cultural competence training including, but not limited to: Latino, Asian-Pacific Islanders, African-American, American Indian, Southeast Asian populations, gay, lesbian and transgender populations, and cultural supervision. The County of San Diego conducts cultural diversity classes regularly. Private providers and County clinics are required to submit a cultural competence report twice a year, listing the staff and the classes taken.

For clients of Native American descent, the Family/Youth Support Partners will coordinate with the appropriate tribal community and with the Indian Health Council.

The following principles regarding cultural competence are affirmed by San Diego County Mental Health Services as essential in the continued progress toward a mental health system that advocates for and provides multilingual and multicultural services for its diverse populations:

- A comprehensive, competent mental health system provides and integrates relevant linguistic and cultural values and capacities in its service system.
- A culturally competent mental health system seeks to understand, respect, and accept differences of multi-cultural groups.
- A system that is moving towards cultural competence develops standards and criteria to evaluate its performance.

The Culturally Competent Clinical Practice Standards currently utilized by San Diego County Mental Health Services were originally written in 1998. These standards have now been revised by the Cultural Competence Resource Team (CCRT) in order to ensure that the Clinical Practice Standards would: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The revised standards are as follows:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
9) Cultural factors are integrated into the clinical interview and assessment.
10) Staff shall take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
14) Staff actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

This program will be expected to follow the Cultural Competence standards for all County services, including sensitivity to gender and sexual orientation.

In working with the homeless and runaway population, Family/Youth Support Partners will be trained to be sensitive to how homelessness and mental health issues have different impacts on males and females. Staff will understand the different reasons why males and females become homeless and different strategies each use to find places to stay for the night. Staff will be trained to understand trauma because many homeless youth have been physically and sexually abused or exploited in the home and on the street and estimates show this is twice as likely in female homeless youth.

Program staff will be trained on issues related to Lesbian, Gay, Bisexual, and Transsexual (LGBT) youth and will provide linkage to LGBT peer support. Children and youth who are Lesbian, Gay, Bisexual, or Transsexual (LGBT) often face rejection from family members which leads to a higher rate of homelessness among these youth. A study by Remafedi in 1987 showed 50% of lesbian and gay youth interviewed report that their parents rejected them due to their sexual orientation and as many as 26% of gay youth are forced to leave home because of conflicts with their families over their sexual identity.

Clinical or staff in direct contact with clients are required to attend four hours of Cultural Competence Training to include “Gay, Lesbian and Transgender Populations”. Private providers and County clinics are required to submit a cultural competence report twice a year, listing the staff and the classes taken.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This program will provide services to in-county residents.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates:

Activity	Date
Design program, budget and staffing	October-November 2005
Board of Supervisors approval	December 2005
Draft and finalize Request for Proposal (RFP)	January-February 2006
Release RFP	March 2006
Proposals due	April 2006
Award / negotiate contract	May-June 2006
Contractor interviews staff	May-June 2006
Orient and train staff	Begin training orientation upon hire
Meet with programs on roles/responsibilities	May 2006
CY5.3-Services for Homeless and Runaways	
Provide services	July 2006
Complete client satisfaction surveys	Submitted at the end of each quarter

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN PROTOTYPE OUTLINE		
County: San Diego	**Fiscal Year:** 2006-07, 2007-08	**Program Work Plan Name:** Cultural/Language Specific Mental Health Services for Latino and Asian/Pacific Islanders
Program Work Plan: CY-3		**Estimated Start Date:** 7/1/2006

Program Description: 1a) Outpatient mental health services shall be provided to Seriously Emotionally Disturbed (SED) Latino and Asian/Pacific Islander (API) children, youth and their families 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 shall be enrolled in a Full Service Partnership (FSP) program to comprehensively address client and family needs. FSP shall include case management and provide intensive services and supports as needed and strong connections with culture-specific community organizations. Services shall be 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.

Priority Population: 1b) This program shall serve Latino and API children and youth identified by self-declaration, up to age 18 who have a diagnosis of a serious emotional disturbance, and their families. Latinos and API children and youth were identified in the Gap Analysis conducted by the County of San Diego as the primary ethnic/racial groups who are un-served, particularly those who are indigent, with a secondary focus on (Medi-Cal) underserved. Healthy Families clients identified as SED through assessment by County staff are eligible for services through the MHSA.
This program will increase access to services for identified un-served/underserved SED Latino and API children and youth who historically have not sought mental health services and who have not responded to traditional models of mental health services. The cultural/language specific services are designed to address disparities in access to mental health services and treatment for Latino and Asian/Pacific Islander ethnic populations.

Cultural and gender approaches to the children and youth will differ and be tailored to their ethnic values and belief systems, and receptive to use of culture-specific practices such as use of indigenous practitioners. There is a need to differentiate strategies among the targeted cultural groups to achieve the most effective outreach, engagement and treatment. For example, it is known that Latinos may seek mental health services from primary care providers rather than mental health providers. There is also a need to differentiate strategies by gender. The cultural perspective of females differs from that of males in the role played and expectations held within the family and specific ethnic and cultural groups. These factors must be considered in treatment for both individual and group settings. Services shall be receptive to gender, language, religion and other cultural

factors, including issues pertaining to immigration patterns and acculturation and the potential for gang involvement. At a minimum, the Provider shall offer services in the threshold languages relevant to the clients in this program, which include Spanish, Vietnamese and English. The fourth threshold language in San Diego County is Arabic; that cultural group is not targeted in this program.							
	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	SD	OE	CY	TAY	A	O
1c) ✓ Provide outreach and treatment to indigent, unserved, uninsured populations noted in Gap Analysis. The Gap Analysis indicated that approximately 5,863 Latino and Asian/Pacific Islander children/youth in San Diego County with mental health issues are unserved; ✓ Contract with a provider who proposes an innovative approach that is values driven and utilizes interventions that have demonstrated efficacy with this target population; ✓ Design specific outreach and engagement methods for this target population; ✓ Provide culture and gender specific mental health services and supports in the community and at home; ✓ Increase linguistic capacity and provide culturally appropriate services, including staff that reflect the cultures of the priority population; ✓ Demonstrate community partnership through collaboration with cultural and faith-based organizations; ✓ Increase client and family participation through development of a Client/Family Advisory Committee and use of a client- and family-focused model; ✓ Provide linkage to services and supports that support the goals of the client treatment plan; ✓ Offer services in settings that are more acceptable to ethnically diverse individuals and have fewer stigmas associated with them;	☒	☐	☐	☒	☐	☐	☐

✓ Provide individualized, culturally competent, and strength based assessment and treatment that have a wellness and resilience focus and that actively involve families and youth in the development of services; ✓ Provide dual diagnosis capable services by applying the CCISC model that include, at a minimum, screening, assessment and referral; ✓ Train clinical staff on System of Care, wraparound principles and approach, domestic violence, and co-occurring disorders.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Cultural/Language Specific Mental Health Services Full Service Partnership (FSP) program is based on principles of community involvement, cultural and linguistic competence and outreach to underserved populations. The mental health services offered in the program will be individualized, client- and family-focused and are designed to be responsive to Latino and Asian/Pacific Islander children and youth with a Serious Emotional Disturbance and their families. Families unable to pay or with limited capacity to pay for mental health services will have priority access. Latinos and Asian/Pacific Islander children and youth were identified as underserved by the Gap Analysis conducted by the County of San Diego in conjunction with community participation through stakeholder forums, both completed for the MHSA. This program advances goals of the Mental Health Services Act by working to eliminate the mental health disparities in the Latino and Asian/ Pacific Islander communities and establish family/youth authentic participation and involvement. The primary goal of the program is to increase the number of Latino and Asian Pacific Islander SED children and youth and their families receiving integrated, culturally specific mental health services within the Children's Mental Health Services (CMHS) System of Care. This program will reduce the service gap and transform the system in the following ways:

- Increasing access to mental health services by minimizing barriers for a previously unserved/underserved group
- Decreasing stigma associated with mental health services
- Offering mental health services specifically tailored to these cultural groups, which may improve retention
- Improving client outcomes by fostering resilience through culturally competent interventions
- Offering linkage to service and supports that further mental health recovery
- Offering services grounded in the local community

The target population for this program is SED Latino or Asian/Pacific Islander, identified by self-declaration, children and youth up to age 18 and their families. First priority will be given to unfunded children/youth and their families, with a secondary focus on Medi-Cal underserved. Healthy Families clients identified as SED through assessment by County staff are eligible for services through the MHSA. The County of San Diego currently offers a range of mental health services that serve diverse populations. Of the 17,286 children and youth served in FY 04-05, 46.5% were Latinos and 2.5% were Asian/Pacific Islanders. However, the Gap Analysis revealed that despite the best efforts of the current providers, 4,975 Latino and 888 Asian/Pacific Islander children, youth and their families remain unserved. Latinos and Asian/Pacific Islanders are underrepresented in intensive programs; this program will go beyond existing services by offering more intensive services, in terms of frequency and range, through Full Service Partnership.

Children's Mental Health is fully committed to continue the transformation of our System of Care that began several years ago. Transformation will be accomplished by contracting with a community-based Provider that will provide culture-specific services to Latino and Asian/Pacific Islanders. To foster innovation in program design, a Request for (Program) Proposal (RFP) has been issued to solicit innovative program ideas that include unique practice approaches that have proven efficacious with Latino and Asian/Pacific Islander families. Best practices for the delivery of mental health services will be proposed by the Bidder. Ability to identify and implement best practice models and interventions with the target population is a criterion of the selection process. As an example, an efficacious intervention for Depressed Latino adolescents (both female and male) is an adapted version of Cognitive Behavioral Therapy. We seek the expertise of the community-based providers, allowing the latitude to apply experience and best practices to program design.

Services will be provided to a minimum of 66 children/youth and their families annually. Mental health services may include family therapy, individualized treatment, rehabilitative and skill building activities and psychiatric services designed to support recovery and foster resiliency in the youth/family. The program design will provide an array of services with different levels of intensity that allow for flexibility based on the need of the children/youth and families. All children and youth shall be assessed to determine if they are Seriously Emotionally Disturbed, and shall be evaluated for domestic violence issues and co-occurring disorders using the CRAFFT (a brief screening test for adolescent substance abuse) as a screening tool. Assessments shall be responsive to the culture, race, ethnicity, acculturation, age, gender, sexual orientation and religious/spiritual beliefs of the children/youth and family.

Full Service Partnership (FSP)

The principles of FSP are integrated into the Statement of Work and Submittal Requirements for the RFP and will be proposed by the Bidders and integrated in the program design. With a program capacity to serve a minimum of 66 children and youth, the

program can more intensively serve the children/youth and families. Caseloads will be low enough that clinician availability is appropriate to the service needs of the individual and family (approximately 10-15 children/youth per clinician). Each child/youth being fully served will be assigned a clinician that is their single point of responsibility. The children/youth and families will have access to a clinician 24 hours a day, 7 days a week. Families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals of their individualized, comprehensive service plan, which may include linkage to services and supports in the community. To maximize effectiveness of linkage to services and supports, they will be driven by the needs of the child/youth and family, which may include extended family or other significant people identified by the client or family (such as a teacher, friend, etc.), to promote authentic participation.

The program will develop a Client/Family Advisory Committee (CAC), which meets on a regular basis, to advise on the contractor's implementation of services. The CAC shall include at least 51% family and youth consumers and community members who reflect the cultures of the client population. The Program Monitor may periodically attend CAC meetings.

Staffing necessary to implement FSP will be proposed by the Bidder to best meet the needs of the families served and the program goals and objectives. Staffing may include clinical staff, parent and/or youth partners, case managers, paraprofessionals, outreach and rehabilitation workers and support staff according to the proposed program design. Program staff shall reflect the cultures and languages of the children/youth and families served.

Cultural Competence

The program shall adhere to the County of San Diego Cultural Competence Plan and Culturally Competent Clinical Practice Standards. The assessment and treatment approaches will be inclusive of specific cultural features that may be present in various disorders, culture-bound syndromes, cultural explanations of illness, help seeking behaviors and appreciation for traditional ethnic and cultural healing practices. The cultural values and life experiences of the child/youth shall be integral in the intervention and shall be reflected in the client's Medical Record. Other Clinical Practice Standards of Culturally Competence that this program will provide will include:

- Providers engage in community outreach to Latino and API communities.
- Providers create an environment that is welcoming to Latino and API communities.
- Staffing at all levels, clinical, clerical, and administrative, shall be representative of the Latino and API community.
- Ensure there is linguistic capacity & proficiency to communicate effectively with the Latino and API populations.
- Use of interpreter services as appropriate and staff are expected to demonstrate ability to work with interpreters as needed.

- Staff shall demonstrate knowledge of diversity within Latino and API populations in terms of social class, assimilation, and acculturation.
- Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the child/youth.
- Psychiatrist(s) consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
- Promotion of an environment that encourages staff to conduct self-assessment as a learning tool.
- Staff actively seek out educational, consultative and multicultural experiences, including cultural competence training.

The County of San Diego threshold languages include Spanish, Vietnamese, English and Arabic; written materials are available. At least one program staff shall speak Spanish and the program may hire staff that are fluent in API languages and/or dialects. Due to the range of API languages, the provider may use the County's contracted interpreter services, as necessary. The provider shall identify a process to determine bilingual proficiency of staff in at least the relevant threshold languages for the County.

Outcome Measures

Outcomes are an essential element of CMHS System of Care. Goals of the system include:

- Maintain client safely in their school and home environment
- Improve client's mental health functioning to enable them to live successfully at home, school, and in the community
- Increase the individuality and flexibility of services to help achieve the client and family's goals
- Increase the level and effectiveness of interagency coordination of services
- Increase the empowerment of families to assume a high level of decision-making in all aspects of planning, delivering, and evaluation of services and support.

The Provider shall implement outcome measures including the Child and Adolescent Measurement System (CAMS) and client satisfaction surveys with children and families at intake, six month intervals and at discharge. The CAMS is an assessment of youth well-being and has five subscales: acuity, social competence, and hopefulness, internalizing and externalizing problems and victimization. CMHS also uses a quadrant model to assess severity of client impairment in eight areas and these quadrant ratings correspond to CMHS System of Care goals as outlined above. Quadrant measures provide additional program and system outcomes beyond the standardized measurement tools. The following outcome measures are required:

- For 80% of discharged clients whose episode lasted 6 months or longer, Child and Adolescent Measurement System (CAMS) total score at discharge shall show clinically significant improvement compared to the client's intake score.

- For 80% of discharged clients whose episode lasted 6 months or longer, the Client Functioning Quadrant that contains at least one of the targeted treatment goals shall be at least one level higher (improvement) at discharge than at admission.
- For 80% of those clients who remain in the program for 6 months or longer, the discharge summary shall reflect no increased impairment resulting from substance use, as measured by the Client Functioning Quadrants rating for substance use.
- Scores on the Family Centered Behavior Scale (FCBS) shall average 80% or higher across questions/test items. The FCBS is used to assess the presence of family-centered qualities, such as clinician responsiveness to family, in mental health services.
- The RFP requests that Bidders propose additional outcome measures specific to their program design.
- FSP programs are required to measure and report individual client performance.

In addition, all programs must achieve the following process objectives:

- All clients are assessed for substance use
- All clients, ages 16 and older, are assessed for transitional service needs
- All clients are assessed for domestic violence issues
- All clients are assessed to determine the need for referral to a primary care physician
- Client satisfaction surveys are completed in accordance with CMHS requirements

Collaboration with ethnic-specific community-based organizations is essential to a culturally competent program; referrals will be coordinated to support the client and family service plan. Examples of such organizations include: schools, community agencies, faith-based organizations, primary care physicians, family support services, alcohol and drug programs, housing resources such as San Diego Housing Commission or other public housing agency, vocational programs and schools. The Provider is required to develop Memorandums of Understanding (MOU) with key community partners within 6 months of contract execution and submit to the Program Monitor.

The Program location and hours of operation shall be accessible, flexible and responsive to the target population. The RFP targeted specific areas of Central San Diego City and National City in the South Bay region based upon prevalence of both poverty and concentration of the ethnic groups. The program site will be proposed by the service provider and will be located in

an area convenient to the target population, including proximity of public transportation. Latino and Asian/Pacific Islander ethnic groups may be better served and/or more responsive to services in community-based settings that have fewer stigmas associated with them. The program will be open during regular business hours 8 am– 5 pm but shall offer flexible scheduling of services based upon client need, inclusive of evenings and weekends. Program shall provide referral after hours or have on call capacity.

The specific staffing for this program will be proposed in the RFP process. However, since underserved Medi-Cal Latino and Asian/Pacific Islander children and youth may also be served within the program, the head of service is required to be a licensed mental health clinician. Other staffing could include clinical staff, rehabilitation workers, parent partners, and support staff. In order to accommodate the range of API languages and increase linguistic capacity, provider may propose inclusion of paraprofessionals with API language skills in program staff. At a minimum, the Provider shall offer services in the threshold languages relevant to the clients in this program, which include Spanish, Vietnamese and English. The fourth threshold language in San Diego County is Arabic, and that cultural group is not targeted in this program. When the proposals are submitted, any client and family positions will be clearly identified as such.

Training for program staff will be proposed by the Bidder in the RFP process. San Diego Mental Health Services has implemented the Continuous Comprehensive Integrated System of Care (CCISC) consensus best practice model in our System of Care for individuals with co-occurring psychiatric and substance disorders. The CCISC model has these four basic characteristics: system level change, efficient use of existing resources, incorporation of best practices, and an integrated treatment philosophy. The program staff shall be trained to, at a minimum, be capable of providing screening, assessment, and referral for dually diagnosed children and youth.

3) Describe any housing or employment services to be provided.

Referrals to housing and employment services will be coordinated as needed to support the client and family service plan. Housing referrals may include community shelters or housing resources such as San Diego Housing Commission or other public housing agency. The San Diego County has 8 housing authorities and the Contractor will be expected to utilize the resources of these housing agencies, in particular, housing authorities that serve high concentrations of Latino and Asian/Pacific Islander communities in order to maintain children, youth and families in their community of choice. Employment services referrals may include CalWORKS or education and vocational training through collaboration with school personnel.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund source for each Full Service Partnership proposed program.

This is a Full Service Partnership program; the average cost for each participant per year is $7,900.

This program, as a Full Service Partnership (FSP), will comprehensively address client and family needs and "do whatever it takes" to meet those needs. FSP will include case management to provide intensive services and supports as needed and strong connections to community resources. The program design will provide an array of services with different levels of intensity that allow for flexibility based on client's varying levels of need. Program staff will work in full partnership with clients and families to develop individualized, comprehensive service plans that include linkage to services and supports in the community. To maximize effectiveness of linkage to services and supports, they will be driven by the needs of the client and family, which may include extended family. Services 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. FSP programs are required to measure and report individual client performance.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Resilience is culture based, different for every culture and mediated by level of acculturation; the core values, beliefs and perceptions of the individual are important to the development of strategies of resilience. CMHS is committed to a culturally competent system. Cultural competence is a principle embedded throughout service delivery. The program staff shall reflect the community served, and in partnership with community-based organizations and role models, will help children, youth and families to foster resilience. Additional role models that exemplify the qualities of recovery and resilience may be found in the members of the Client/Family Advisory Committee (CAC). Key staff is expected to have awareness and knowledge of a range of Latino and API cultures and knowledge of both within and between group differences.

The intent of this program is to assist children/youth and their families to realize their goals by utilizing an individualized approach that includes skill building to foster resiliency. As children and their families become partners in their care, they are empowered to realize their full potential. One strategy that will be utilized is to connect the youth to social supports, including culturally appropriate groups in the community. The strategy of embedding services within the community provides intervention across multiple life domains and is particularly suitable for SED children, whose challenges occur in many settings. The key to the

success of the recovery process is the client plan. Clinical staff is key in helping the individual client by engaging the family in a team effort, helping the client and family define their goals and expectations, planning and implementing multi-layered interventions that become part of the client plan. Effectiveness and necessity of treatment is established through a Utilization Review Committee that reviews the treatment of each client at no more than six month intervals to insure that clients are making progress or that alternate treatment goals are established.

Programs have contractual requirements such as the program outcomes, which are correlated with the recovery goals of the children/youth and family, described in the program description above. Each program is required to submit a Monthly Status Report to the County Program Monitor in which they report program activities, outcomes, quality assurance activities, staffing, cultural and language capacity, and staff training. The Program Monitor conducts monthly regional meetings with providers and obtains verbal program reports. Program Monitor site visits are conducted at least bi-annually to ensure program compliance with contract requirements. Medical record reviews are conducted at least annually by the County Quality Improvement department.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This program is a new service in which the Provider will be determined by the RFP process. The County of San Diego currently offers a range of mental health services that serve diverse populations. However, the Gap Analysis revealed that despite the best efforts of the current providers, 4,975 Latino and 888 Asian/Pacific Islander children, youth and their families remain unserved. This program will target those unserved children and youth that are SED and will go beyond existing services by offering more intensive services in terms of frequency and range through Full Service Partnership.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The specific staffing for this program will be proposed in the RFP process to best meet the needs of the families served and the program goals and objectives. Staffing may include clinical staff, parent and/or youth partners, case managers, outreach and rehabilitation workers and support staff according to the proposed program design. Program staff shall reflect the cultures and languages of the children/youth and families served.

The Client/Family Advisory Committee (CAC) mentioned in the Program Description, shall include family and youth consumers and community members who reflect the cultures of the client population to provide oversight and direction to develop and implement the program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals of their individualized, comprehensive plan, including referral and linkage to services and supports in the community. To maximize effectiveness of linkage to services and supports, they will be driven by the needs of the child/youth and family, which may include extended family, to promote authentic participation.

Collaboration with community-based organizations is essential to a culturally competent program. Examples of such organizations include: ethnic-specific community agencies, faith-based organizations, primary care physicians, family support services, alcohol and drug programs, housing resources such as San Diego Housing Commission or other public housing agency, vocational programs and schools. The Provider is required to develop Memorandums of Understanding (MOU) with key community partners within 6 months of contract execution and submit to the Program Monitor. Additional collaboration strategies will be proposed by the Bidder.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

This program will adhere to the expectations for all CMHS programs as defined in the Mental Health Cultural Competency Plan which includes hiring multi-cultural/bilingual staff, ensuring all staff receive at least 4 hours per year of cultural competence training, and have access to interpreter services as needed (for language and deaf/hard of hearing needs).

The service provider shall demonstrate that program staff is culturally competent to serve the culturally diverse backgrounds of the clients in the community through the following mechanisms:

- Provision of a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served that are linguistically and ethnically diverse providers, inclusive of consumers/family member staff, administrative, clerical support staff, and clinical staff.
- Identification of a process to determine bilingual proficiency of staff in at least the threshold languages for the County.
- Ongoing cultural competency training provided to staff and reinforcement of training in the program.
- Demonstration of integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

Arrangements will be made for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary. San Diego County has written material available in the four designated threshold languages (English, Spanish, Vietnamese, and Arabic).

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Sensitivity to gender and sexual orientation is part of the Cultural Competence Plan and expectations for the County. Of current CMHS clients, 60% are male and 40% female. Typically, children/youth who are the most disruptive in their life domains are the most likely to be referred. These children/youth are more often males. Female children/youth more often internalize problems and are under identified. The Provider will work with referral sources to identify the specific mental health needs of Latina and Asian/Pacific Islander females.

Staff is trained on gender differences as well as lesbian, gay, bisexual, and transgender (LGBT) issues as part of the Cultural Competence Plan. For adolescents, identification of gender issues and sexual orientation issues are particularly crucial to client outcomes.
As part of the submittal requirements of the RFP, the Bidders are expected to describe how they will provide services in a manner that is sensitive to sexual orientation and gender. Bidders are also required to submit a plan for training specific to increasing cultural awareness and competence of the program and agency.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide services for in-County residents and for children and youth transitioning back from out-of-County placement.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All known strategies are listed in Section IV. Additional strategies may be proposed by the Bidder during the RFP process.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisor approval for the MHSA Plan	December 13, 2005
Submitted MHSA Plan to the State	December 15, 2005
Request for Proposals posted	February 8, 2006
Pre-proposal conference	February 15, 2006
Proposals due	March 8, 2005
Selection committee reviews proposals and determines competitive bidders	March - April
Notice of Intent to Award contract is posted	May 2006
Negotiations with prospective contractor	June 2006
Contract executed	July 1, 2006
Contractor hires and trains staff	July 1 – 15, 2006
Program begins serving clients	July 15, 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: San Diego	**Fiscal Year**: 2005-06, 06-07 & 07-08	**Program Work Plan Name:** Mental Health and Primary Care Services Integration
Program Work Plan: CY-4.1 (also links with A-7 and OA-3)		**Estimated Start Date: April 1, 2006 (Contract execution date)**

1a) A brief description of the program: MHSA funds will be used to pay for mental health assessment and treatment services to children/youth and their families at various community health clinic settings across San Diego County that also provide mental health services. Services will be coordinated and managed through a master contract with the Council of Community Clinics and will be open to all community clinics within San Diego County willing to abide by the terms of the contract. All contracted clinics will be either Federally Qualified Health Centers (FQHCs) or Indian Health Services (IHS) clinics.

1b) Identification of the age and situational characteristics of the priority population to be served in this program: Children and youth, who are seriously emotionally disturbed, and their families who have been identified by the gap analysis, community input and the MHSA Child/Youth Workgroup as being unserved. Prospective clients are currently receiving physical health care services at community clinics but are not currently receiving needed mental health assessment and treatment services because they are un-insured.

	1d) Fund Type				**1d)** Age Group				
1c) Identification of strategies for which you will be requesting MSHA funds for this program. 1d) Identification of the finding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a program.	FSP	Sys Dev	O E	OTO	C Y	TA Y	A	O A	A L L
1c) ✓ Integrated physical and mental health services by providing services via primary care community clinics. Will provide mental health assessment, information, referral and brief mental health services; ✓ Model supports collaboration between mental health and primary care and other physical care providers to improve integrated services; ✓ Community based program to increase access to care in a normative setting for those who may be more responsive to services in health care settings;	☐	☐	☒	☐	☒	☐	☐	☐	☐

✓ Individualized, culturally competent, and strength based assessment and treatment plans with families/youth actively involved in the development of the treatment plan; ✓ Community clinics are located across San Diego County in rural, urban, and suburban communities and neighborhoods; ✓ Community clinics serve a broad diverse population. Individual clinics may serve ethnic groups representative of the community and neighborhood in which they are located; ✓ Training on wraparound principles and approach, domestic violence and co-occurring disorders (CCISC model) will be provided to clinical staff; ✓ Services will screen for dual diagnosis and, at a minimum, include screening, assessment, and referral, a wellness, strength-based and resilience focus, wraparound approach, assess for domestic violence, address in treatment or refer for services when appropriate, and will adhere to San Diego County's Cultural Competence standards; Training to Primary Care providers regarding the mental health system will be developed. Note: this is not funded under this project Work Plan but will be covered under separate One Time Only Training funds.									

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

The County of San Diego is proposing to utilize the many community clinics in San Diego County to provide mental health treatment services to children and adolescents and their families. Services will be targeted toward uninsured families. The Service modality will be coordinated through a master agreement with the Council of Community Clinics to manage the authorization of care and provide general system management. The Council of Community Clinics will develop sub-contracts with individual clinic providers and reimburse for services provided by staff of the participating clinic organizations on a fee-for-service basis and authorize treatment and payment for necessary medications. The Council of Community Clinics represents the consortium of community clinics and Indian Health Services providers in San Diego County. The Council of Community Clinics was selected as the provider and coordinator of this program because they already serve in this role for the County for specialist

care for Ryan White funds for the County of San Diego Office of AIDS Coordination and for dental services for San Diego County's First Five Commission.
San Diego County elected to pursue this program model because there are already 13 clinic organizations (9 community clinics and 4 Indian Health Services' provides) that offer mental health services at 27 different locations throughout San Diego County. At this point, it has not been determined exactly how many of the clinics will participate in the program although all clinics have expressed a strong interest in partnering with the County for this MHSA component especially since it will be focused on families with no other health coverage.

The goal of this program is to provide integrated care between the primary care provider and the mental health provider within the same clinic structure. Due to lack of coverage, many patients seen by the primary care providers appear to be in need of mental health care, but there have been no means to fund the assessment and treatment.

This work plan is specific to Children and Youth. However, similar services are envisioned to Adults (work plan A-7) and Older Adults (work plan OA-3) also utilizing the Council of Community Clinics as the coordinating entity among all participating clinics. The Older Adult Work Plan has some additional outreach components but all three are designed to improve coordination and integration of primary care and mental health services.

The existing network of providers includes:

a) Family Health Centers of San Diego. Seven different sites serving zip codes 92103, 92113, 92109, 92115, 92101, 91977, and 92104.
b) Imperial Beach Health Center. One site serving 91932.
c) Indian Health Council (Indian Health Services-IHS). Two sites serving 92082 and 92070 zip codes. Both zip codes are in rural areas of the County.
d) La Maestra Community Health Centers. One site serving 92105 zip code.
e) Mountain Health and Community Services. Three sites serving rural east San Diego County including zip codes 91901, 91934 and 91906.
f) Neighborhood Health Care. One site serving the 92025 zip code.
g) North County Health Services. Two sites serving 92054 and 92069 zip codes.
h) San Diego American Indian Health Center (IHS). One urban site serving zip code 92103.
i) San Diego Family Care. Three sites serving 92111 and 92105. There are separate adult and pediatric sites to serve the 92105 zip code.

j) San Ysidro Health Center. One site serving 92173 zip code.
k) Southern Indian Health Council (IHS). One site serving the 91903 zip code.
l) Sycuan Medical/Dental Center (IHS). One site serving the 92019 zip code.
m) Vista Community Clinic. Three sites serving 92084, 92054 and 92083 zip codes.

As a general rule, regular clinic hours are Monday through Friday from 8 A.M. to 5 P.M. However, clinics will normally have one or two days a week where they are open until at least 7 P.M. or later and some of the larger clinic sites will be open on Saturdays, to provide increased access to working families.

Target Population: The target population is Children and Youth, who are seriously emotionally disturbed, and their families who have been identified by the gap analysis, community input and the MHSA Child/Youth Workgroup as being unserved. Prospective clients are currently receiving physical health care services at community clinics but are not currently receiving needed mental health assessment and treatment services because they are uninsured.

Program Goals: Integrated physical and mental health services by providing services via primary care community clinics.

Types of Services to be performed: Services to be performed include mental health assessment, information, referral and brief mental health services. Council of Community Clinics will manage the allocation of service funds for both assessment, treatment, medications and even outreach, if needed. They will authorize treatment after receipt of assessment.

What will the Services promote: The Services will promote community based program to increase access to care in a normative setting for those who may be more responsive to services in health care settings. Individualized, culturally competent, and strength based assessment and treatment plans with families/youth actively involved in the development of the treatment plan.

Number of clients estimated to be served: An estimated 635 annually will be served annually. All patients referred will be entitled to an assessment. If the assessment indicates they need treatment, services will be authorized. During the initial 3 months of the program an estimated 159 will be served.

Where will the clients come from: From with the existing patient population at community clinics. Patients will be receiving physical health care but are uninsured and not receiving mental health treatment although such treatment may be needed.

3) Describe any housing or employment services to be provided.

The program will not be directly involved in the provision of either housing or employment services. Community Clinics will make referrals to appropriate community resources should specific issues be identified. For example, clinics will refer to the nearest County Family Resource Center for access and screening regarding other services the County Health and Human Services Agency might provide in that region.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This is not a Full Service Partnership program. It is Outreach and Engagement.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This a unique program in that the clients are seeking medical care at a community clinic and as part of the clinic's effort to provide care they have identified possible issues related to mental health that should be addressed if the client is to be treated in a holistic manner. Since the target population is the uninsured, it is likely that the mental health issues have not been addressed. For children and youth, the issues may be identified as part of preventative health care visits or as part of the many health education activities that clinics participate in both within the clinic and the community. For example, community clinics regularly participate in community health fairs in the community and they may come in contact with families that need comprehensive care. Another example may be a teenager who may be treated for some injury in a recreational or sporting activity and the nurse and/or physician becomes aware of some other emotional or mental health issues that warrant a referral for assessment.

A key component of this project will be providing training to primary care providers on how to identify potential emotional or mental health issues that would warrant referral for assessment. Separate from the funds identified for this work plan activity, the County of San Diego will be allocating One Time Only training funds for specific training for Primary Care providers. The Council of Community Clinics is specifically interested in coordinating the training for all participating clinics. In order to maximize

participation of all clinics in a County as large as San Diego County, trainings will be de-centralized to the various regions of San Diego County as much as possible.
The contracts will specify the expectations regarding training.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program in terms of providing services at community clinic sites and a new strategy of trying to integrate physical health care and mental health care within the same program.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Community clinics have long been involved in utilizing clients and family members within their service delivery model wherever possible. There are a great many people who, because of their own positive experience with community clinics as patients, later went to work for community clinics either as staff or in some volunteer capacity. As medical model programs, many of the medical staff do need appropriate professional credentials. However, many former clients have joined clinic staff in a support capacity or have become community outreach workers working for individual clinics.

In addition, all clinic organizations have Boards of Directors that include consumer representatives. Feedback from those consumer representatives on Clinic Boards regarding the implementation of this model will be incorporated into the evaluation of this program. In addition, the Council of Community Clinics, as the lead contractor for this program will conduct a series of client/family focus groups to elicit direct client/family member input on the program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Health and Human Services Agency is organized into 6 geographic regions across the County. An Executive Level staff (Deputy Director – Regional General Manager) is responsible for one or more of the geographic regions. Each Regional General Manager has initiated a collaborative model within each region to bring stakeholders, including providers, into partnership with the County to discuss key issues of each region. Community Clinics have been participating in the Regional Collaboratives since

the Health and Human Services Agency (HHSA) was established in the late 1990s. These Regional Collaboratives include the full spectrum of health and social services agencies as well community stakeholders. With the creation of a HHSA Behavioral Health Division merging Adult/Older Adult Mental Health, Children's Mental Health and Alcohol and Drug Services, there will be greater participation of mental health and alcohol and drug service providers into the Regional Collaboratives. This will facilitate greater coordination with the community clinics.

This project will enable the County to specifically address access for Native Americans within San Diego County. All of the existing Indian Health Services clinic organizations are members of the Council of Community Clinics. The four Indian Health Service providers include three rural organizations (Indian Health Council, Southern Indian Health Center, Sycuan Medical Center) and one Indian Health Services provider (San Diego American Indian Health Center) which targets Native Americans living in the urban areas.

It is also the expectation that the addition of the MHSA funded Mental Health/Primary Care Integration model will facilitate greater collaboration between the clinics and traditional mental health providers and the County.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Clinics serve an ethnically diverse population across San Diego. Globally the primary care clinics who are members of the Council of Community Clinics serve a largely minority population broken down as follows: 57% Hispanic, 3% Asian, 6% African-American, 25% White, and 9% Other. The large percentage of Other reflects the large number of multi-racial persons seen at community clinics. These numbers do not include the Native American population served at the four Indian Health Services provider agencies. These numbers do not also include the patients seen by Family Health Centers of San Diego which operates in several neighborhoods with significant African American populations. Since the communities seen by FHCSD also have many Spanish speaking families, 95% of the FHCSD Mental Health Staff are bi-lingual. Individual clinics may have different ethnic mixes. For example, San Diego Family Care, with clinics in the Linda Vista and Mid-City neighborhoods the City of San Diego serves a high percentage of Indo-Chinese and other Asian groups. La Maestra Clinic which is also located in the Mid City neighborhood served primarily Hispanics in the area but also serves various Asian/Pacific Islander populations. Community Clinics have individually adopted strategies to address serving culturally and linguistically diverse communities as they have developed in order to provide appropriate primary care services. Clinics have embraced the "promotora" model of training community health workers as a viable means to reach out to the community. Community workers have been used for

purposes such as diabetes education, Healthy Families and Medi-Cal enrollment outreach, and in the North County, outreach to migrant agricultural workers. In addition to ethnic minorities, Mountain Health and Community Services has been a leader in developing effective strategies to reach out to rural populations in Eastern San Diego County.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Contracting with Community clinics will provide a unique opportunity to utilize provider organizations that have considerable experience with these specific target populations. Community Clinics are one of the leading providers of medical services for the County Office of AIDS coordination for primary care services under the Ryan White Act. This role has enabled the clinics to establish strong working relationships with social service agencies serving the Lesbian, Gay, Bisexual and Transgender (LGBT) communities of San Diego County. The clinics have been involved with Ryan White funding for over 15 years and this involvement has made them trusted partners with the LGBT community.

As an example, FHCSD policies include recruitment procedures and standards for representation of the community served; these policies address cultural sensitivity, diversity, and inclusiveness. On-going clinic supervision of mental health staff also addresses the cultural issues of each clinical case, with culture and diversity issues routinely discussed in weekly individual and group supervision meetings. Within the past year, FHCSD staff have attended external trainings; a sample of these topics: Latino Culture, Muslim Culture, African-American Culture, Asian Culture, Hearing Impaired Culture, Transgender Culture, Disabled Culture and Native American Culture.

In addition, the community clinics serve approximately 40% of all families enrolled in Medi-Cal managed care in San Diego County (Healthy San Diego Geographic Managed Care model). Community Clinics are also a significant provider of services to Healthy Families and CHDP services in San Diego County. Since 2/3 of enrollees in Medi-Cal Managed Care are children (both boys and girls) and Healthy Families and CHDP are exclusively boys and girls, community clinic providers have significant institutional knowledge of the specific needs of families and how to best address those needs.

11) Describe how services will bee used to meet the service needs for individuals residing out-of-county.

This program will provide services to in-county residents only.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Exhibit IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Approval by the Board of Supervisors of the MHSA CSS plan and approval of the sole-source contract with the Council of Community Clinics	12/13/05
Development of draft Statement of Work by County staff	January, 2006
Preliminary meeting – Council of Community Clinics and Clinic Directors	2/13/06
Contract Finalized	3/31/06
Implementation and start-up period	4/1/06 to 4/15/06
Services begin to clients	4/15/06

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN PROTOTYPE OUTLINE		
County: San Diego	**Fiscal Year**: 2005-06, 2006-07, 2007-08	**Program Work Plan Name:** Mobile Psychiatric Emergency Response
Program Work Plan: CY 4.2		**Estimated Start Date**: July 1, 2006

Program Description:

The program is a voluntary mobile crisis mental health assessment team for children and youth located in the North Region of San Diego County. Currently, the County of San Diego operates a Mobile Assessment Team for children and youth in the Emergency Screening Unit located in the South Region of the County that responds to crisis calls for screening and assessment services, and community input urged the establishment of similar mobile crisis services for children and youth in the North Region.

Priority Population:

This program shall provide services to unserved, uninsured/underserved children/youth up to age 17 years of age with SED and their families who are experiencing a mental health crisis or urgent need for mental health services. Priority shall be given to individuals who are seriously emotionally disturbed (SED) as defined in the Welfare and Institutions Code 5600.3 and who have Medi-Cal or who are unfunded/indigent. The target population, children and youth up to the age of 18, makes up approximately 35% of the population in San Diego County's North Region. (Source: Based on the US Census Bureau from SANDAG). Three percent (3%) of Children's Mental Health clients were hospitalized in FY03-04, and 12% of CMHS clients received crisis services from County or contract programs.

The North Coastal Region is home to 487,592 persons, while the North Inland Region has a total population of 494,003. The North Inland Region encompasses 60% of the land area of San Diego County and is geographically the largest of the six Health and Human Services regions. A significant population of Latino families resides in the North region and the city of Oceanside has a substantial Pacific Islander population.

1c) Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	1d) Fund Type				1d) Age Group				
	FSP	Sys Dev	OE	OTO	CY	TAY	A	OA	ALL
	☐	☒	☐	☐	☒	☐	☐	☐	☐
✓ Develop one mobile team to provide emergency mental health evaluations and crisis intervention through a contracted provider. ✓ Provide linkages to other mental health services when hospitalization is not required. ✓ Increase access to crisis mental health evaluations in the North Region of San Diego County. ✓ Provider will screen for dual diagnosis, and will include assessment and referral as appropriate. ✓ The current assessment standard forms and processes for the entire Mental Health System will be modified to ensure consideration of domestic violence, screening and referral when appropriate. Referral to services when needed will adhere to San Diego County's Cultural Competence standards. ✓ Assessment and treatment plans will be individualized, culturally competent and strength-based and developed with the active involvement of the youth and families. ✓ Clinical staff will be provided training on wraparound principles and approach, domestic violence and co-occurring disorders (CCISC model). ✓ The program services is estimated to cost $154,800 and will be aligned with MHSA ALL-3, Walk -In Assessment Center, which has an original CSS funding allocation of $723,000, and is intended to provide "walk-in" emergency mental health services to children, youth, adults and older adults in the North Region.									

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The proposed program will provide a mobile crisis mental health response team for in the North County community, for children and youth up to the age of 18. Priority shall be given to individuals who are seriously emotionally disturbed (SED) as defined in the Welfare and Institution Code Section 5600.3 and who have Medi-Cal or who are unfunded/indigent. San Diego County Mental Health Services will contract this program, paired with the North County Walk-In Assessment Clinic (MHSA ALL-3), to a community based organization through the Request for Proposals (RFP) process.

The program, by providing crisis intervention services aims to prevent escalation, promote management of mental illness, increase the safety, and reduce unnecessary and costly utilization of emergency and inpatient services for SED children, youth and their families. The program will refer and link individuals to services as an alternative/diversion to hospitalization when clinically indicated, consistent with the mandate of maintaining the least restrictive mental health program available in the community when hospitalization is not required. Referrals may include, but are not limited to, community based outpatient mental health clinics, school based mental health programs, public health clinics, Tribal mental health clinics, community support, and education groups. This program advances the MHSA goal of integrated services and timely access for clients and their families to the mental health system. If hospitalization is warranted, referrals and linkage to local inpatient psychiatric treatment programs will be completed, including contacting agencies/individuals in the community authorized to initiate involuntary detainment for evaluation and treatment (per WIC 5150).

The services will be provided by a mobile assessment team composed of one full time and one part time licensed clinicians who will respond to the calls of the clients during business hours, to be maintained consistent with the time of “peak” volume of crisis services found within the community, e.g., between 12pm and 8pm. The program is expected to respond to calls within 4 hours of receipt. The program will provide comprehensive and integrated assessments of mental health/substance abuse, domestic violence, crisis intervention, phone triage, information and referrals to community based services and/or hospitals, and follow-up appointments and psychotropic medication management when needed for children and youth. Services to clients will be voluntary. Clients requiring involuntary services may be referred and linked to the Psychiatric Emergency Response Team (PERT, a current contractor) or a local facility designated as having detainment authority under the Lanterman-Petris-Short (LPS) Act and WIC 5150.

The contractor shall have a defined mechanism for emergency telephone consultation and/or referral of clients after hours.

The program will establish a collaborative relationship with PERT, local LPS facilities, regional outpatient and school based mental health providers, local Tribal authorities, community primary health care clinics, fee for service hospital provider, and other agencies in the North Region to maximize access to the mental health needs of the clients.

It is estimated that 215 consumers per year will benefit from the program.

3) Describe any housing or employment services to be provided.

The program will not provide direct housing and employment services to the clients. The Health and Human Services Agency has two Family Resource Centers in the Region with eligibility and case management staff who can provide employment services through the CALWORKS program and housing referrals to clients on public assistance and social workers who can refer clients to shelters and housing facilities in the area. The County of San Diego has a Homeless Assistance Program that can assist homeless clients already on public assistance. The clients can also be referred to the housing specialists of the San Diego County Department of Housing and Community Development for eligibility to the Section 8 Housing Program or rental assistance.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This program is not funded through a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The outreach and engagement activities that will be undertaken will provide an immediate mental health intervention and increase the safety of SED children, youth and families with the goal of preventing escalation and promote management of mental illness. The program will plan and provide services in a manner consistent with the Children's Mental Health System of Care philosophy and principles. Qualified licensed clinicians will ensure the achievement of the goals of recovery or resiliency.

Program staff will be required to attend four hours per year of Cultural Competence training and a wraparound eight hours basic course (for staff who has not taken the course in the last four years). Clinical staff shall be required to meet the licensing Continuing Education Units (CEUs) and other paraprofessional staff shall have a minimum of eight hours of clinical training per year.

The program will be monitored on a regular basis to ensure that the contractor will comply with the service delivery requirements of the Statement of Work as contained in the Request for Proposals which are:

1. Provide, operate and maintain community client and mental health promotion services in accordance with the State Department of Mental Health (DMH) Information Notice 96-02 regarding staff qualifications.
2. Use forms for recording client information and activities in case files as directed by the Program Monitors.
3. Have a defined mechanism for emergency telephone consultation and/or referral of clients after hours.
4. Demonstrate a family partnership in the development and provision of service delivery which shall be reflected in the client chart.
5. Demonstrate organizational advancement of family partnership and community collaborations in the areas of program design, development and policies and procedures.
6. Submit a Monthly Status Report which shall contain noteworthy activities/unusual events, community contact/interaction with other agencies, client complaints/grievance and request for a transfer of provider, programmatic issues and actions initiated to solve or mitigate them, emerging issues or potential problems, quality improvement activities, position listing, staff changes, staff development/training, monthly wait list, family participation, caseload per staff, number of admissions and discharges, number of active cases and number of incident reports.
7. Compliance with all applicable provisions of the Children's Organizational Provider Handbook, Organizational Provider Financial Eligibility and Billing Procedures Manual and Documentation and Uniform Clinical Records Manual.
8. Institutionalization of a Client/Family Advisory Group.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

There is no child/youth focused mobile crisis response program currently operating in this geographic area. The program is a new service that will be provided exclusively to North San Diego County Region residents, and will complement the existing mental health outpatient clinics and school based services in the region. At present there are two mental health hospitals, 17 outpatient clinics, 1 clubhouse in the North Inland Region; 1 hospital, 1 crisis residential provider, 14 outpatient clinics and one clubhouse in the North Coastal Region. (Source: Cultural Competency Standard Annual Update 2003-2004).

The Statement of Work was issued in the website of the Purchasing and Contracting Department of the County of San Diego. An Industry Day was held on 01-17-06 to generate comments and possible improvements to the Statement of Work before a Request for Proposal is completed. A Source Selection Committee will be convened to review and analyze the technical and cost proposals of the interested providers of the proposed service. The provider/agency which will meet the requirements contained in the Statement of Work and with the most reasonable cost will be selected.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Clients will not be participating in the provision of direct mental health services. The contractor will be required to establish a Client/Family Advisory Group to ensure client/family input at all levels of the operation and provision of services within the program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The SDMHS, Children's Mental Health Services has twelve (12) contracts with for-profit and non-profit organizations operating several clinic and school based outpatient programs in the North Region to provide outpatient mental health counseling for the target population. This current program will be expected to establish a collaborative linkage to facilitate referrals to the existing programs/services. In addition, the program will be expected to make collaborative connections with Tribal entities in the North County Region, including, but not limited to educational outreach efforts in the form of public-community speaking events, interface with existing Tribal physical and mental health programs, and continuing education for staff on issues related to mental health services for Native American populations.

San Diego Mental Health Services has implemented the Continuous Comprehensive Integrated System of Care model (CCISC) and is in the process of training all programs to provide screening, assessment and referral for dually diagnosed children and youth. Regular meetings are conducted by the System of Care Council to discuss program implementation and future plans. Mental Health Services is in the process of merging with the Alcohol and Drugs Services to form a Behavioral Health Services Division. This will integrate and improve service delivery to clients who have co-occurring disorders. Two other programs of the

Mental Health Services Act CSS Plan will address the needs of the clients for employment and housing; CY-5.3 Homeless/Runaway, and TAY-1 Integrated Services and Supported Housing.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

To ensure that the program will be competent to meet the needs of culturally and linguistically diverse communities, the staff will be required to attend four hours per year of Cultural Competence training. Programs will be made aware of the disproportionately greater frequency of youth (ages 12-17) hospitalization constituting 78.2% of the total population utilizing this service; 21.5% of clients utilizing psychiatric hospitalization were children, between the ages of 6 and 11. However, there was no relative ethnic disparity for populations utilizing emergency mental health services, when compared to the overall CMHS population distributions. Programs will be reminded of the ethnic disparity identifying Hispanic and Asian/Pacific Islanders as unserved populations within CMHS in general, and will be asked to provide an outreach plan to target these populations.

The County of San Diego Training and Development Department conducts Cultural Diversity Classes regularly. Mental Health Services has a Cultural Competency Plan Annual Update FY 2003-2004 document, which contains strategies to effectively provide cultural competent services to a gender-sensitive, culturally, and linguistically diverse population of the County. Private providers and County clinics are required to submit a Cultural Competence Report twice a year listing the ethnic/racial background of all staff as well as their language capacities, and the classes related to cultural competency that were taken.

A current contract, Interpreters Unlimited, provides interpreter services for mental health providers and County clinics.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Analysis of the gender of clients hospitalized within the CMHS population indicated there was no disparity between males and females utilizing this service – 51.6% of children and youth hospitalized in FY03-04 were female, while 48.4% were male. No data was available on the sexual orientation among users of crisis and hospital services, but providers will be required to attend County training on sensitivity to issues of sexual orientation and gender.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide services to in-county residents. Eligible clients coming from other counties with the intent to stay in San Diego County will be provided necessary emergency mental health services.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies were listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates:

Activity	Date
Industry Day, Request for Proposal, Pre Proposal Conference	February 2006
Review of Proposals, meeting of Source Selection Committee	March 2006
Select Winning Bid, Negotiation of Contract	April, 2006
Processing of Contract by Purchasing and Contracting Department	May, 2006
Orientation of Contractor	June, 2006
Contract Execution	July 1, 2006
Hiring of Staff, Program Mobilization	July – September, 2006
Program fully operational	September – On going
Submit year end reports	June, 2007
Evaluate program output, compliance with outcomes	July – August, 2007
Review of expenditures against approved budget	July – August
Provide feedback to MHS Administrators, Board of Supervisors	September, 2007
Program Monitoring	December, 2007
Submit report to the State	

Feedback on Program Performance	January, 2008
Evaluate over all performance and compliance with the requirements Of the Statement of Work	February, 2008
Recommend corrective action if necessary to improve performance or recommend penalty for non-compliance	March – April, 2228
Recommend non renewal of contract or secure new budgets for contract extension for additional year	May – June, 2008

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year: 2005-06,** 2006-07, 2007-08	**Program Work Plan Name:** Medication Support for Wards and Dependents.
Program Work Plan: CY-5.1		**Estimated Start Date:** July 1, 2006

1a) Program Description: The Medication Management Clinic will provide short-term (up to three months) stabilization treatment with psychotropic medication, case management and linkage to on-going treatment for 116 children/youth at any given point of time. Those children and youth who require services for a longer period of time will be referred and linked with a community-based organization or private treatment. Services will be provided for wards and dependents, and those children/youth at risk for wardship or dependency, who are seriously emotionally disturbed as defined by the Welfare & Institutions Code 5600.3 and who have been specifically referred by the Probation Department or Child Welfare Services via the Juvenile Court, or Child Welfare Services via the Critical Assess Release Early (CARE) Unit which is a specialized unit within Child Welfare Services designed to divert children/youth from placement at Polinsky Children's Center (a temporary emergency shelter). Child Welfare Services and the Probation Department shall refer to private insurance and/or the current provider system prior to attempting access to the Medication Management Clinic. Services will include psychiatric evaluation, consultation, assessment and medication monitoring. It will also assist the child and family with support, linkage and coordination for ongoing mental health services if needed.

1b) Priority Population:

- Children/youth with severe emotional disturbances who lack funding and who have exhausted resources for medication management and have been referred by the Probation Department via the Juvenile Court.
- Children/youth with severe emotional disturbances at risk of wardship referred by the Juvenile Court.
- Children/youth with severe emotional disturbances at risk of dependency referred by Child Welfare Services via the Critical Assess Release Early (CARE) Unit which is a specialized unit within Child Welfare Services designed to divert children/youth from placement at Polinsky Children's Center (a temporary emergency shelter). Wards and dependents with severe emotional disturbances who have been discharged from juvenile institutions on psychotropic medication, and who do not have an outpatient psychiatrist and have been referred by the Probation Department or Child Welfare Services via the Juvenile Court, or Child Welfare Services via the CARE Unit.

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c)	☐	☒	☐	☒	☐	☐	☐
✓ Short-term (up to 3 months) stabilization treatment with psychotropic medication and linkage to community-based or private on-going treatment. Those children and youth who require services for a longer period of time will be referred and linked with a community-based organization or private treatment. ✓ Services will include psychiatric evaluation, consultation, assessment, case management and medication monitoring. ✓ Medical treatment will be individualized and culturally competent. It will be flexible and responsive to the diverse populations served. ✓ Appropriate referrals within 3 months including, but not limited to: community mental health clinic, private psychiatrist, school-based program, or other specialized mental health services. Referrals may include housing and employment services as needed ✓ Provision of an initial appointment for evaluation of referred youth within 2 weeks of referral, for 95% of referrals. ✓ Documentation of contact with referring party, including the Juvenile Court (with appropriate releases of information) shall be in the chart within 5 business days of the initial evaluation, for 95% of opened cases. For cases referred by Juvenile Court, the chart shall include a copy of a letter sent by the psychiatrist to the referring judge documenting the findings of the evaluation, recommendations, and treatment. ✓ Facilitate the process for the child or youth to receive Medi-Cal benefits if							

appropriate within 2 weeks of referral for 95% of eligible children/youth ✓ Coordinate and receive referrals from the Probation Department or Child Welfare Services via the Juvenile Court, or Child Welfare Services via the CARE Unit. Coordination shall include sharing clinical information. ✓ A utilization management plan; triage system; and ability to provide information to Child Welfare Services, the Probation Department and Juvenile Court. ✓ Access to Family/Youth Information and Education Program (MHSA CY2.1). ✓ Demonstrate family partnership in the development and provision of service delivery, in accordance with CMHS policy, including full participation of family members/caregivers in treatment. Such efforts shall be reflected in the client's chart. ✓ Flexible funding to assist families to obtain transportation for visits to the clinic. ✓ A Human Resource Plan that includes how contractor recruits, hires and retains linguistically and ethnically diverse providers, inclusive of consumers/family member staff, administrative, clerical support staff, and clinical staff. ✓ In addition to cultural competency training, program staff providing mental health services shall have at least 16 hours per year of clinical training ✓ Program Manager shall be a full-time, licensed mental health professional (per the state of California) with a minimum of three year's direct clinical experience working with children and adolescents. Any exception to the full-time requirement shall have prior approval by the Children's Mental Health Program Monitor.							

✓ Enroll clients in low cost or free medication programs available through pharmaceutical companies or obtain free samples to offset the cost of medication. Flexible funding may be used to obtain medication for families with no other means to obtain them. ✓ Capacity to screen, assess and refer clients with co-occurring disorders and provide intervention activities designed to encourage engagement in longer term alcohol or drug abuse treatment. ✓ All staff who provide direct services participate in a one-time basic orientation to wraparound principles, the role of the Juvenile Court and the Probation Department ✓ Attend monthly regional provider planning and coordination meetings, Behavioral Health meetings, CMHS system-wide meetings and other meetings as designated by program monitor. ✓ Program shall have a defined mechanism for emergency telephone consultation and/or referral of clients after hours. ✓ In accordance with Title 9 regulations, clinic must be Short-Doyle/Medi-Cal certified prior to the effective date for commencing services. ✓ Current standard assessment forms of the entire Children's Mental Health System have been modified to ensure consideration of domestic violence, screening and referral when appropriate.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Medication Management Clinic will provide short-term (up to three months) stabilization treatment with psychotropic medication, case management and linkage to on-going treatment for 116 children/youth at any given point of time. Those children and youth who require services for a longer period of time will be referred and linked with a community-based organization or private treatment. Services will be provided for wards and dependents, and those children/youth at risk for wardship or dependency, who are seriously emotionally disturbed as defined by the Welfare & Institutions Code 5600.3 and who have been specifically referred by the Probation Department or Child Welfare Services via the Juvenile Court, or Child Welfare Services via the Critical Assess Release Early (CARE) Unit which is a specialized unit within Child Welfare Services designed to divert children/youth from placement at Polinsky Children's Center (a temporary emergency shelter). Child Welfare Services and the Probation Department shall refer to private insurance and/or the current provider system prior to attempting access to the Medication Management Clinic. Services will include psychiatric evaluation, consultation, assessment and medication monitoring. It will also assist the child and family with support, linkage and coordination for ongoing mental health services if needed.

The Juvenile Court, both Dependency and Delinquency, have cited the need for a Medication Clinic to respond to the mental health requirements of children and youth. The clinic will transform the system by providing needed services to those children and youth who are unable to access psychiatric care through current services (either County operated or contracted clinics or private insurance). It will also specialize in contacting organizational and fee for service providers in order to coordinate care and referrals. In addition, the clinic will provide much needed feedback to the Juvenile Court, the Probation Department and Child Welfare Services.

The program will focus on the assessment, evaluation and treatment (one-on-one therapy and family counseling) of children/youth less than 18 years of age, who meet criteria for "seriously emotionally disturbed" as defined by the Welfare & Institutions Code, Section 5600.3 and who have been specifically referred by the Probation Department or Child Welfare Services via the Juvenile Court, or Child Welfare Services via the CARE Unit.

The goals of the program are to provide psychiatric assessments as to the need for psychotropic medications, the prescription and monitoring of such medications and their effects, and coordination and communication with other persons or entities involved in each child's care and supervision to the target population. The goal is also to assist the child and family with support, linkage and coordination to community or private ongoing mental health services if needed.

Children/Youth and their families receiving services from the Meds Clinic will have access to the Family/Youth Information and Education Program (MHSA CY2.1). This MHSA-funded program will be family operated and designed to provide/coordinate a

County-wide family and youth information/education program on mental illness and serious emotional disturbances (SED) to children/youth with SED and their families and to provide special outreach to un-served, ethnically diverse populations as per the Gap Analysis (Latino and Asian/Pacific Islanders). The program advances the MHSA goals by de-stigmatizing mental illness, and by increasing information and education regarding mental illness.

System of Care principles shall be evident and operationalized in policies, program design, and practice. All services shall be provided in accordance with all Children's Mental Health Services initiatives including but not limited to: Dual Diagnosis/Co-Occurring Disorders (COD), Youth Transition and Cultural Competence.

Services shall be coordinated and integrated with County of San Diego, Health and Human Services Agency (HHSA) Children's Mental Health Services (CMHS), HHSA Regions, Probation, Child Welfare Services, San Diego Regional Center, education, physical health providers, community resources, and other organizations and groups serving mental health clients. The program shall provide services in the Central community area within Health and Human Services Agency's Central Region geographic service area. This area was selected in response to an analysis that indicated the highest need for this program was in the Central Region. The program will be located in one or more service sites that are centrally located to families receiving services. The program will be Medi-Cal site certified for all service locations, including compliance with regulations regarding storage of any medications stored on site. Hours of service shall be Monday through Friday from 8:00-5:00. The selected provider will propose flexible hours to accommodate after-hour appointments. The County encourages flexible scheduling to meet the needs of families.

3) Describe any housing or employment services to be provided.

This program will work with officers from the Probation Department and with social workers from Child Welfare Services to identify needed housing and employment resources. Family Resource Centers in the Central Region will provide employment services and housing referrals to clients on public assistance; and social workers will refer clients to shelters and transitional housing facilities in the area. The clients may also be referred to one of the local housing authorities to determine eligibility to the Section 8 Housing Program, or rental assistance. For transition age youth in need of housing, the program will refer to an existing program through Mental Health Services. The Transition Age Youth portion of an adult program assists youth in obtaining housing and provides vouchers for the deposit on apartments. Families will be referred to housing programs that are being developed through the Mental Health Services Act: TAY-1 Integrated Services and Supportive Housing; CM-1 Homeless Integrated Services and Supported Housing; CM-2 Justice Integrated Services and Supported Housing.

Employment assistance will be made through the Regional Occupation Program and other employment agencies in San Diego County. An MHSA-funded program, A-6, Supported Employment Services will provide an array of job opportunities and supports to help youth who will transition from this program into the Adult Mental Health System.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This program is not funded by Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The primary goal is to stabilize treatment with psychotropic medication and promote linkage to community-based or private providers for on-going treatment. This program is designed to keep children/youth out of trouble as, historically, they have cycled back into the system in order to obtain needed medication. The program shall be required to comply with the service delivery requirements of the Statement of Work as contained in the Request for Proposals which are:

a. Provide, operate and maintain community client and mental health services in accordance with the State Department of Mental Health (DMH) Information Notice 96-02 regarding staff qualifications.

b. Use forms for recording client information and activities in case files as directed by the Program Monitors.

c. Have a defined mechanism for emergency telephone consultation and/or referral of clients after hours.

d. Resiliency is advanced by demonstrating family partnership in the development and provision of service delivery which shall be reflected in the client chart. The family will increase their resiliency by actively taking part in the treatment plan development.

e. Submit a Monthly Status Report which shall contain noteworthy activities/unusual events, community contact/interaction with other agencies, client complaints/grievance and request for a transfer of provider, programmatic issues and actions initiated to solve or mitigate them, emerging issues or potential problems, quality

improvement activities, position listing, staff changes, staff development/training, monthly wait list, family participation, caseload per staff, number of admissions and discharges, number of active cases and number of incident reports.

f. Compliance with all applicable provisions of the Children's, Adult, Older Adult Organizational Provider Handbooks, Organizational Provider Financial Eligibility and billing Procedures Manual and Documentation and Uniform Clinical Records Manual.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program**.**

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The program will ensure that program staff includes qualified individuals with experience as mental health clients or family members of mental health clients. In addition, the program will be required to have a Client/Family Advisory Group, which meets on a regular basis, to advise on the contractor's implementation of services. The Advisory Group shall include family and youth consumers and community members who reflect the cultures of the client population.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

San Diego Mental Health Services participates in on-going meeting with other County divisions such as Probation, Juvenile Courts, Child Welfare Services and Housing and Community Development. Quarterly, Children's Mental Health Services holds meetings with all participating providers to discuss system transformation and issues in common. The program will collaborate with Juvenile Courts, Juvenile Probation Officers and Child Welfare Services Protective Service Workers by sharing clinical information. The program will also collaborate with Juvenile Forensic Services and Community Mental Health Clinics to provide linkage to community providers. The goal is to transition the child/youth by linking them to community-based clinics and private providers. All collaborative activities are reported to the County on the Monthly Status Report that is submitted to the program monitor.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The following table shows the percentage breakdown of ethnicity in San Diego County verses the percentage of youth active to both Children's Mental Health and Probation.

Ethnicity	San Diego County 2000 Actual Census Data*	San Diego County 2004 Estimated Census Data*	Youth Active to CMHS and Probation**
African American	5.7%	5.3%	20%
Native American/ Indian	0.9%	0.6%	1%
Asian/Pacific Islanders	9.4	10.8%	4%
Hispanic/Latino	26.7%	29.4%	46%
White/Caucasian	66.5%	72.1%	25%
Other/Mixed	17.5%	11.2%	4%

* 2000 Data – United States Census Bureau

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Overall, 17% of youth receiving CMHS services are also active to Probation. The data shows a disproportionate number of African-Americans and Latino/Hispanic youth active to Probation in relation to the general population. Although Mental Health Services cannot impact the diversity of the children/youth that are in Juvenile Hall, Children's Mental Health Services can ensure that services provided to the children/youth served by this program are culturally competent. San Diego County Mental Health Services is guided by the Cultural Competence Plan that seeks to provide multicultural and multilingual services for the diverse populations of the County. These include: A culturally competent mental health system that seeks to understand, respect and accept the differences of multicultural groups, and a system that is moving towards cultural competence by developing standards and criteria to evaluate performance outcomes. The Cultural Competence Resource Team (CCRT) was formed to further these efforts in policy, program and practice. Measures already in place include, but are not limited to: Cultural competence expectations embedded in all contracts awarded; private providers and County clinics required to submit a Cultural Competence Report twice a year listing the staff and the classes taken.

The Culturally Competent Clinical Practice Standards currently utilized by SDCMHS were originally written in 1998. These standards have now been revised by the Cultural Competence Resource Team (CCRT) in order to ensure that the Clinical Practice Standards would: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The revised standards for this program are as follows:

- Create an environment that is welcoming to diverse communities.
- Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
- There is linguistic capacity & proficiency to communicate effectively with the population served.
- Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
- Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
- Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
- Cultural factors are integrated into the clinical interview and assessment.
- Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
- Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
- Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
- Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
- Staff actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Translation services are provided by an existing contract, Interpreters Unlimited, and are available to all providers upon request. To ensure that program goals or values will be promoted, staff will be given four hours per year Cultural Competence training, and a wraparound 8 hour basic course (for staff that have not take the course in the last four years). Clinical staff shall be

required to meet the licensing Continuing Education Units (CEUs) and other paraprofessional staff shall have a minimum of eight hours of clinical training per year.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The program is designed to serve children/youth that have contact with the Juvenile Justice System. Historically the population of children/youth active to both Children's Mental Health Services and Probation has a higher percentage of males (72%) to females (28%). Thus the program is expected to serve more males than females. However, San Diego County operates the Girls Rehabilitation Facility that serves up to 50 Juvenile Court female wards, ages 11 to 18, and this population will also be served by this program. This program will be embedded in the overall Cultural Competence guidelines and expectations for all county services. Sensitivity to gender and sexual orientation is part of the cultural competency expectations for the County. Clinical or staff in direct contact with clients are required to attend four hours per year of Cultural Competence training.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The services will be open to those children coming in from out-of-county. One MHSA funded wraparound program (MHSA CY-7) is designed to step down children residing in group homes, both in-county and out-of-county. The Meds Clinic program will be available to that population also.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Design program, budget and staffing	October-November 2005
Board of Supervisors approval	December 2005
Draft and finalize Request for Proposal (RFP)	January-February 2006

Release RFP	February 2006
Proposals due	March 2006
Award / negotiate contract	May-June 2006
Contractor interviews staff	May-June 2006
Secure facility	May-June 2006
Contract executed	July 1, 2006
Services begin	July 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year**: 2005-06, 2006-07, 2007-08	**Program Work Plan Name:** Outpatient Therapy and Outreach – Juvenile Court and Community Schools (JCCS)
Program Work Plan: CY-5.2		**Estimated Start Date**: April 1, 2006 pending plan approval

1a) Program Description: Integrated and coordinated outreach and mental health services to include Seriously Emotionally Disturbed (SED) youth attending the community based Juvenile Court and Community Schools (JCCS).

1b) Priority Population: Unserved, uninsured youth with SED attending the community based Juvenile Court and Community Schools countywide. Latino youth ages 13 to 18 are the priority population.

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ School-based outreach and mental health treatment services to increase access to services for uninsured, unserved youth who are involved in the juvenile justice system and/or expelled from their local school district for various offenses. ✓ Increase access to Latino youth who are underserved according to the gap analysis. ✓ Collaboration with Juvenile Court and Community Schools designed to coordinate service efforts to assist youth in returning to home school district and achieving academic success. ✓ Individualized, culturally competent, and strength-based assessment and treatment plans with families/youth actively involved in the development of the treatment plan; ✓ Current standard assessment forms of the entire Children's Mental Health System have been modified to ensure consideration of domestic violence, screening and referral when appropriate. ✓ Training on the wraparound principles and approach, domestic violence and on a consensus best practice for co-occurring disorders (Continuous Comprehensive Integrated System of Care, CCISC model) will be provided to all clinical staff;	☐	☐	☒	☒	☐	☐	☐

✓ Services will be dual diagnosis capable and will, at a minimum, include screening, assessment, integrated treatment and referral, a wellness, strength-based and resilience focus, and will adhere to San Diego County's Cultural Competence standards; ✓ Access to Family/Youth Peer Support Partners ✓ This program may utilize an evidence based practice or efficacious intervention such as Motivational Interviewing, Cognitive-Behavioral Therapy, Functional Family Therapy or CCISC and train new staff in the model. ✓ Program will have an advisory group which meets on a regular basis, to advise on the contractor's implementation of services. ✓ The program shall have a Client/Family Advisory Committee (CAC) that meets on a regular basis, to advise on the contractor's implementation of services. The CAC will include at least 51% client/family members and will reflect the ages and cultures of the client population.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Youth involved in the juvenile justice system and other extremely high risk youth such as those who have been expelled from their home school district attend the JCCS community schools. Countywide there are approximately 1600 youth enrolled in community based (non-institutional) classrooms at over 45 sites. The current program has been serving Medi-Cal youth at over 20 school sites. These youth have been unserved and underserved in community mental health programs. Over 70% of JCCS youth countywide are Latino and in some regions, such as South, 90% of the youth enrolled in JCCS classrooms are Latino.

JCCS community schools are regionalized and each region has a principal, teachers, a school counselor and beginning this year, a parent liaison assigned to engage the families in the youth's educational process.

The JCCS students are highly mobile in terms of their educational placement and most students are only in a particular classroom for one semester. As a result of the frequent classroom changes, these youth are seen short term for about 4 months unless they move to another JCCS classroom where services are provided. The clinicians provide follow up for at

least 30 days during transition to the home district and link the youth and families to school based or other mental health services.

In the past 4 years, Children's Mental Health Services (CMHS) began transforming the system of care by collaborating with school districts to offer mental health services to Medi-Cal eligible children/youth on school sites. Each district was given choice as to their mental health provider, under contract with Children's Mental Health Services. JCCS was identified as a "district" and selected their provider and priority school sites. (These classrooms are located in small shopping malls and other accessible community sites). Mental health services are provided in four of the six regions of the county. This program will expand services to JCCS youth in two ways: 1) services will be expanded to serve un-insured youth county-wide and 2) services will be expanded to both North Coastal and North Inland regions of San Diego County which have not been served due to the low incidence of Medi-Cal clients in the North JCCS classrooms.

The program will provide integrated, dual diagnosis capable mental health services to a very high-risk population of at least 60 SED youth annually who often have not been served in community based programs. Few community-based programs are designed specifically to serve this population of youth who are not generally responsive to traditional outpatient therapy. Motivation is a key to successful treatment and educational success and the existing program staff has trained in Motivational Interviewing, an evidence based practice that has proven successful with clients who are more difficult to engage. The program advances the goals of MHSA to reduce institutionalization and promote integrated service experiences for clients and families.

The youth referred are assessed to determine if they are seriously emotionally disturbed and are evaluated for domestic violence issues and co-occurring disorders using the CRAFFT, a brief screening tool for adolescents. This program will offer individualized services, group services and skill building designed to support recovery and foster resiliency in the youth. Family therapy and psychiatric services, including medication management are also provided. Groups are generally skill focused and may include anger management, dual diagnosis recovery, decision-making and socialization (including dealing with sexual harassment). A cognitive-behavioral approach works well with these youth. Every youth at JCCS who was expelled from their home school district has a specific rehabilitation plan which outlines requirements that must be completed in order to return to the district. These plans frequently include mental health services, anger management groups and problem solving. Many of the youth have co-occurring disorders which are addressed through recovery oriented groups and linkage to more intensive substance abuse services if needed. This program provides these services to Medi-Cal youth and will be expanded to include similar services to uninsured youth and families. The

program supports recovery and resilience by helping the youth develop an expanded view of themselves and what is possible for them.

Services will be offered throughout the day at the school sites or another community setting. Many of the JCCS classrooms provide education to one group of students in the morning and another in the afternoon, so the provider will be offering services throughout the full day. JCCS sites provide educational services year around, and do not have summer break. When schools are on break such as Winter Holiday, youth are seen in the home or other community settings. Family therapy is an essential component of the program and the program provides outreach to the parents through home visits. The focus is on supporting the parents to develop a positive relationship with the youth and defining their role in the family. Outreach efforts and flexible hours including evening appointments are essential to engaging JCCS families. The addition of a family liaison to the regional school staff is a great asset in partnering and engaging the families in the educational and mental health services.

San Diego Mental Health services has implemented the Continuous Comprehensive Integrated System of Care (CCISC), a consensus best practice model in our system of care for individuals with co-occurring psychiatric and substance disorders. The CCISC model has these four basic characteristics: system level change, efficient use of existing resources, incorporation of best practices, and an integrated treatment philosophy. The program staff shall be trained to, at a minimum, be capable of providing screening, assessment, treatment and referral for dually diagnosed youth and link them to additional services not provided by the program such as inpatient care.

CMHS and the JCCS provider coordinate closely with JCCS personnel. Regular collaborative meetings take place that include CMHS, the contracted provider and JCCS personnel. Meetings also take place monthly among the provider, JCCS counselor and parent liaison in each region to coordinate referrals, integrate efforts to work with the youth and problem solves any issues arising in the collaborative process.

The program will develop an advisory group that meets on a regular basis, to advise on contractor's implementation of recovery-oriented services. The Client/Family Advisory Committee (CAC) will include at least 51% client/family members and will reflect the ages and cultures of the client population.

Outcomes are an essential element of CMHS system of care. All providers, including school based providers, implement outcome measures including the CAMS and client satisfaction surveys with children and families at intake, six month intervals and discharge. CMHS also uses a quadrant model to assess severity of client impairment in eight areas and

these quadrant ratings correspond to CMHS system of care goals as outlined above. Quadrant measures provide additional program and system outcomes beyond the standardized measurement tools.

The following outcome measures are required of the JCCS school based program:

- For 80% of discharged clients whose episode lasted 4 months or longer, Child and Adolescent Measurement System (CAMS) total score at discharge shall show clinically significant improvement compared to the client's intake score. The CAMS is an assessment of youth well-being and has five subscales: acuity, social competence, and hopefulness, internalizing and externalizing problems and victimization.

- For 80% of discharged clients whose episode lasted 4 months or longer, the Client Functioning Quadrant (CFQ) that contains at least one of the targeted treatment goals shall be at least one level higher (improvement) at discharge than at admission.
- For 80% of those clients who remain in the program for 4 months or longer, the discharge summary shall reflect no increased impairment resulting from substance use, as measured by the Client Functioning Quadrants rating for substance use.
- Scores on the Family Centered Behavior Scale (FCBS) shall average 80% or higher across questions/test items. The FCBS is used to assess the presence of family centered qualities, such as clinician responsiveness to family, in mental health services.

In addition, all programs must achieve the following process objectives:

- All clients are assessed for substance use
- All clients, ages 16 and older, are assessed for transitional service needs
- All clients are assessed for domestic violence issues
- All clients are assessed to determine the need for referral to a primary care physician
- Client satisfaction surveys are completed in accordance with CMHS requirements

Dependent upon each individualized Service Plan, children, youth and families may be linked to other resources in the community, including but not limited to primary health care providers, family support services, alcohol and drug programs, regional Family Resource Centers (FRC's), and mentorship programs.

3) Describe any housing or employment services to be provided.

Youth and families with housing needs will be identified and linked with housing resources such as local shelters, Section 8 Housing assistance and low income housing or rental assistance. Families will be linked to Health and Human Services Agency Family Resource Centers (FRC) located in each of the six regions in San Diego County. FRC's can provide employment and housing referrals to clients on public assistance and social workers can also refer clients to shelter and transitional housing facilities in each region

One of the key factors of resiliency is developing meaningful opportunities for the youth. Setting goals for obtaining meaningful work can be an effective means of strengthening the family and assisting youth to become self-sufficient. Through collaboration with JCCS and the youth's home school district, youth can be referred for vocational training or employment services. JCCS youth who are special education eligible each have a transition plan as part of their Individual Educational Plan which addresses youth readiness for employment.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A – This program is not funded through a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The recovery goal for this program is to improve mental health and self-management of the youth so they stay out of trouble, improves functioning in the community and transition to a mainstream school campus. Recovery goals must be individualized, culturally competent and developed with youth and family participation. The key to ensuring that a youth's recovery goals are met is the service plan. The plan is youth and family driven and is a blueprint for successful recovery. The mental health services are also an enhancement to the educational program that will focus on the youth successfully achieving their rehabilitation plan with their home school. The goals of the rehabilitation plans are directed toward recovery and developing the skills to be successful in academics, behavioral management and interpersonal skills. Many of the JCCS youth have alcohol or other substance abuse issues and recovery plans also address dual diagnosis issues.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is an augmented program currently serving only Medi-Cal clients and will now include services to low income, uninsured youth and their families.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Youth and their families will have access to family run programs in the community. They also have access to the parent liaisons that work in each region of the county and are hired by JCCS to assist families with the educational process and referral to resources. Families may access regional collaborative established to serve families.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The program will collaborate with Juvenile Court and Community School personnel including teachers, school counselors, administrative personnel and family liaisons in each region. The collaboration is designed to share information and resources and work together to help the youth and family achieve their school rehabilitation plan and recovery goals.

Since many of the JCCS youth are on probation, the program maintains close collaboration with juvenile probation officers. Although this program will address co-occurring disorders, and many of these youth have substance abuse problems, the program will collaborate closely with other alcohol and drug programs. For example, teen recovery centers are located in each region of the county and can provide the youth with after-school drug free activities.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

This program will adhere to the overall Cultural Competence standards and expectations for all county services, and specific outreach and engagement will occur with the un-served/underserved groups of consumers who are Latino and or Asian-Pacific Islander. Since in the JCCS program, the majority of youth are of Latino descent, the program will require bilingual and bicultural Spanish–speaking staff.

Practice standards include the following:

- Providers engage in community outreach to diverse communities.
- Providers create an environment that is welcoming to diverse communities.
- Staffing at all levels (clinical, clerical, and administrative) shall be representative of the community served.
- There is linguistic capacity and proficiency to communicate effectively with the population served.
- Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
- Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
- Staff shall demonstrate knowledge about
    - specific cultural features that may be present in various disorders.
    - culture-bound syndromes
    - cultural explanations of illness
    - help seeking behaviors, include faith-based, in diverse populations
    - appreciation for traditional ethnic and cultural healing practices.
- Cultural factors are integrated into the clinical interview and assessment.
- Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
- Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
- Psychiatrists consider the role of cultural factors (ethnopsychopharmacology) in providing medication services.
- Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
- Staff actively seeks out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Staff is also trained in sensitivity to gender specific issues such as identification of severe emotional disorders in females and issues related to Lesbian Gay Bisexual Transgender (LGBT) youth. These youth when identified may need specific services designed to meet their unique needs. The JCCS youth also need training and interventions related to gender sensitivity due to high incidence of sexually inappropriate comments or behavior that resulted in them being expelled from their home schools.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Services will be focused on in-county residents with a SED diagnosis**.**

12) If your county has selected one or more strategies to implement with MHSA funds that are not listd in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

December 13, 2005	**Board of Supervisor Approval of MHSA Plan**
December 15, 2005	**Submitted MHSA Plan to State**
December 29, 2005	**Developed work plan for program expansion**
January 21, 2006	**Statement of Work completed for expanded program services**
February 15, 2006	**Budget revisions due from contractor**
March 15, 2006	**Anticipated approval of MHSA Plan**
April 1, 2006	**Contract amendment executed**
April 1 - 8, 2006	**Contractor hires and trains new staff**
April 8, 2006	**Program serves expanded client population.**
December 31, 2006	**Staff completes training in evidence based practice**

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: San Diego	**Fiscal Year:** 2006-07, 2007-08	**Program Work Plan Name:** Homeless/Runaway Mental Health Services
Program Work Plan: CY-5.3		**Estimated Start Date:** July 1, 2006

1a) Program Description: Intensive mental health services, case management, and psychiatric services, including medication management, for 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. Clients will be enrolled in a Full Service Partnership (FSP) program to comprehensively address client and family needs. FSP will include case management and provide intensive services and supports as needed and strong connections with homeless-specific community organizations. Services will be strength-based, focus on resilience and recovery, encompass outreach and a range of mental health services as required by the needs of the target population.

1b) Priority Population: Children/youth under age 18 with a SED who are homeless or runaway (underserved) in the Central Region of San Diego city.

A youth is considered homeless if they do not have a permanent residence. This includes youth who have runaway from their home or have been excluded from their homes by parents or guardians, youth who are living in shelters or other temporary housing arrangements, and youth living on the street.

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Contract with a provider who will meet the program requirements specified in the Request for Proposal; ✓ Provide intensive mental health services and case management; ✓ Enroll clients in a Full Service Partnership to comprehensively address client and family needs; ✓ Provide outreach and engagement to homeless youth and linkage to existing homeless youth outreach workers and community resources;	☒	☐	☐	☒	☐	☐	☐

✓ Access Family/Youth Peer Support Partners (MHSA CY 2.2); ✓ Develop a Client/Family Advisory Committee which meets on a regular basis and includes at least 51% clients/family members which reflect the ages and cultures of the client population to advise program on service implementation; ✓ Provide individualized, culturally competent, and strength-based assessment and treatment plans which focus on increasing resilience and were developed with active involvement from the child/youth and/or family; ✓ Screen for domestic violence issues and co-occurring disorders and provide referrals and linkage as needed; ✓ Train clinical staff on system of care and wraparound principles and approach, domestic violence, and co-occurring disorders; ✓ Provide dual diagnosis capable services using the CCISC model that will, at a minimum, include screening, assessment, treatment, and referral to services not provided within this program and a wellness, strength-based and resilience focus. Within one year from contract award, program will meet integrated dual-diagnosis capability criteria using the CCISC model; ✓ Use flex funds to purchase goods and services for clients based upon individual client need. Flex funds are resources for the client that are tied, on an individual basis, to the service plan goals; ✓ Utilize effective interventions based on cognitive-behavioral treatment that is trauma focused and deals with issues of sexual abuse and exploitation; ✓ Use motivational interviewing techniques to build rapport with highly guarded youth.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Program will provide intensive outpatient services and case management for homeless and runaway children/youth with SED. Program will offer outreach to youth who access shelter care and to those who do not utilize shelter services. Program staff will link closely with schools for homeless children and youth, homeless day programs, homeless shelters and outreach workers to identify those homeless youth most in need of mental health services. All children and youth will be assessed to determine if they are Seriously Emotionally Disturbed and evaluated for domestic violence issues and co-

occurring disorders using the CRAFFT (a brief screening test for adolescent substance abuse) as a screening tool. Assessments will be responsive to a client's and family's culture, race, ethnicity, acculturation, age, gender, sexual orientation, and religious/spiritual beliefs.

Services will be provided through contract with a community-based provider. To foster innovation in program design, a Request for Proposal (RFP) has been issued to solicit innovative program ideas. The RFP seeks the expertise of the community-based provider, allowing them latitude to apply experience and best practices to program design. This program advances the goals of MHSA to reduce institutionalization and promote integrated service experiences for clients and families.

With an annual target population of 43 children and youth, the program has capacity to more intensively serve children, youth, and their families by having smaller caseloads per staff member and assigning one point of contact for each client who is available 24 hours a day, 7 days a week. Clients will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals of their individualized plan. The program will provide integrated, dual diagnosis mental health services to a very high-risk population who often have not had access to community-based mental health programs. Few community-based programs are designed specifically to serve this population of youth who are not generally responsive to traditional outpatient therapy. Additionally, homeless youth are often afraid to apply for Medi-Cal, do not qualify for full scope Medi-Cal, or are not able to maintain Medi-Cal eligibility so they have been unable to access the wide array of EPSDT mental health services.

This program will offer individualized, culturally and linguistically competent services designed to support recovery and foster resilience. Mental health services may include individual therapy, rehabilitative and skill building activities, family therapy, and psychiatric services including medication management. At day sites or schools, therapy groups which are generally skill focused and may include anger management, dual diagnosis recovery, decision-making, and trauma recovery may be offered. The program may utilize effective interventions based on cognitive-behavioral treatment that is trauma focused and deals with issues of sexual abuse and exploitation. Motivational interviewing techniques may be utilized to build rapport with highly guarded youth. Many of the youth have co-occurring disorders that are addressed through treatment, recovery oriented groups, and linkage to substance abuse programs including self-help groups.

Clients will be enrolled in a Full Service Partnership (FSP) program to comprehensively address client and family needs. The FSP will include case management and provide intensive services and supports as needed and strong connections

with homeless-specific community organizations such as the Monarch School for homeless youth, the Storefront emergency shelter for homeless and runaway youth, and homeless transitional living programs such as Take Wing. The program also strives to help the youth reunite with their family or extended family members whenever possible.

Program staff is license and license-eligible providers who are highly flexible and committed to offering services that are culturally competent and promote recovery and resilience. Depending upon the proposed program design, peer partners or rehabilitation workers with experience in substance abuse treatment may be hired as staff. At least half of the clinical staff members are expected to be bilingual. Staff can also access interpreter services available to all CMHS providers.

San Diego Mental Health Services has implemented the Continuous Comprehensive Integrated System of Care (CCISC) consensus best practice model in our System of Care for individuals with co-occurring psychiatric and substance disorders. The CCISC model has these four basic characteristics: system level change, efficient use of existing resources, incorporation of best practices, and an integrated treatment philosophy. The program staff shall be trained, at a minimum, to be capable of providing screening, assessment, treatment, and referral for dually diagnosed youth to services not provided within this program. With additional staff training, this program will provide integrated mental health and substance abuse intervention. Within one year from contract award, program will meet integrated dual-diagnosis capability criteria using the CCISC model.

The program will develop an advisory group that meets on a regular basis, to advise on contractor's implementation of recovery-oriented services. The Client/Family Advisory Committee (CAC) will include at least 51% client/family members and will reflect the ages and cultures of the client population.

Outcomes are an essential element of CMHS system of care. All providers implement outcome measures including satisfaction surveys. CMHS uses a quadrant model to assess severity of client impairment in eight areas and these quadrant ratings correspond to CMHS system of care goals. Quadrant measures provide additional program and system outcomes beyond the standardized measurement tools.

The following outcome measures are required of this program:

- For 80% of discharged clients whose episode lasted 4 months or longer, the Client Functioning Quadrant that contains at least one of the targeted treatment goals will be at least one level higher (improvement) at discharge than at admission.

- For 80% of those clients who remain in the program for 4 months or longer, the discharge summary will reflect no increased impairment resulting from substance use, as measured by the Client Functioning Quadrants rating for substance use.

In addition, all programs must achieve the following process objectives:

- All clients are assessed for substance use
- All clients, ages 16 and older, are assessed for transitional service needs
- All clients are assessed for domestic violence issues
- All clients are assessed to determine the need for referral to a primary care physician
- Client satisfaction surveys are completed in accordance with CMHS requirements

Programs will be monitored through Monthly Status Reports, site visits, and regular meetings with their County Program Monitor.

3) Describe any housing or employment services to be provided.

As a Full Service Partnership program, staff will provide case management services and intense support to provide connections to homeless outreach workers and housing and employment services. Housing referrals may include community shelters, transitional age housing, or housing resources such as San Diego Housing Commission or other public housing agency or Section 8 providers. Clients have access to Health and Human Services Agency Family Resource Centers (FRC) that can provide employment and housing referrals to clients on public assistance and social workers can refer clients to shelter and transitional housing facilities. Employment service referrals may include educational and vocational training.

Reunifying youth with their families or relatives as part of a stabilization plan, when appropriate, is a primary goal of this program. One of the key factors of resiliency is developing meaningful opportunities and strengthening support systems for the client. Setting goals for obtaining stable housing or employment can be an effective means of assisting the client to become more self-sufficient.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

The average cost for each participant per year is $7,900.

This program, as a Full Service Partnership (FSP), will comprehensively address client and family needs and "do whatever it takes" to meet those needs. FSP will include case management to provide intensive services and supports as needed and strong connections to community resources. Each client will have a single point of contact within the program who will be available 24 hours a day, 7 days a week. Caseload expectations for this program are half of a typical outpatient program to allow staff time to focus on each individual client's needs. The program design will provide an array of services with different levels of intensity that allow for flexibility based on client's varying levels of need. Program staff will work in full partnership with clients and families to develop individualized, comprehensive service plans that include linkage to services and supports in the community. To maximize effectiveness of linkage to services and supports, they will be driven by the needs of the client and family, which may include extended family or other significant people identified by the client or family (such as a teacher or outreach worker). Services 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 will also develop a referral protocol with and provide linkage to the Family/Youth Peer Support Partners Program (MHSA CY2.2).

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Homeless youth often have multiple overlapping issues surrounding emotional and mental health, substance abuse, and physical health. Homeless youth frequently come from abusive and neglectful homes and have suffered trauma and sexual exploitation both in the home and on the streets. Youth who are aging out of the Juvenile Justice and Child Welfare Systems are also at increased risk for homelessness. The risks for this population are multiplied by the potential for substance abuse and gang involvement. Depression, post traumatic stress disorder, and suicide attempts are all common in the histories of homeless youth.

Program services focus on mental health needs, co-occurring disorders and harm reduction within a recovery philosophy. Recovery goals must be individualized, culturally competent, and developed with youth and family participation. The key

to ensuring that the youth's recovery goals are met is motivating the client to participate in treatment and get off the streets. The service plan is client driven and is a blueprint for successful recovery. Program will provide mental health services to achieve the following goals designed to increase the homeless youth's resilience:

- Address immediate emotional crises and ongoing mental health issues
- Promote healing from traumatic experiences
- Increase street safety behaviors
- Develop stabilization plans including family reunification, when possible, or other suitable placement
- Training on independent living skills to prepare for a lifestyle off the streets
- Reduce recidivism related to criminal habits and activities
- Increase school attendance and performance
- Address and treat substance abuse issues
- Linkage to existing homeless youth outreach workers, community resources, and Family/Youth Support Partners

Program will provide linkage, including developing a referral protocol, to the Family/Youth Support Partners (MHSA CY 2.2) to promote recovery and resiliency for the child/youth and their family.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Staffing necessary to implement the program and Full Service Partnership will be proposed in the Request for Proposal submissions by contractors to best meet the needs of the clients and families served and the program goals and objectives. Staffing may include clinical staff, parent and/or youth partners, case managers, outreach and rehabilitation

workers and support staff according to the proposed program design. Staff will reflect the cultures and languages of the children/youth and families served. Program will be responsible for developing linkage, including a referral protocol, to the Family/Youth Peer Support Partners program (MHSA CY 2.2).

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

San Diego County has a coalition of organizations dealing with the homeless, including homeless youth, which provide temporary nightly shelter and transition age housing. This program will closely collaborate with community-based agencies serving homeless youth such as the Monarch School, Storefront, or Take Wings through outreach, shelters, day programs, and schools. Program will collaborate and provide linkages to all needed services as defined in the client plan, including but not limited to primary health care providers, community based homeless organizations, social services, shelters, education, law enforcement, employment, and alcohol and drug programs. Memorandums of Understanding (MOU) with key community partners will be developed within 6 months of contract execution.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Although statistics are hard to come by regarding the age, gender, and ethnicity of the homeless population, it is clear that youth who are aging out of the Juvenile Justice and Child Welfare systems are at risk for homelessness. As minority youth, such as Latinos, African Americans, and American Indians are more likely to receive services from Juvenile Justice or Child Welfare, they may also have increased risk of homelessness.

CMHS is committed to a culturally competent system. This program will adhere to the overall cultural competence standards and expectations of all county services. The County of San Diego, Mental Health Services has a Cultural Competence Plan which contains strategies to effectively provide culturally competent services to the broad array of ethnicities, cultures, and languages that comprises San Diego County. The San Diego County Mental Health Cultural Competence Plan defines cultural competence as a set of congruent behaviors, attitudes, and policies that enables systems, agencies, and 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. The program will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County and will make arrangements for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary.

Programs are required to adhere to the following standards for cultural competence:

- Engage in community outreach to diverse communities
- Create an environment that is welcoming to diverse communities
- Staffing at all levels (clinical, clerical, and administrative) will be representative of the community served
- There is linguistic capacity and proficiency to communicate effectively with the population served
- Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed
- Staff will demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
- Staff will demonstrate knowledge about:
    - specific cultural features that may be present in various disorders
    - culture-bound syndromes
    - cultural explanations of illness
    - help seeking behaviors, include faith-based, in diverse populations
    - appreciation for traditional ethnic and cultural healing practices
- Cultural factors are integrated into the clinical assessment
- Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client
- Culture-specific consideration consistent with the cultural values and life experiences of the client will be integral in the intervention and will be reflected in progress notes, treatment planning and discharge planning
- Psychiatrists consider the role of cultural factors (ethnopsychopharmacology) in providing medication services
- Providers promote an environment that encourages staff to conduct self-assessment as a learning tool
- Staff actively seeks out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Program staff is trained to be sensitive to how homelessness and mental health issues have different impacts on males and females. Staff will understand the different reasons why males and females become homeless and different strategies each use to find places to stay for the night. Staff will target areas for outreach where homeless persons congregate and will identify and target location differences between homeless males and females to ensure outreach to both sexes. Staff will be trained to treat trauma and self-harm behaviors because many homeless youth were physically and sexually abused or exploited in the home and on the street and estimates show this is twice as likely in female homeless youth.

Program staff is sensitive to and trained on issues related to Lesbian, Gay, Bisexual, and Transsexual (LGBT) youth and will provide linkage to LGBT peer support. Children and youth who are Lesbian, Gay, Bisexual, or Transsexual (LGBT) often face rejection from family members which leads to a higher rate of homelessness among these youth. A study by Remafedi in 1987 showed 50% of lesbian and gay youth interviewed report that their parents rejected them due to their sexual orientation and as many as 26% of gay youth are forced to leave home because of conflicts with their families over their sexual identity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The services will be provided for in-county residents.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

December 13, 2005	Board of Supervisor approval for the MHSA Plan
December 15, 2005	Submitted MHSA Plan to the State
February 8, 2006	Request for Proposals posted
February 15, 2006	Pre-proposal conference
March 8, 2006	Proposals due

March – April 2006	Selection committee reviews proposals and determines competitive bidders
May 2006	Notice of Intent to Award contract is posted
June 2006	Negotiations with prospective contractor
July 1, 2006	Contract executed
July 1-15, 2006	Contractor hires and trains staff
July 15, 2006	Program begins serving clients

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: San Diego	**Fiscal Year:** 2006-07, 2007-08	**Program Work Plan Name:** Early Childhood Mental Health Services
Program Work Plan: CY-6		**Estimated Start Date: July 1, 2006**
1a) Program Description: This program is designed to provide family therapy with a focus on children ages 0-5 who have been assessed as seriously emotionally disturbed (SED) and require mental health services.		
1b) Priority Population: Children ages 0-5, and their families**,** who have been assessed as SED and require mental health services.		

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ▪ An Evidence-based practice will be applied to this service with a strong consideration for the "*Incredible Years"* model or other evidence based practice that has demonstrated efficacy with young children and their families. ▪ The program will be contracted to a provider who will meet the requirements specified in a Request for Proposal. ▪ Family treatment with a focus on children ages 0-5 who are assessed as SED and require mental health services. ▪ Coordination with First 5 Regional Service Networks developed through the First 5 Commission as part of their new Health and Development Project. Collaboration will also occur with other agencies and organizations that provide early childhood services. ▪ Individualized, culturally competent, and strength-based assessment and treatment plans which focus on increasing resilience of the child and caretaker. Families will be actively involved in the development of the treatment plan. ▪ Outreach through home-based services and other locations within the community. ▪ Current standard assessment forms of the entire Children's Mental Health	☐	☒	☐	☒	☐	☐	☐

System have been modified to ensure screening of domestic violence and co-occurring disorders within the family and will provide referrals when appropriate. ▪ The program will have a Client/Family Advisory Committee (CAC) which meets on a regular basis and will include at least 51% clients/family members and will reflect the ages and cultures of the client population. ▪ Training on system of care and wraparound principles and approach, domestic violence, cultural competence, and co-occurring disorders will be provided to all clinical staff. ▪ Provide dual diagnosis services using the CCISC model that will, at a minimum, include screening, assessment and referral and a wellness, strength-based and resilience focus. Within one year from contract award, program will meet integrated dual-diagnosis capability criteria using the CCISC model.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Program services are designed to provide family therapy with a focus on children age 0 - 5 that have been assessed as seriously emotionally disturbed (SED) and requiring mental health services. Program services will be contracted to a community based provider through a Request for Proposal process in which bidders can creatively propose a specific program design. Program proposals shall utilize an Evidence Based Practice (EBP) model for young children and their families. Proposals can consider use of either the Incredible Years Program as a treatment model or another evidence based practice for this target population. Evidence based practices refers to a body of scientific knowledge about service practices, about the impact of treatments on children's mental health conditions, or about the impact of treatments on the child's mental health condition, or about the impact of preventative interventions on the course of children's development. Due to the diversity of young children in the County, the EBP should also be effective across cultures. The program is intended to transform the Children's Mental Health System through outreach and the implementation of EBP with young children and their families and serve approximately 55 children and families per year.

Children's Mental Health Services partnered with First 5 Commission staff to develop the Statement of Work for the RFP process. One goal of the project is to increase service integration among early childhood programs through collaboration of the program with First 5 Commission Regional Service Networks developed as part of their new Health and Development Project. These regional networks will conduct developmental assessments on young children and collaborate through referral to this project. The program is intended to compliment the efforts of the new First 5 projects by providing treatment services in one region of the county. The RFP allows bidders to propose services in one of more areas of the county with high incidence of young children in poverty as defined by the gap analysis. These areas include the Central Region, South Region or North Inland Regions of the County. While the Central Region of San Diego is the most diverse ethnically, the highest number of Latino young children is located in the South and North Inland regions.

The target population for this project is SED children ages 0 - 5 and their families. All SED children under age 6 are underserved in our mental health system, so the program will serve both uninsured and MediCal children and families.

SED is not clearly defined in very young children. The target population is children who manifest behavioral disorders and/or trauma. Assessment will focus on the acuity and/or degree of impairment and developmental delay based upon mental health issues. While the problems should be seen over time, the general criteria for SED of 6 months or more is not required for this young age group. Early treatment intervention is the goal to increase resilience in the child and family so the child is better prepared to function in school and with other children. Often the young SED child has difficulty adjusting in preschool and day care centers and may be asked to leave multiple day care centers prior to entry into kindergarten.

A Statement of Work was developed for this Request for Program Proposal (RFP) project to encourage creativity rather than being proscriptive about the program design. Additionally a draft Statement of Work was presented to the stakeholder community for input prior to finalizing the RFP. Specific services will be proposed by the community based providers in the RFP process. Parameters other than implementation of an EBP include outreach to families in the home and community and including behavioral management techniques for parents. Providers may offer parent groups, parent and child interaction, trauma intervention and social skills training for young children. Programs such as Incredible Years focus on parent training and child social skills training that have between proven effective

as a treatment program for young children with early onset conduct problems. All interventions must take into account cultural and language needs of the family and be flexible as well as culturally competent in approach.

Whatever EBP is proposed, fidelity to the model is critical and the RFP requests a clear plan in the program design to insure fidelity. Fidelity means that the provider delivers the program in it's entirely using all the components and therapeutic processes recommended by the developer.

Program staffing could also include a psychiatrist or developmental pediatrician to consult with program staff.

Program hours must be flexible to meet the needs of the families. While "office" hours are generally 8 – 5, programs are expected to provide services during evening hours and on weekends, if needed. The program must have a plan for families in crisis to obtain help when the program is not open. All families shall have a crisis prevention plan which includes planned interventions to de-escalate crisis and emergency telephone numbers when additional assistance is needed.

The purpose of this broad-based project is to promote children's abilities to learn at their optimal potential by:

- Identifying and addressing problems that can impact children's learning as early as possible., Mental health services address problems, that can impact a child's cognitive functioning and school readiness., strengthen parent competencies by training parents in positive communication, behavior management skills, child-directed play skills, consistent and clear limit setting, and non violent discipline.
- Improving child functioning at home, in day/child care, and in the community.
- Strengthening child's social competence, reducing behavior problems, and increase positive interactions with peers and parents.
- Maintaining client safely at home or home-like living environment.
- Educate parents of the importance of encouragement and praise and provide them with the knowledge and skills they need to promote their children's health and development.
- Parent support and empowerment is woven into all services to instill hope. And foster resiliency of the family.

- A single staff person will be responsible for the child and family.

San Diego Mental Health Services has implemented the Continuous Comprehensive Integrated System of Care (CCISC) best practice model in our System of Care for individuals with co-occurring psychiatric and substance disorders. The CCISC model has these four basic characteristics: system level change, efficient use of existing resources, incorporation of best practices, and an integrated treatment philosophy. The program staff shall be trained and capable of providing, screening, assessment, and referral for dually diagnosed parents.

The program will also develop a Client/family Advisory Committee (CAC) which meets on a regular basis to advise other implementation of the program. The CAC shall include at least 51% family member and shall reflect the cultures of the client population.

3) Describe any housing or employment services to be provided.

The program will provide linkage to housing and employment services for the families. The County Health and Human Services Agency (HHSA) has Family Resource Centers located in each region with staff that can provide employment services and housing referrals to families on public assistance. Social workers are available who can refer clients to shelters and transitional housing facilities. The families can also be referred to the San Diego County Department of Housing and Community Development for eligibility for the Section 8 Housing Program or rental assistance. The County of San Diego also has a CalWorks Program which is designed to transition people from welfare to work. It provides temporary cash assistance to eligible families with minor children, to move families with children from dependency to self-sufficiency through employment.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A – The program is not funded by a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The program will develop and implement an individualized, strength-based, culturally competent, child and family driven service plan. The plan will identify client baseline functioning, strengths and resilience, co-occurring disorders and domestic violence issues. The family will be linked to other services and supports that assist the child and family in achieving the goals identified in their plan. The Service plan will identify outcome goals and objectives that define success for the individual client and family.

To ensure that program goals and values will be promoted by the program, Children's Mental Health, has a contractual requirement, including the expectation that the program provider recommend specific program outcomes.

CMHS contracts require staff to attend 8 hour training on system of care and wrap around services. Each program is also required to complete a Utilization Review process of client services at least every six months. As mentioned earlier, this program will provide an evidence based practice and the provider must submit a plan to demonstrate how the program will assure fidelity to the model proposed.

Each program is required to submit a monthly status report to the County Program Monitor in which they report program activities, outcomes, quality assurance activities, staffing, cultural and language capacity, and staff training. The Program Monitor conducts monthly regional meetings with providers and obtains verbal program reports. Program Monitor site visits are conducted at least annually to ensure program compliance with system of care values and contract requirements. Medical record reviews are conducted at least annually by the County Quality Improvement Division of CMHS.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program. The First 5 Commission provides developmental assessment and services through contract to the 0-5 year old population through their newly established Network Service Providers. However there currently are very limited age specific SED mental health services being provided to this population through the Children's Mental Health System. CMHS has the Developmental Evaluation Center (DEC) program contracted through

children's hospital which provides assessment, but not treatment services. One other CMHS provider offers mental health treatment in our system of care to children ages 0 – 5.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

San Diego County has family-run organizations that offer parent support and regular monthly educational training for families. The program will provide linkage to the family run programs and other organizations that offer family support.

The program is required by contract to include family partnership in the development and provision of service delivery. It is also required to demonstrate organizational advancement of family partnership in the areas of program design, development, policies and procedures, etc. Individualized plans that focus on the recovery and resiliency of the family are developed in partnership with the family (in this program the child is too young to be involved in development of a plan).

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The program will collaborate closely with the First 5 Commission's newly developed regional Integrated Service Network Providers in the targeted region(s) that address the health and developmental needs of children ages 0-5. The service network providers contracted with First 5 Commission, will be a primary source of referral for this program. Referrals may also come from other agencies, pre-school or day care providers or primary care providers. The program is expected to develop linkages with these other organizations providing early childhood services. Linkage may be made to CALWorks as another source of referral for parents who are having difficulty with their welfare to work plan for self-sufficiency due to their child's behavioral problems. Parents who demonstrate substance abuse or co-occurring disorders shall be linked to the network of Behavioral Health services in San Diego County. San Diego County has family-run organizations through mental health that offer family support and monthly parent education seminars.

In the submittal requirements for the RFP, the bidders are being asked in their proposals, to describe their collaboration with other community partners that serve the same target population and their strategies for outreach, obtaining referrals within the community and linkages beneficial to the children and families served by this project.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

CMHS is committed to a culturally competent system. This program will adhere to the overall cultural competence standards and expectations of all county services. As stated in the program description, selection of an evidence based practice shall include efficacy with diverse cultural populations. The Incredible Years Model, for example, has been translated to various ethnic populations and has been shown to promote positive parenting in African American, Chinese American, Asian American, Hispanic, Korean, and British multi-ethnic parents.

The practice standards utilized by San Diego County Mental Health Services are as follows:

- Providers engage in community outreach to diverse communities based
- Providers create an environment that is welcoming to diverse communities.
- Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
- There is linguistic capacity & proficiency to communicate effectively with the population served.
- Use of interpreter services is appropriate and staff will be able to demonstrate ability to work with interpreters as needed.
- Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
- Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
- Cultural factors are integrated into the clinical interview and assessment.
- Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.

- Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
- Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
- Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
- Staff will actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

San Diego County Mental Health has in place a Cultural Competence Plan that guides how services are provided to a culturally and linguistically diverse population. Sensitivity to gender and sexual orientation is part of the cultural competency expectations for the program. Even at the young age of the children in this program, it is essential that the program identify differences in how young girls and boys are raised and tailor interventions to foster resilience and educate parents in dealing with the children's gender differences.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide services to in-county residents.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV, although expansion to this age group was based on San Diego community input during the planning process.

13) Please provide a timeline for this work plan, including all critical implementation dates.

December 13, 2005	Board of Supervisor approval for the MHSA Plan was approved on December 13, 2005
December 15, 2005	Submitted MHSA Plan to the State

January 24, 2006	Statement of Work completed for the proposed program
February, 8, 2006	Request for Proposals posted
February 15, 2006	Pre-proposal conference
March 15, 2006	Program proposals due
March – April 30, 2006	Selection committee reviews proposals and determines competitive bidders
May, 2006	Notice of Intent to Award contract is posted
June 2006	Negotiations with prospective contractor
July 1, 2006	Contract executed
July 15, 2006	Contractor hires and trains staff*
July 15, 2006	Program begins serving clients
September 30, 2006	Program fully operational
December, 2006	Program has completed initial training in Evidence Based Practice (EBP).
August, 2007	Additional training on EBP model completed.

*Evidence based practice training developers determine when their training will occur. As a result, it is not clear exactly when the provider can be trained. We established some latitude in our Request for Proposal with the understanding that it would be as soon as possible after execution of the contract. The program will provide mental health services pending full implementation of the EBP.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year:** 2005-06, 2006-07, 2007-08	**Program Work Plan Name**: Wraparound Services
Program Work Plan: CY-7		**Estimated Start Date**: July 2006

1a) Program Description: The Contractor shall provide a full range of wraparound services to the target population of Severely Emotionally Disturbed (SED) youth and their families who are served by the Child Welfare Services (CWS) or Probation Department and who are appropriate for stepping down from residential treatment to home or home-like settings and are at risk of return to a higher level of care. Eligible clients shall receive highly individualized services to maximize the capacity of the family to meet the child's needs and thereby reduce the level of care from a group home placement to a home or home-like setting. The services shall be a Full Service Partnership (FSP) program to comprehensively address client needs. FSP shall include case management to provide intensive services and supports, as needed, and strong connections with ethnic-specific community organizations. Services shall be strength-based and focus on resilience and recovery, outreach, and encompass a range of mental health services as required by the needs of the individual clients. In addition the contractor shall operate a certified mental health Early, Periodic Screening Diagnosis and Treatment (EPSDT) clinical program providing medication support services for children and adolescents, who are full scope Medi-Cal beneficiaries, are SED as defined by the Welfare & Institutions Code 5600.3 and who meet target population criteria of youth referred by the Wraparound San Diego program. All mental health services shall be family-focused, culturally proficient, and community-based in their orientation.

1b) Priority Population: Children/youth, including Medi-Cal eligible, ages 3 through 18 with SED, who are transitioning home or to a home-like setting from residential-based services and who are demonstrably at risk of returning to a higher level of care. These children will be referred by Child Welfare Services and Probation Department.

Contractor shall provide the services described herein to the following target population who meet medical necessity criteria in accordance with California Code of Regulations Title 9 and criteria as Severely Emotionally Disturbed as defined in Welfare and Institutions Code, Section 5600.3, who have been specifically referred by the Probation Department or CWS. Population may include emancipating minors. Contractor's service priorities shall be as follows:

- Dependents and wards ages 3 through 18 who are transitioning home or to a home-like setting from residential-based services and who are demonstrably at risk of returning to a higher level of care.
- Exceptions to the target population shall be made on a case-by-case basis in collaboration with the Child Welfare Director and CMHS.

Contractor's EPSDT specialty mental health services shall be provided to full-scope Medi-Cal beneficiaries less than 21 years of age, who meet medical necessity criteria in accordance with California Code of Regulations Title 9, and who have been

specifically referred by the Wraparound San Diego program. These youth shall be transitioning home or to a home-like setting from residential-based services, and demonstrably at risk of returning to a higher level of care and therefore being removed from their home. Exceptions to the target population shall be made on a case-by-case basis by Children's Mental Health Services, County of San Diego.							
	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Wraparound services available 24/7; ✓ Emphasis on engagement of family members/caretakers, to assist them in facilitating successful transition for their children stepping down from residential care; ✓ Client caseload 8-10 per staff; ✓ Coordination with multiple systems (Child Welfare Services, Juvenile Justice, Education); ✓ Individualized, culturally competent, and strength based assessment with families/youth actively involved in the development of the treatment plan; ✓ Current standard assessment forms of the entire Children's Mental Health System will be modified to ensure consideration of domestic violence, screening and referral when appropriate. ✓ Orientation and training on domestic violence and co-occurring disorders will be provided to all clinical staff; ✓ Direct service providers shall participate in the existing Children's System of Care Wraparound Training Academy to support integration and a seamless approach to a continuous service delivery system; one-time funds in first year set aside to provide training; ✓ Embedded within this dual diagnosis capable program, there will be a dual diagnosis enhanced service component available to serve youth ages 14-17. This component will be closely coordinated with the MHSA TAY dual diagnosis residential program. ✓ Services will, at a minimum, include screening, assessment and referral; will include a wellness, strength-based and resilience focus; will assess for domestic	☒	☐	☐	☒	☐	☐	☐

violence, address in treatment or refer for services when appropriate and will adhere to San Diego County's Cultural Competence standards. ✓ ESPDT specialty mental health services will be provided to Medi-Cal eligible children/youth referred by the Wraparound San Diego Program. These services will include medication assessment, treatment, monitoring and referral.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

County of San Diego will contract with a community-based organization to provide a full range of wraparound services to the target population of youth and their families who are served by Child Welfare Services (CWS) or Probation Department. Eligible clients shall receive highly individualized services to maximize the capacity of the family to meet the child's needs and thereby reduce the level of care from a group home placement to a home or home-like setting. The contractor shall enroll eligible clients in a Full Service Partnership (FSP) program to comprehensively address client needs. FSP shall include case management to provide intensive services and supports, as needed, and strong connections with ethnic-specific community organizations. Prompt and appropriate therapeutic interventions, including psychiatric services, will be provided as appropriate for each individual client. Services shall be strength-based and focus on resilience, recovery and outreach, and encompass a range of mental health services as required by the needs of the individual clients. Services will be dual diagnosis capable with a dual diagnosis enhanced component to serve children and youth ages 14-17. The program's services are to be provided with the goal of assisting youth placed in group home placement to be returned safely to their home or a home-like setting and function successfully at home, at school, and in the community.

Wraparound teams, which include a Care Coordinator and Parent Partner for each child and family, will develop and implement a Wrap plan which reflects the progression from dependence to self-sufficiency. As the client progresses through the phases of engagement, planning, implementation, and transition, family progress will be promoted through such factors as family involvement, family decision-making, reliance on formal supports, and development of informal supports. Contractor shall prepare a service plan for each child which shall be individualized, strength-based, and developed to meet the specific treatment needs of the client within the context of the client's family and community systems. Specified types of services, and the frequency and duration of each service, shall be determined based on the unique needs and service goals of the client. Contractor's services shall be planned and delivered in accordance with the Children's Mental Health Services system of care philosophy and principles. To the maximum extent possible, services

shall be community-based, and shall emphasize the strengths of the client and family. Assessment, treatment planning and delivery, and referral for adjunct services shall be provided with demonstrated consideration of educational/school issues including school functioning and potential learning deficiencies or disabilities. Consideration shall be demonstrated by identification of relevant education-related issues with appropriate and relevant assessment and treatment documentation. Contractor shall demonstrate consideration of relevant gender-specific issues in the assessment process, treatment planning and implementation. Consideration shall be demonstrated by identification of relevant gender-specific issues with appropriate and relevant assessment and treatment documentation. Contractor shall demonstrate interagency coordination of services for the program and within individual client plans, including coordination with Child Welfare Services and Probation Department. Contractor shall operate the program in accordance with Comprehensive, Continuous, Integrated System of Care (CCISC) principles and practices, CMHS policies and procedures No. 01-06-117, and the Charter and Consensus Document – Co-Occurring Psychiatric and Substance Abuse Disorders. Contractor shall adhere to youth transition planning, if appropriate, in accordance with CMHS policy. Contractor shall coordinate transitional services between its outpatient program and HHSA Adult / Older Adult Mental Health Services, or to independent living. It is anticipated that the program will serve approximately 113 clients annually, who are referred by CWS social workers and probation officers. The services will be provided in the community, across the County, and shall be available (with a minimum of on-call coverage) 7 days per week, 24 hours per day. This program advances MHSA goals by providing integrated, family-driven services that incorporate wraparound philosophy and address co-occurring disorders for unserved and under-served populations. Children's Mental Health and Child Welfare will jointly monitor this program to ensure that services are transformative. The contractor will develop and provide to the County a training and staff development plan that incorporates core wraparound principles. In addition, wraparound staff will participate in a multiple-day training on wraparound, skill-building and other topics that promote recovery and resiliency.

The EPSDT specialty mental health services component program shall provide medication support services to full-scope Medi-Cal qualified children/youth who meet target population criteria. All other rehabilitation option services shall be provided as appropriate by referral, so that the full range of services is provided.

- Services shall be provided by a psychiatrist and include evaluation, medication monitoring, and other consultative services.
- Psychiatrist(s) shall have completed a training program in a child or adolescent specialty (must be Board eligible in child and adolescent or adolescent psychiatry). Exception to this psychiatrist qualification requirement may only be approved by the Children's Mental Health Services Assistant Deputy Director.
- Supervision of the psychiatrist is to be provided by the contractor

3) Describe any housing or employment services to be provided.

The program will facilitate referral and linkage for clients, and their families, as appropriate to housing and employment services, including Family Resource Centers, the Department of Housing and Community Development, and the Regional Occupation Program. Services shall include intensive case management through family service coordination to all children enrolled in the program and shall ensure that services delineated in the service place are provided. A network of providers of both goods and services that support family self-sufficiency and help maintain the child/youth in their home shall be developed. Policies and procedures regarding the use of flexible funds shall be developed in order to preclude duplication of effort and to better reflect the goal of supporting the needs of the child/youth and family. Basic family needs of food, shelter and clothing shall be addressed in conjunction with providing emotional support, treatment and direction. The self- sufficiency of the child/youth and family includes the pursuit of employment. The employment of age-appropriate youth supports the goal of "normalization," and encourages growth and independence. The comprehensive approach of the wraparound philosophy and process will assure that the full array of services in the community are recognized and integrated with the program's services as appropriate.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

The average cost for each participant per year is $16,814.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Program services are focused on promoting recovery and resiliency by being strength- based, family-focused, culturally proficient, community-oriented, and individually tailored. The core goals and services are designed to promote self-sufficiency and maximize youth and family capacity to function successfully. This occurs through the identification and enhancement of both internal and external naturally-existing resources. Services shall include an assessment of resiliency factors affecting the child/youth. These factors may include but not be limited to commitment to school; involvement in extra-curricula activities; relationship with parents and other adults; parent involvement; interpersonal relationships; involvement in faith community; ability to manage stress; and organizational skills. Services will be provided

to strengthen positive attachments and activities, and identify areas of concern to be replaced with pro-social activities leading towards age-appropriate self-sufficiency.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This new program will expand on existing wraparound services in San Diego County, making the service more available to previously unserved children and families by targeting youth in high level of care residential-based programs who transition to a home-like setting with the benefit of the program's services. An existing wraparound program targets children/youth at risk of residential care. This program will step youth down from a residential setting and provide the supports necessary to preclude a return to a higher level of care.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Parent Partners will be hired by the program to function as core members of each child's wraparound team, and provide family support services as part of the overall services provided. The contractor shall have a Program Advisory Group (PAG) which meets on a regular basis to advise on the contractor's implementation of services. The PAG shall include family and youth consumers and community members who reflect the cultures of the client population. The Program Monitor or designee may periodically attend PAG meetings.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Collaboration has occurred, and will continue to occur, at various levels and stages in the development and delivery of services. There is ongoing collaboration with multiple child-serving systems. Program and contract planning have occurred through a partnership of Children's Mental Health Services (CMHS) staff with staff of CWS and the Probation Department. Through the shared planning process there is an effort to closely coordinate the requirements and activities of each department, the roles of the various child and family-serving professionals, and to optimize the efficient use of

funding for wraparound services for the target population. Contract development and monitoring of contractor performance will be provided by a team of staff from both CMHS and CWS.

At the level of program delivery, the program will be required to facilitate and document the participation of all appropriate child-serving systems (i.e., social workers, probation officers, educators, health care providers, juvenile court) in the wraparound service planning. The program also will closely collaborate with residential service providers to ensure the most appropriate transition in living arrangement and care, and with multiple community-based service providers identified in individualized service plans for each child and family.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies will be used to meet their needs.

The following table shows the percentage breakdown of ethnicity in San Diego County verses the percentage of youth active to both Children's Mental Health and Probation.

Ethnicity	San Diego County: 2000 Actual Census Data*	San Diego County 2004 Estimated Census Data*	Youth Active to CMHS and Probation**
African American	5.7%	5.3%	20%
Native American/ Indian	0.9%	0.6%	1%
Asian/Pacific Islanders	9.4	10.8%	4%
Hispanic/Latino	26.7%	29.4%	46%
White/Caucasian	66.5%	72.1%	25%
Other/Mixed	17.5%	11.2%	4%

* 2000 Data – United States Census Bureau
** San Diego County, 6th Annual Children's System of Care Report

Overall, 17% of youth receiving CMHS services are also active to Probation. The data shows a disproportionate number of African-Americans and Latino/Hispanic youth active to Probation in relation to the general population. Children's Mental Health Services can ensure that services provided to the children/youth served by this program are culturally competent. San Diego County Mental Health Services is guided by the Cultural Competence Plan that seeks to provide multicultural and multilingual services for the diverse populations of the County. These include: A culturally competent mental health system that seeks to understand, respect and accept the differences of multicultural groups, and a system

that is moving towards cultural competence by developing standards and criteria to evaluate performance outcomes. The Cultural Competence Resource Team (CCRT) was formed to further these efforts in policy, program and practice. Measures already in place include, but are not limited to: Cultural competence expectations embedded in all contracts awarded; private providers and County clinics required to submit a Cultural Competence Report twice a year listing the cultural and linguistic background of all staff members as well as experience and training with certain special populations, such as transition age youth or youngsters with cases in Juvenile Court. The County assists its providers in developing staff cultural competence through quarterly trainings on various ethnically diverse populations, their beliefs about mental illness, and cultural concerns. Services will be provided by staff reflecting the culture and language of the children/youth being served. A resource guide will be available to identify culture specific programs to include but be limited to programs such as Para Las Familias Center, Union of Pan Asian Communities Multi-Cultural Family Services, UPAC Rainbow Center, and the Border Youth Project.

Translation services are provided by an existing contract, Interpreters Unlimited, and are available to all providers upon request. To ensure that program goals or values will be promoted, staff will be given four hours per year Cultural Competence training, and a wraparound 8 hour basic course (for staff that have not take the course in the last four years). Clinical staff shall be required to meet the licensing Continuing Education Units (CEUs) and other paraprofessional staff shall have a minimum of eight hours of clinical training per year.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Current definitions of culture include interpersonal differences such as gender and sexual orientation. The program will demonstrate competence in the recognition and integration of relevant gender and sexual orientation issues into the assessment process, treatment planning and implementation, and staff training. The County assists its providers in developing sensitivity to sexual orientation issues through the availability of specific trainings including but not limited to an overview of the LGBT population. Historically the population of children/youth active to both Children's Mental health Services and the Probation Department has a higher percentage of males to females. Resources will be identified to guarantee that gender specific and gender sensitive treatment is available such resources include but are not limited to the Girls Rehabilitation Facility and the Community Assessment/Working to Insure and Nurture Girls Success Team.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

It is anticipated that the program can be of particular benefit to dependents and wards that are residing out-of-county in residential-based treatment programs. The program will assist those children who are appropriate for transitioning from such a placement to a local home-like setting, to complete the transition successfully and progress toward self-sufficiency.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All the strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Design program, budget and staffing	October-November 2005
Board of Supervisors authorization	December 2005
Draft Statement of Work	December 2005
SOW feedback/planning with stakeholders	January 2006
Finalize Request for Proposals (RFP)	February-March 2006
Release RFP	March 2006
Proposal review/Source selection process	April 2006
Award/Negotiate contract	May-June 2006
Contract executed	July 2006
Secure facility/Hire staff	July-August 2006
Program services begin	July-August 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year:** 2005-06, 2006-07, 2007-08	**Program Work Plan Name**: Placement Stabilization Services
Program Work Plan: CY-8		**Estimated Start Date**: July 2006

1a) Program Description: Contractor shall offer a Medi-Cal certified mental health clinical program in conjunction with Child Welfare Services (CWS) and, directly or by referral (once placement is stabilized and suitable services are available through a provider acceptable to the child/youth and family), provide a full range of rehabilitation option services for 150 children, adolescents, and their families who are full scope Medi-Cal beneficiaries and who meet target population criteria of Severely Emotionally Disturbed (SED) youth served by the CWS, and at risk of change of placement from their home, homelike setting or group home of six (6) or fewer residents. Eligible clients shall receive case management, assessment and treatment, including specialized approaches such as anger management groups and parent education. Contractor shall provide a unit of psychologists and a psychiatrist who shall offer County-wide mental health services, including but not limited to professional case consultation to CWS staff, and other appropriate mental health services as required by the needs of the target population and CWS. All mental health services shall be family-focused, culturally proficient, and community-based in their orientation. Program will be designed to achieve the following goals in this order of priority: 1) Return children/youth to their family or family like settings, 2) Deter children/youth from being placed in a higher level of care, 3) Stabilize placement.

1b) Priority Population: Children's Mental Health Services and Child Welfare Services have cited the need for services to respond to the mental health requirements of SED children/youth in out-of-home placements and at risk of change of placement, and their families or caretakers. Contractor's Early Periodic Screening Diagnosis and Treatment (EPSDT) services shall focus on the assessment, evaluation, and treatment including case management of full-scope Medi-Cal beneficiaries less than 18 years of age, who meet criteria for "seriously emotionally disturbed" as defined by the Welfare & Institutions Code 5600.3 and who have been specifically referred by Child Welfare Services. Services may be brief in nature or short term in duration. Contractor's service priorities shall be as follows:

Children and youth less than 18 years of age who are placed at home, foster care or small group home and are demonstrably at risk of change of placement i.e. placement at a higher level of care and therefore at risk of being removed from their home, foster home or small group home. These clients may be defined as those whose primary referral problems include, but are not limited to, the following:

- Repeated truancy or suspensions from school, or Student Attendance Review Board (SARB referral)
- Stealing, not including food items.
- Cruelty toward animals.

- Property destruction, especially fire setting.
- Aggression toward peers (not siblings), especially fighting resulting in injury.
- Physical aggression toward adults, especially teachers and/or police.
- Repeated defiance of rules and authority figures other than parents.
- Substance abuse
- Severe problems with temper outbursts, taking into account the child's age and developmental status.
- Associates primarily with much older and/or delinquent youth; no pro-social interests or adult mentor.
- History of change of placement.
- Young adults aged 18 up to 21 who meet criteria and whose EPSDT services have been initiated by Contractor prior to the client's 18th birthday.

Exceptions to the defined target population shall be made on a case-by-case basis by Children's Mental Health Services, County of San Diego in collaboration with CWS.

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Mental health services for children and youth with Medi-Cal in out-of-home placements through Child Welfare Services. Program will be designed to achieve the following goals: 1) Return them to their family, 2) Deter child/youth from being placed in a higher level of care, 3) Stabilize their placement; ✓ Address behavioral problems that can lead to change of placement; ✓ Treatment provided in a family or family-like (e.g. foster home or foster family agency) setting; ✓ Address strategies to support child/youth school success; ✓ Coordination of services between Mental Health Services (MHS), CWS, and Family/Caretaker; ✓ Individualized, culturally competent, and strength-based assessment and treatment plans with families(caretakers) /youth actively involved in the	☐	☒	☐	☒	☐	☐	☐

development of the treatment plan; ✓ Current standard assessment forms have been modified for the entire Children's Mental Health System to ensure consideration of domestic violence, screening and referral when appropriate; ✓ Orientation and training on wraparound principles and approach, domestic violence and co-occurring disorders will be provided to all clinical staff.							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

A contract shall be awarded subsequent to the County's competitive request for proposal process. The services provided shall be delivered through a Medi-Cal certified mental health clinical program in conjunction with Children's Mental Health Services and Child Welfare Services and, directly or by referral(once placement is stabilized and suitable services are available through a provider acceptable to the child/youth and family), provide a full range of rehabilitation option services for children, adolescents, and their families who are full scope Medi-Cal beneficiaries and who meet target population criteria of Severely Emotionally Disturbed (SED) youth served by Child Welfare Services (CWS), and at risk of change of placement from their home, homelike setting or group home of six (6) or fewer residents. Eligible clients shall receive case management, assessment and treatment, including specialized approaches such as anger management groups and parent education. Contractor shall provide psychologists and a psychiatrist who shall offer County-wide mental health services, including but not limited to professional case consultation to CWS staff, and other appropriate mental health services as required by the needs of the target population and CWS. All mental health services shall be family-focused, culturally proficient, and community-based in their orientation. Program will be designed to achieve the following goals: 1) Reducing institutionalization by returning children/youth to their family, 2) Stabilization of placement, 3) Deter child/youth from being placed in a higher level of care. The contractor, in collaboration with Child Welfare Services, will identify a specific evidence-based model that builds child/youth and caregiver skills in managing problem behavior. Services will, at a minimum, include screening, assessment (including the assessment of co-occurring disorders and for domestic violence), and treatment or referral for services when appropriate. Services will have a wellness, strength-based and resilience focus and will adhere to San Diego County's Cultural Competence standards.

3) Describe any housing or employment services to be provided.

This program will work with social workers from Child Welfare Services to identify needed housing and employment resources. The program will facilitate referral and linkage for clients, and their families, as appropriate, to housing and employment services, including Family Resource Centers, the Department of Housing and Community Development, and the Regional Occupation Program. Family Resource Centers will provide employment services and housing referrals to clients on public assistance; and social workers will refer clients to shelters and transitional housing facilities in the area. The clients may also be referred to one of the local housing authorities to determine eligibility for the Section 8 Housing Program, or rental assistance. For transition age youth in need of housing, the program will refer to an existing program through Mental Health Services. The Transition Age Youth portion of an adult program assists youth in obtaining housing and provides vouchers for the deposit on apartments.

Employment assistance will be made through the Regional Occupation Program and such as employment agencies in San Diego County.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A -- This program is not funded by a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Program services are focused on promoting recovery and resiliency by being strength-based, family-focused, culturally proficient, community –oriented, and individually tailored. The core goals and services are designed to promote self-sufficiency and maximize youth and family capacity to function successfully. This occurs through the identification and enhancement of both internal and external naturally existing resources. Children's Mental Health Services and Child Welfare Services have cited the need for services to respond to the mental health requirements of children and youth placed in their home, homelike or small group home setting and at risk of change of placement. The program will serve those children and youth referred by CWS and at risk of change of placement. The program shall coordinate closely with CWS through the establishment of a strength and evidence-based program including linkage to family support promoting recovery/resiliency in the child/youth and family. Psychiatric and psychological services will be provided County-wide to

support children and families as well as to provide consultation to CWS staff. Contractor shall provide the services to accomplish the following goals:

- The stabilization of children and youth in their home, homelike or small group home setting, avoid placement in a higher level of care, increase school attendance and improve school performance, and improve the child's functioning at home, school, and in the community.
- Provide assessment and treatment services to youth served by the Child Welfare System
- Contractor shall provide no less than 900 hours, or 54,000 minutes of billable time per fulltime equivalent (FTE) of direct service staff.
- Contractor shall meet the standards that correspond to their particular service modality as delineated in the current Program Outcome Standards, and shall deliver units of service in accordance with the approved program and budgets. Any changes to the total number of units of service shall require a contract amendment.
- Contractor shall ensure provision of an initial appointment within five (5) business days of referral for 90% of eligible children, youth and families.
- 75% of enrolled children and youth will avoid placement in a higher level of care or change of placement.
- Contractor shall ensure staff training that incorporates skills building in conjunction with strength and evidence-based approaches promoting resiliency and self-sufficiency in children, youth and families.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new area of service delivery focus. Children's Mental Health Services and Child Welfare Services have cited the need for stabilization services to respond to the mental health requirements of children and youth placed in their home, homelike or small group home setting and at risk of change of placement. The EPSDT program shall coordinate closely with CWS and refer to other programs as necessary. This program will provide immediate specialty mental health intervention conducted by a licensed psychologist and/or psychiatrist to children/youth and families/caregivers in crisis and consultation to CWS staff charged with assisting children/youth and families/caregivers in stabilizing placements.

Included in the intervention will be the identification of existing resources both within the system of care and within the family and community at large.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Contractor shall propose the specific staffing for this program to best meet the program goals and objectives. Staffing may include clinical staff, parent and/or youth partners, case managers, outreach and rehabilitation workers and support staff according to the proposed program design. The contractor shall have an Parent Advisory Group (PAG), which meets on a regular basis, to advise on the contractor's implementation of services. The PAG shall include family and youth consumers and community members who reflect the cultures of the client population. The Program Monitor or designee may periodically attend PAG meetings.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Children's Mental Health Services and Child Welfare Services have cited the need for services to respond to the mental health requirements of SED children/youth in out-of-home placements and at risk of change of placement, and their families or caretakers. Currently, impulsive and destructive children have taxed the patience of caregivers resulting in the sudden loss of placement. Services have not been immediately available to address the family's and child/youth's needs; consequently, the placement has been lost. The proposed services will coordinate information and intervention to immediately intercede with the expectation that the child/youth's behavior will be brought under control and that the placement will be maintained. There will be coordination and collaboration with child serving agencies, family of origin and current caretakers. CWS and CMHS will provide integrated services to assist the child/youth and family in maintaining the clients at home or a home-like setting. Medi-Cal qualified children/youth who meet target population and SED criteria.

The program shall include prompt therapeutic interventions with clients in crisis. The program shall provide mental health clinical programs offering mental health services, either directly or by referral, including but not limited to, individual, collateral, and/or group/family psychotherapy services, rehabilitation, medication support services, and crisis intervention as needed at a frequency based on the treatment plan. Services shall be provided at the clinic site(s) and at designated

out-of-clinic sites(s), including small group home, home, foster home, targeted school programs and other community settings relevant to the child/youth's treatment plan.

The program shall have a service plan for each client that shall be individualized and developed to meet the specific treatment needs of the client within the context of the client's family and community systems, including but not limited to CWS, education, Probation Department and other child serving providers. Specified types of services, and the frequency and duration of each service, shall be determined based on the unique needs and service goals of the client and family. To the maximum extent possible, services shall be community-based, and emphasize the strengths of the client and family. Services will include the identification of community resources for additional and sustained services once stabilization of the home or home-like setting has been established. Assessment, case management, treatment planning, delivery, and referral for adjunct services shall be provided with demonstrated consideration of educational/school issues including school functioning and potential learning deficiencies or disabilities. Contractor shall demonstrate family partnership in the development and provision of service delivery, in accordance with CMHS policy, including full participation of family members/caregivers in treatment. Such efforts shall be reflected in the client's chart. Contractor shall demonstrate organizational advancement of family partnership in the areas of program design, development, and policies and procedures. Contractor shall demonstrate interagency coordination of services for the program and within individual client plans. All services shall be coordinated with CWS and juvenile court as relevant. Contractor shall adhere to youth transition planning, if appropriate, in accordance with CMHS policy. Contractor shall coordinate transitional services between its outpatient program and HHSA Adult / Older Adult Mental Health Services, or to independent living.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies will be used to meet their needs.

The County of San Diego recognizes that cultural norms, values, beliefs, customs and behaviors influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. For these reasons it is required that providers incorporate cultural competence standards at all levels of the organization and within the managed care environment. The provider shall create an environment that is welcoming to diverse communities. Staffing at all levels shall be representative of the community served and linguistic capacity shall be provided in order to guarantee effective communication with the population being served. Providers are required to engage in a culturally competent needs assessment and engage in outreach based on the needs assessment. The use of interpreters may be appropriate when staff is able to demonstrate the ability to effectively work with interpreters. All staff shall demonstrate knowledge of and appreciation for diversity within ethnic and cultural groups as well as knowledge of specific cultural features that may be present in various

disorders, culture-bound syndromes, cultural explanations of illness, unique help-seeking behaviors in diverse populations, and an appreciation for traditional ethnic and cultural healing practices. Provider shall actively seek educational, consultative and multicultural experiences including a minimum of four (4) hours of cultural competence training annually. To assess the cultural competence of staff system-wide, CMHS periodically administers a Cultural Competence Survey. In addition, providers report the cultural and linguistic background of all staff members twice a year as well as experience and training annually. The County has developed policies and procedures regarding the linkage of clients who speak either threshold languages or non-threshold languages with linguistically and culturally appropriate services.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Current definitions of culture include interpersonal differences such as gender and sexual orientation. The program will demonstrate competence in the recognition and integration of relevant gender and sexual orientation issues into the assessment process, treatment planning and implementation, and staff training. Sensitivity to gender and sexual orientation is part of the cultural competency expectations for the County. Consideration shall be demonstrated by identification of relevant gender-specific issues with appropriate and relevant assessment and treatment documentation.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide services to in-county residents. Services to children/youth residing outside the County, in a foster home or small residential facility and meeting target population criteria, shall be determined eligible for services on a case by case basis in collaboration with CWS and CMHS.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates:

Activity	Date
Design program, budget and staffing	October-November 2005
Board of Supervisors approval	December 2005
Draft and finalize Request for Proposal (RFP)	January-March 2006
Release RFP	March 2006
Proposals due	March 2006
Award/negotiate contract	May-June 2006
Contract executed	July 1, 2006
Secure facility, hire staff	July 2006
Services begin	July 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN

County: San Diego	Fiscal Year: 2005-06, 06-07, 07-08	Program Work Plan Name: Integrated Services and Supported Housing
Program Work Plan #: TAY -1, linked with TAY-2 and TAY-3		Estimated Start Date: July, 2006

1a) A brief description of the program: This program provides Individualized, comprehensive, integrated, developmentally, age appropriate intensive Assertive Community Services (ACT) for 16 to 24 y/o Transition Age Youth (TAY) that include culturally competent rehabilitation and recovery mental health services for TAY with a Serious Mental Illness (SMI). An array of supportive housing options (100 units) will also be provided, for 18 y/o only including short term housing, transitional and permanent supported housing.

1b) Identification of the age and situational characteristics of the priority population to be served in this program: TAY with SMI who are homeless or at risk of homeless, are unserved, may have been in juvenile institutions or justice system and are users of acute inpatient care and/or who may also have a co-occurring mental illness and substance abuse. In accordance with AB599, veterans are eligible for this program.

	1d) Fund Type				1d) Age Group				
1c) Identification of strategies for which you will be requesting MHSA funds for this program. 1d) Identification of the funding Types that will be used and the age group of the priority populations to be served for each strategy.	FSP	Sys Dev	OE	OT	CY	TAY	A	OA	ALL
	☒	☐	☐	☐	☐	☒	☐	☐	☐
✓ Age and developmentally appropriate diversion and re-entry services that are community based, comprehensive, integrated and individualized with wraparound services provided 24/7 by personal service coordinators; ✓ Services include outreach and engagement, mental health services, intensive case management and rehabilitation and recovery services; ✓ Care coordination, skill development, supported education/ employment and housing services; ✓ Staff to consumer ratio is approximately 1 to 10; ACT Team members share responsibility for the treatment, support and									

rehabilitation services; ✓ Includes comprehensive and integrated mental health and substance abuse services and individualized client centered treatment / service plan; ✓ Staff will attend monthly meetings for care coordination of youth aging out of Children's system to identify mental health needs when transitioning to Adult services ✓ Probation officer will be embedded in ACT team; in-reach care coordination services to TAY with a SMI who are incarcerated in the local juvenile institutions or jails will be provided; ✓ 100 housing units will be identified and will include an array of housing options via one-time funds and may include: short term housing, Single Room Occupancy (SRO), transitional and permanent subsidized housing, dorm housing and/or master leasing; ✓ Linkages to physical healthcare providers/health insurance plans and care coordination; ✓ One time training funds will be used to provide ACT training, technical assistance and consultation in implementing a high fidelity program, and Copeland's Wellness and Recovery Action Plan and Deegan's Intentional Care Guidelines.									

NOTE: THIS PROGRAM WILL ALSO PROVIDE HOUSING AND SUPPORT SERVICES FOR CLIENTS COMPLETING RESIDENTIAL TREATMENT AT MHSA FUNDED TAY-3.

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

Contractor shall provide services to TAY with a SMI who are homeless or at risk of homeless, who are unserved, may have been in juvenile institutions or justice system and are users of acute inpatient care and/or who may also have co-occurring mental illness and substance abuse. San Diego Mental Health Services (SDMHS) will contract with a community based agency to provide new services that are age and developmentally appropriate and include outreach and

engagement, Assertive Community Treatment (ACT), 24/7 intensive case management, wraparound services and community based outpatient mental health services, rehabilitation and recovery services, supported housing, supported employment and education, and peer support services. Assertive Community Treatment (ACT) Team services are an evidence-based practice that has repeatedly demonstrated its effectiveness with people who have serious mental illness who have not been adequately served by the usual service system. SAMHSA's ACT Implementation Resource Kit (2003) describes:

> "Assertive community treatment (ACT) is a way of delivering comprehensive and effective services to individuals who are diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. At the heart of ACT is a transdisciplinary team of 10 to 12 practitioners who provide services to approximately 100 people. Services are delivered directly by the team as opposed to being brokered from other agencies or providers. To ensure that services are highly integrated, team members are cross-trained in each other's areas of expertise to the maximum extent possible. Team members collaborate on assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure each person receives the services he or she needs to support his or her recovery from mental illness. The course of recovery from severe mental illness and what it means to have a life that is not defined by a severe mental illness differs among people. Consequently, ACT services are highly individualized and there are no arbitrary time limits on the length of time an individual receives services. Most services are provided in vivo, that is, in the community settings where problems may occur and support is needed rather than in staff offices or clinics. By providing services in this way, people get the treatment and support they need to address the complex, real world problems that can hinder their recovery. Each person's status is reviewed daily by the team so the nature and intensity of services can be adjusted quickly as needs change. At times, team members may meet with a person several times a day, but as the individual's needs and goals change, the nature and frequency of contacts with the individual also change.

> One probation officer will be embedded in the ACT Teams to assist with justice system involvement, diversion strategies and re-entry to the community. This model has been extremely effective in our AB2034 program to support clients with legal system issues, re-entry into the community and/or prevention and diversion from the justice system. Services provided by this PO will include case management of legal issues and care coordination. This shall be reviewed after the first year to determine the ongoing need for the Probation Officer in the 3rd year. Assertive Community Treatment (ACT) model is an evidence-based practice which will serve this population well, especially the 24/7 capability. This program will advance the goals of the MHSA by increasing access to care for

unserved TAY with SMI who are a priority population under the act. In addition, this program will advance rehabilitation and recovery practices by assisting clients in their personal recovery, self- sufficiency and in seeking and sustaining employment and educational goals.

Clients may be referred from outreach efforts, juvenile institutions or justice system, Mental Health providers who served youth and TAY or psychiatric hospitals. In a full fiscal year 156 TAY (30 per year to be 16 & 17) will be served in this program. Clients will be linked to community mental health providers, schools, colleges, vocational programs (to include: MHSA TAY 2 Clubhouse and MHSA TAY-3 services) or MHSA Employment Services that is being developed under this Community Services and Supports (CSS) plan. To assist in their recovery and self-sufficiency TAY will be provided supportive housing services, to include temporary, transitional and permanent housing for 18 and older TAY only, to include shelters, Board and Care facilities, specialized programs such as Reese Village and other housing opportunities to be funded under MHSA. Housing for 16 & 17 year olds will include Polinski Center and foster care planning/placement. This program will also provide supportive employment services for their clients and may refer to specific additional vocational, pre employment & employment services offered at our clubhouses other employment services shall be utilized such as Employment Services (a program under Department of Rehab), Job Options and the MHSA Employment services.

The program shall be centrally located; hours shall be 24/7 with on-call staff and services provided in the community, at the client's home/school/clubhouse/clinic or any appropriate site where TAY feels comfortable. This program will be linked to other MHSA TAY services included in the CSS Plan and they are: MHSA TAY 2 Clubhouse, and MHSA TAY-3 - Dual Diagnosis Residential Treatment facility as well as the enhanced MHSA TAY Outpatient services that will be provided through the MHSA in approximately 11 existing outpatient mental health clinics. Additional client specific services shall be identified as well as community self help programs (such as Greater San Diego Youth Alcoholics Anonymous or Narcotics Anonymous) and those of our current system of mental health & alcohol and drug service providers, such as MITE, Gifford Dual Diagnosis program, Nosotros or Serenity House. As this TAY population has many needs in regards to substance abuse and involvement with gangs, in addition to collaboration with community programs, the staff shall participate in specific trainings regarding both substance abuse and gang culture.

The ACT team will be a multidisciplinary team, that will follow ACT team standards with 2 teams composed of a Licensed Team Leader, 1 RN, 3 MHW (master's level), 2 MHW (bachelor's level), 1 Peer specialist, 1 Employment Specialist, 1 Program Specialist, 1 Substance Abuse Specialist plus 1 FTE psychiatrist serving both teams."

Contractor shall assure that ACT Team staff includes qualified individuals with experience as mental health clients or family members of mental health clients in all positions that they qualify for. Peer support specialists can be tremendously valuable in promoting hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. The program will encourage its clients to link with client-operated services, including the TAY clubhouse, other local clubhouses and the to-be-established MHSA Client-Operated Peer Support Services Program.

3) Describe any housing or employment services to be provided.

Clients who are 18 y/o and older will be provided supportive housing services by our contractor who will utilize one-time MHSA housing funds ($1,320,000) to subsidize short-term, transitional and permanent housing for 100 homeless clients in the program. The contractor shall provide a continuum of supportive housing options, that may include: emergency short stay housing, Single Room Occupancy (SRO's), transitional housing, independent living and subsidized permanent housing, The program's designated housing lead will work with the to-be-identified County Mental Health Services MHSA housing technical expert (to be provided under MHSA funds) to identify and develop housing capacity for homeless clients that is long term and permanent.

Supportive employment services will include job coaching, job readiness assessment, job skill development and assistance with competitive employment placement. By placing clients on the job and providing on going long term job support clients shall be supported in their individual employment goals by the Employment Specialist embedded in each team. Additionally, the vocational, pre employment & employment services offered at our clubhouses and Employment Services a program under the State Department of Rehab can compliment the work that the Employment Specialist will provide when specific needs are identified by the client. This program will advance rehabilitation and recovery practices that are developmentally appropriate and will assist TAY clients in their recovery, self sufficiency and in seeking/sustaining employment and housing. The supported housing program will be required to address the risk and minimize the disparity by assuring that both African American and American Indian youth are receiving services. In addition, the program will be required to conduct special efforts to outreach to females, with a particular emphasis on single mothers.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Average cost per client/per year without the housing is $12,000. One-time housing funds of $1,320,000 will be utilized to develop 100 housing units for clients in this program at a cost of $13,200 per housing unit.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. **Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

Rehabilitation and recovery interventions are client directed and provided in the service array that will be provided, to include: individualized wellness, relapse and recovery action plans, skill development, peer supports, social and recreational supports, supported employment, supported education and supported housing. Training and technical assistance will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills.

These components will advance MHSA goals by providing client directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, reduce homelessness, contact with the justice system and reduce inappropriate use of acute inpatient care and medical care. Training funds are provided for the required training on the ACT model to ensure fidelity to these evidence based practice standards.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program and contractor will be determined by the County Request For Proposal (RFP) process.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

This program shall have a minimum of 2 FTE Peer Specialist and 2 FTE Employment Specialist positions (these could be shared positions of 10 or more hours per week) who will work directly with clients and link with family members who

support our clients. Some of the services that could be provided by these Peer / Employment Specialists include peer education, peer support groups, assisting team members as case aides, mentoring and role modeling. Additionally peers and family members shall be involved in volunteer roles to support whenever appropriate and with approval of our TAY clients. This program shall link clients to our client run clubhouses, particularly the TAY clubhouse planned under MHSA funds to assist clients in their rehabilitation and recovery. A sample budget is shown in Exhibit 5b; the final program may vary based on the details of the best proposal received, but will maintain staffing by persons with personal client/consumer experience. The program is expected to collaborate and link with other client-run organizations, including the TAY clubhouse and other local clubhouses, NAMI, the California Network of Mental Health Clients, and the local Mental Health Clients for Wellness and Recovery group.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Our successful experience with the AB2034 Homeless Integrated Services program (which targets 10%TAY) has demonstrated successful stakeholder collaboration with multiple community based organizations that include; homeless providers, mental health providers, justice and public safety sector entities, diversion providers, housing providers, the business community, faith based organizations and health providers. The success of this program lies in forging similar collaborations and partnerships to address the multiple needs of the homeless TAY. Some of these strategies include: weekly meetings with the Sheriffs' Department and Juvenile system designees to identify TAY clients in need of intensive services, in-reach at these facilities for screening and assessment during detention of TAY, care coordination with designated staff while client is in detention and discharge plan for re-entry into community.

Additionally by collaborating with Children's Welfare Services, Children's Mental Health Services and foster care services we shall help 16 & 17 year old TAY to avoid becoming homeless. One such strategy will be our plan to have this program link with the transition planning done for youth aging out of our Children's Services. Currently they hold monthly meetings for discharge planning of TAY and our ACT team shall participate in these meetings providing another resource for this population. This group tends to include a large population of Latinos, African Americans, Native Americans and a few Asian Americans, contractor of this program shall ensure that these communities are served. Strategies to support the employment and education goals include collaborations with Community Colleges, to develop apprenticeships and connect to Trade Schools, High Schools connecting to GED programs and the business community. By collaborating and partnering there will be system improvements in the delivery of care, in the reduction of inappropriate use of services and

a reduction in costs for the community. The integrated ACT model of practice has been well documented as evidence based practice and has demonstrated positive outcomes related to reductions in hospitalizations, incarceration and homelessness.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The ACT model is an evidenced based best practice of intensive case management that provides the varied services that our TAY require. In addition to mental health they will have the employment, housing, substance abuse and peer support that address the multiple issues faced by our TAY.

The program will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients in the geographic regions to be served, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County, will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

The Culturally Competent Clinical Practice Standards of SDCMHS: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The Practice Standards to be implemented in this program will be that the provider shall engage in a culturally competent community needs assessment and engage in community outreach to diverse communities based on the needs assessment. The program shall create an environment that is welcoming to diverse communities. The requirement that staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served with linguistic capacity and proficiency to communicate effectively with the population served. Use of interpreter services is appropriate

and staff is able to demonstrate ability to work with interpreters as needed. Training shall be provided to demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

Also staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.

Cultural factors shall be integrated into the clinical interview and assessment, and staff shall take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client. Additionally, Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning. When providing medications, Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing these services. Program shall also promote an environment that encourages staff to conduct self-assessments as a learning tool. Last but not least staff shall actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Though all racial/ethnic groups & genders are underrepresented for TAY, outreach efforts shall be directed to the homeless, justice system clients and those aging out of foster care. We currently have over 1,900 youths receiving mental health services in jail. Of the 11.5% of African American TAY receiving services, the majority are provided in jail or hospital settings. At this time 29% of the TAY receiving mental health services are Latino and the Latino poverty percentage is 41%, the Asian/Asian Pacific Islanders are underrepresented across all age groups. See our Gap Analysis report. This program will have a requirement that 33% of staff be bilingual and bicultural, our Peer Specialist positions will also be representative of the cultural population of those served in this program.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Our gap analysis indicates that both genders are underserved but contractor of this service shall describe efforts made to ensure females are served. The County provides training on sexual orientation yearly (with a specific TAY sexual orientation training available) and each of our trainings on cultural groups offers gender-sensitivity/gender differences as a

unique area of education. The provider of this service shall identify staff to attend these trainings. This program shall link those TAY who identify sexual issues to services such as Lesbian & Gay Center or the Stepping Stones program which serve these populations. This provider shall identify interventions that are gender sensitive and provide care coordination with physical health providers for any co morbid conditions (i.e., pregnancy or other physical health conditions). Though data is not available it is generally accepted that approximately 10% of the TAY population would have sexual orientation issues and that this population, recent research has reported, may have a higher percentage of mental health issues. In addition, the program will be required to serve females at a rate consistent with prevalence reports, with a particular emphasis on young women who have been abused and who demonstrate self-harm behaviors.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This service will be provided to those residing in San Diego County only. However, clients from San Diego residing in out-of-county long term care will be assessed for this service and their discharge plan may include enrollment in this program or other relevant TAY programs

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors Approval	December 2005
RFP statement of work circulated to community	January 2006
RFP Proposals due	March 2006
Contract to be Negotiated / Awarded	June-July 2006
Staff trained	July 2006
Services begin	July 2006

Expand enrollment of clients	July –January 2007
Fully implemented with full caseload	February 2007
Make adjustments to program operations based on program evaluation	July 2007

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Clubhouse & Peer Support Services
Program Work Plan #: TAY-2, linked with TAY-1 and TAY-3		Estimated Start Date: July, 2006

1a) Description of Program: A new member-run age-appropriate Clubhouse for Transition Age Youth (TAY) who have a Serious Mental Illness (SMI) and are in need of, social and recreational activities, skill development and employment and educational opportunities. The program will serve approximately 420 young adults countywide and be located in the North-Central region of San Diego County.

1b) Priority Population: Underserved TAY with a SMI, age 18-24, who would benefit from age-appropriate educational, vocational, social and recreational activities with other peer-members of their age group. In accordance with AB599, veterans are eligible for this program.

	1d) Fund Type			**1d)**Age Group			
1c) Identification of strategies for which you will be requesting MSHA funds for this program. 1d) Identification of the finding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a program.	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ The member-run TAY Clubhouse program will provide peer education and support, advocacy, employment and educational support services, skill development classes and social and recreational activities that are age-appropriate for TAY with a SMI. ✓ Peer specialists will facilitate wellness and recovery groups and classes such as Schizophrenia Anonymous; Dual Recovery Anonymous; advocacy regarding benefits; education about health services, educational, housing, life management and vocational resources; skill development classes in budgeting, shopping, cooking, laundry, grooming, rental agreements, dealing with landlords, roommates, and developing relationships, ✓ Employment Support Services will include resume writing, interviewing practice, appropriate dress, telephone courtesy, punctuality and appropriate employee behaviors; job linkages and job placement, long term job support club to share successes and problem-solve difficult job situations;	☐	☒	☐	☐	☒	☐	☐

✓ Referrals to physical healthcare providers ✓ Social and Recreational Activities will provide normalizing activities and socialization outlets to help members develop interests, hobbies, improved self-care, coping strategies, satisfying interpersonal relationships and appropriate behaviors.							

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

San Diego County Mental Health Services (SDMHS) through a competitive bidding process will contract with a community based organization to provide a program with the MHSA goals of providing employment, vocational training, pre-employment activities, education, a network of supportive relationships and meaningful use of time and capabilities by developing a new Clubhouse/Peer Support Services for underserved TAY with a SMI that addresses TAY-specific needs with age-appropriate activities to engage their interest and assist in their wellness and recovery from serious mental illness.

This program will serve TAY individuals with specific focus on the diverse population of the County and will address the needs of TAY from a cultural and gender specific focus. Members transitioning from foster care, the children's system of care, or other non- traditional living environments will be outreached and engaged to join the clubhouse. The program will address their educational, health, vocational and interpersonal needs. The goal and purpose of the TAY clubhouse will be to provide an environment where these young adults can relate to peers in a peer directed program which will support their development of self-sustaining skills, achieving and maintaining relationships, and sustaining housing and supportive employment. In the Clubhouse social, vocational, educational and recreational activities will support the TAY to identify their own directions and peer support. We have proposed that this clubhouse will serve approximately 420 TAY in a full year of operation.

Other MHSA TAY programs and existing TAY services will link and refer TAY to this Clubhouse in order to provide more opportunity for TAY to relate to others who share their experience, this will be helpful to decrease the stigma of mental illness for this population and provide normalizing activities to integrate the young adult in the community. In addition to our Clubhouse these clients shall be linked public Department of Rehabilitation, Job Options, Family Resource Centers,

Clinics (both physical and mental), educational programs, self help groups in the community and others identified as needed on an individual basis.

The program has been requested for the general area of our North Central Region for several reasons. In our gap Analysis process it was noted that a high population of our TAY reside or receive services in this region and there is not currently a Clubhouse in this region. Our contract shall specify that this site be easily accessible, and within 4 blocks of public transportation. The program will be open from 10 AM to 7 PM with the flexibility of hours when evening or weekend activities are planned. Additionally the members will have the opportunity to determine if these hours are the most appropriate for the Clubhouse activities, and may recommend changes.

Staffing composition may include a program manager who would manage program, staff and facility, three full time Activity Coordinators- (one bilingual) who would organize social, recreational, and educational activities, three employment Coordinators –(one bilingual) who would provide educational and employment support and one clerical support staff. These positions shall all be client or family members. One-time funding is included to cover training costs specific to this model. In addition, six weeks of program start-up funds are included in the budget request.

3) Describe any housing or employment services to be provided.

This program will not provide housing, however staff will provide linkages and referrals to existing housing opportunities. The program will have information available on housing programs or shared housing opportunities. Members will be assisted in sustaining housing by supporting the member in skill acquisition to sustain housing and live independently.

Employment opportunities such as temporary and transitional employment positions will be identified off site, and developed and provided on site for members, including pre-employment activities such as resume preparation and increasing interview skills. Job supports may include job coaching, skill development classes and job support clubs. . Services will include referrals for educational and vocational training programs. Program shall provide supportive employment services for their clients and may refer to specific additional vocational, pre employment & employment services offered at our other clubhouses plus other employment services shall be utilized such as Employment Services (a program under Department of Rehab), Job Options and the MHSA Employment services.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

NA; as this is not an FSP program.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Recovery is an individual goal that can be achieved through increased education and employment, and skill development, social and recreational activities. Recovery will be reinforced through the role models provided when peers achieve or maintain education, employment and community goals. Key staff in this program shall be those peers who improve and begin to provide support (either volunteer or paid) for new peers. Annual Clubhouse survey to measure increased self-sufficiency and empowerment. Clubhouse newsletter to document members' community outreach to those less fortunate, mutually shared Clubhouse activities and educational and employment adventures and successes. Employment and educational activities of members will be tracked by clubhouse and reported to the County Program Monitor.

Training and technical assistance will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This will be a new program and distinct from the other County Clubhouses.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Consistent with current Clubhouse programs, this new clubhouse program will be expected to recruit and hire clients and/or family Members to provide its services and supports. Additionally our clubhouses are encouraged to offer

opportunities for volunteers to participate in providing classes, groups or activities that members (or their families) desire. This program shall participate in our Clubhouse Directors meetings where issues, activities and opportunities are shared and support provided.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Clubhouse will collaborate with local institutions, businesses and companies to identify volunteer opportunities and paid employment positions for their members. Collaboration will include companies such as the City of San Diego City Works program, TJ Maxx, PetCo Park, and the San Diego SHARE program (who currently work with our clubhouses) and explore other businesses for more opportunities for Clubhouse members. Collaborations with ethnic student unions at our colleges/universities in San Diego shall be encouraged such as Asian American Student Union and Hispanic Federation. This program will also participate in the Clubhouse Directors meeting where all clubhouses share ideas, activities that are successful and less than successful to support one another. This program will collaborate with community college districts, adult education programs and the Dept. of Rehabilitation to provide educational training and employment supports. Collaboration with existing TAY programs such as North Inland Transition Age Youth services, our Foster Care providers, the local Psychiatric Emergency Response Team (PERT), plus drug and alcohol staff at the TAY Dual Diagnosis Residential Treatment facility (MHSA TAY 3 shall be maintained through regular meetings.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The program shall ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients in the geographic regions to be served, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County, will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

This program will require that all staff participate in sexual orientation trainings with a specific TAY sexual orientation focus and in gender-sensitivity/gender differences as a unique area of education. These trainings are offered by our County Training and Development Unit. In addition, this program will link those TAY who identify sexual issues to services such as Lesbian & Gay Center or the Stepping Stones program which serve these populations and to MHSA TAY outpatient enhanced services in all the regions of the county. Contractor for this program shall ensure that activities, classes or groups specifically for young women shall be offered at the clubhouse.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The Clubhouse is available to San Diego County residents and would be used as a resource for those TAY who are returning to the County after placement out of county.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors Approval	December 2005
Issue Request for Proposal	by March, 2006
Negotiate and Award Contract	by July 2006
Program staff hired	July 2006
Staff trained	July - August 2006
Begin services to clients	July, 2006
Review reports, suggest changes	October, 2006

Review program, make revisions or amendments	July, 2007

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: TAY Dual Diagnosis Residential Treatment Program
Program Work Plan: #TAY-3, linked to TAY-1, TAY-2		Estimated Start Date: July, 2006

1a) Description of Program: Comprehensive 24/7 residential dual diagnosis (mental health and substance abuse) services for Transition Age Youth (TAY) 18 to 24 y/o that are comprehensive, individualized, culturally competent and linguistically appropriate with integrated mental health and substance abuse services and supports. Clients will be accepted from all regions.

1b) Priority Population: TAY with a serious mental illness and substance abuse disorders, ages 18-24 years old, who are diagnosed with co-occurring serious mental illness and substance abuse. In accordance with AB599, veterans are eligible for this program.

	1d) Fund Type			1d) Age Group			
1c) Identification of strategies for which you will be requesting MSHA funds for this program. 1d) Identification of the finding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a program.	FSP	Sys Dev	O E	C Y	TAY	A	OA
✓ Dual diagnosis treatment in a residential facility on a voluntary basis; ✓ 12-bed capacity, 3 to 5 month average length of stay, if additional length of stay is clinically indicated, client will be extended; ✓ Integrated mental health and substance abuse treatment; ✓ A dual diagnosis best practice model will be used i.e., Comprehensive Continuous Integrated System of Care (CCISC) to be reflected in treatment planning and individualized service plan; ✓ Education/classes on substance abuse and mental health with the goal of supporting living successfully in the community; ✓ Mental health and recovery counseling groups; ✓ Peer support services; ✓ Care coordination, skill development, supportive educational and supportive employment services with an overall emphasis on building	☒	☐	☐	☐	☒	☐	☐

independent living skills; ✓ Clients referred from TAY 1 (Intensive Case Management) shall be linked back at discharge, other clients will be assessed for level of need and if appropriate will be referred to any of the MHSA –TAY proposed services; ✓ Linkage and care coordination with physical healthcare providers/health insurance plans.							

NOTE: THIS PROGRAM HAS BEEN CHANGED FROM ORIGINAL CSS SUBMISSION. THIS RESIDENTIAL PROGRAM IS LINKED TO THE HOUSING AND SUPPORT SERVICES IN MHSA FUNDED TAY-1. SERVICES SHALL BE ONGOING FOR AS LONG AS INDIVIDUAL CLIENTS MAY REQUIRE THEM. BOTH TAY-1 AND THIS PROGRAM WILL BE OPERATED BY THE SAME CONTRACTOR.

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

SDMHS will contract with a community based organization to provide a comprehensive 24 hour residential dual diagnosis services for 36 TAY, ages 18 -24, with individualized, culturally appropriate and integrated services and supports. The program will use the Comprehensive, Continuous, Integrated System of Care (CCISC) model an integrated and comprehensive treatment, training and administrative approach that supports the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis -specific and stage-specific treatment for each disorder.

This model is based on the following 8 clinical consensus best practice principles: 1) dual diagnosis is an expectation, not an exception and the interaction with the client shall be welcoming 2) the treatment relationship is empathic, hopeful, continuous 3) treatment services can be planned by using the four quadrant national consensus model for system level planning 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced 5) each disorder should be considered equally important and integrated dual primary treatment is required 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions 7) there is no one type of dual diagnosis program or intervention that is correct, treatment services are matched to client needs 8) outcomes are individualized

The program shall provide services that include rehabilitation & recovery services (such as individual & groups educating and supporting TAY), care coordination, individualized client-directed services, supported employment/education, and peer support services. The program shall develop community collaborations to provide employment and housing linkages and options for transition to independent living and employment. This program will also follow the MHA Village TAY model that offers a youth-oriented, teaching, "discovery" model of services. This model will be provided by directing staff of this program to participate in the TAY Academy Immersion training at MHA Village in Long Beach, California. This training shall instruct staff in: 1) TAY Matrix –an assessment tool to evaluate communities and providers' strengths and weaknesses in their capacity to support transition age youth, 2) Developmental appropriateness of supports - The importance of assessing functional/behavioral strengths and deficits from a perspective that is age appropriate 3) Engagement strategies – Discussion of the development of a youth-oriented, welcoming culture 4) Service approaches – focus on teaching/mentoring vs. case-management 5) Career development –presentation on supported education and supported employment 6) Housing continuum-identification of gaps in the housing array and potential solutions 7) Community living skills – approaches to the teaching/mentoring of life skills 8) Wellness- strategies to inspire and nurture life dreams of transition age youth and to identify barriers such as psychiatric symptoms, drugs and alcohol, and lack of skills 9) Discussion/process groups – exploration of the common struggles and value conflicts that arise when working with transition age youth. The groups emphasize storytelling by providers and members.

The program shall hire a minimum of 2 peer positions and contractor shall assure that program staff includes qualified individuals with experience as clients or family members of mental health clients, or substance abusers in recovery, in all positions that they qualify for. Peer support specialists can be tremendously valuable in promoting hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. The program will encourage its clients to link with client-operated services, including the TAY clubhouse, other local clubhouses and the to-be-established MHSA Client-Operated Peer Support Services Program.

This program is designed as an integrated piece of the TAY services in our County, with the three MHSA programs TAY 1, 2 & 3 contracted together under one community based agency. This will support strong linkages within these three programs to provide the full range of services that our TAY clients with SMI, and substance abuse, often require. Referrals will come from MHSA 1 or 2, other TAY mental health programs, Children's mental health providers, Justice system and youth transitioning from foster care. Clients shall be assessed for level of need at discharge and will return to TAY 1 for Intensive Case Management or may be referred to any of the MHSA-TAY proposed services.

3) Describe any housing or employment services to be provided.

Clients in the program will be housed during the treatment phase and as part of discharge planning continue treatment and receive support in improving or maintaining their housing options with MHSA TAY 1 (ACT Team). When planning discharge linkages and placement to housing options (such as local Housing Authorities, listing of affordable housing and listings of room mate situations) shall be considered if appropriate. Clients shall be provided pre-employment assessment, employment supports, job readiness and job linkages provided by the program Employment specialist who may utilize the groups, tools and services of the TAY Clubhouse (or our other County Clubhouses or Employment services which is linked to Department of Rehabilitation). The Employment Specialist will work with the TAY on assisting the TAY in obtaining and maintaining supported employment and could continue to be a resource during his aftercare period and this effort shall be supported by the TAY 1 program should the client continue in treatment there.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Average cost for each participant is $275.65 per day, includes services and housing this cost for a 120 days average length of stay is $33,078.00.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. **Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

Rehabilitation and recovery interventions are client directed and embedded with service array to include; individualized wellness and recovery action plan (Copeland's WRAP), skill development, peer supports, social and recreational supports, supported employment, supported education and linkages to housing options will provided. These components will advance MHSA goals by providing client directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, contact with the justice system and reducing inappropriate use of acute inpatient care and medical care. Service delivery by consumers ensures recovery goals are continuously reinforced. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery.

TAY will also be linked to MHSA TAY clubhouse and aftercare groups that will focus on further developing and sustaining skills learned while at the residential treatment program, to support employment or educational goals and the aftercare and/or self help 12 step groups in the community (Alcoholics Anonymous, Narcotics Anonymous) shall be utilized to reinforce the progress made toward recovery from substance abuse.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This will be a new service. This program will be a system improvement that will provide dual diagnosis residential treatment specifically for the TAY population.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or ther entity.

A minimum of one Peer specialist will be hired and peer volunteers recruited as peer support and/or case aids to assist clients in their rehabilitation and recovery. Peers and family members shall be recruited to provide support/education groups, assist TAY in accessing needed services/ benefits and to participate in aftercare activities. Contractor shall assure that staff includes qualified individuals with experience as mental health clients or family members of mental health clients or substance abusers in recovery, in all positions that they qualify for. Peer support specialists can be tremendously valuable in promoting hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. The program will encourage its clients to link with client-operated services, including the TAY clubhouse, other local clubhouses and the to-be-established MHSA Client-Operated Peer Support Services Program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. **Explain how they will help improve system services and outcomes.**

Stakeholder collaboration with multiple community based organizations will be required and include; substance abuse providers, (such as MITE, Serenity House and Nosotros) mental health providers, (such as our providers who will be

receiving TAY funds under MHSA TAY 4) justice and public safety sector entities, such as Sheriff's Department, faith based organizations and community health providers. Outcomes related to this program include, reductions in substance use, reduction in psychiatric symptoms, reduction in inappropriate hospitalizations and contacts with the justice system. A close collaboration will be established with the MHSA TAY-2 Clubhouse and the MHSA TAY-1 Intensive Case Management program for services upon return from this residential treatment program. Outreach to student organizations (such as Hispanic Federation, NAACP, Tribal Star or Asian American Students) whose members might serve as role models and mentors, will be expected of our provider. These African American, Latino, Native American and Asian student groups could serve as role models and support for our clients, as well as providing learning experiences for the students.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The program will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients in the geographic regions to be served, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County, will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

Though all racial/ethnic groups & genders are underrepresented for TAY, outreach efforts shall be directed to the homeless, justice system clients and those aging out of foster care. We currently have over 1,900 youths receiving mental health services in jail. Of the 11.5% of African American TAY receiving services, the majority are provided in jail or hospital settings. At this time 29% of the TAY receiving mental health services are Latino and the Latino poverty percentage is 41%, the Asian/Asian Pacific Islanders are underrepresented across all age groups. This program has a requirement that a minimum of 5 FTE or 45% of staff are bilingual.

The Culturally Competent Clinical Practice Standards of SDCMHS: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent

practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.
The Practice Standards to be implemented in this program will be that the provider shall engage in a culturally competent community needs assessment and engage in community outreach to diverse communities based on the needs assessment. The program shall create an environment that is welcoming to diverse communities. The requirement that staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served with linguistic capacity and proficiency to communicate effectively with the population served. Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed. Training shall be provided to demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

Also staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.

Cultural factors shall be integrated into the clinical interview and assessment, and staff shall take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client. Additionally, Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.

When providing medications, Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing these services. Program shall also promote an environment that encourages staff to conduct self-assessments as a learning tool. Last but not least staff shall actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The County provides training on sexual orientation yearly (with a specific TAY sexual orientation training available) and each of our trainings on cultural groups offers gender-sensitivity/gender differences as a unique area of education. The provider of this service shall identify staff to attend these trainings. This program shall coordinate care and link when appropriate those TAY who identify sexual issues to programs such as Lesbian & Gay Center or the Stepping Stones

program which serve these populations. This provider shall identify interventions that are gender sensitive and provide care coordination with physical health providers for any co morbid conditions (i.e., pregnancy and other physical health conditions). Contractor shall ensure that efforts are made to offer services to young women in an appropriate and equal manner.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This service will be for San Diego County residents only and those who maybe returning from out of county placements would be assessed for this service.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors Approval	December 2005
Post RFP	by February 2006
Negotiate and Award Contract	July 2006
Identify and prepare program site	July, 2006
Program staff hired	July, 2006
Staff trained	July-August, 2006
Begin services to clients	August, 2006
Site review	by February 2007
Recommend changes/amendments	by April 2007

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Enhanced Outpatient Mental Health Services for Transition Age Youth (TAY)
Program Work Plan #: TAY-4		Estimated Start Date: July 1, 2006

1a) Description of Program: Enhanced outpatient mental health services for Transition Age Youth (TAY) who are unserved, have a serious mental illness (SMI), and are in need of age and developmentally appropriate mental health and rehabilitation and recovery services to include outreach and engagement, mental health services and peer supports provided by peer specialists.

1b) Priority Population: Persons served will be unserved TAY with a SMI ages 18 to 24 y/o including those who may have co-occurring substance abuse disorders of mental illness and substance abuse who are not utilizing mental health, rehabilitation and recovery services due to access barriers, lack of engagement or awareness about the types and benefits of services such as integrated treatment for co-occurring disorders and age appropriate services. In accordance with AB599, veterans are eligible for this program.

	1d) Fund Type			**1d)** Age Group			
1c) Identification of strategies for which you will be requesting MSHA funds for this program. 1d) Identification of the finding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a program.	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ This program will provide age and developmentally appropriate mobile outreach, engagement and mental health services, including rehabilitation and recovery services, to improve access to care for unserved TAY with a SMI (18-24 y/o), including those who may have co-occurring substance abuse disorders; ✓ Staff will provide rehabilitation and recovery services including evidence-based practices such as: integrated dual disorders treatment and illness management and recovery; ✓ Peer specialists will provide mobile outreach and engagement strategies that are age and developmentally appropriate to engage TAY ✓ Linkages and care coordination will be made to other services per TAY individual need to include physical healthcare providers	☐	☒	☐	☐	☒	☐	☐

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

The providers of this service shall be determined in 4 out of the 6 of the Health and Human Services Agency (HHSA) regions via competitive bidding process, as these services have been added to the reprocurement (that was previously planned) of these regional services. In the 2 remaining regions existing contracts will be amended to add these services. These 2 regions are contracted with community- based agencies who have served the County for over 25 years.

There are 11 Bio-psychosocial Rehabilitation (BPSR) programs that will receive MHSA expansion funding and shall hire staff and peer specialists to provide outreach and engagement, mental health assessment, rehabilitation and recovery services and support services to these TAY in the community. Approximately 470 TAY will be provided services and client referrals may come from Children's Mental Health Services, Children's Welfare Services, schools, family members, mental health providers and the justice system. These services shall include mental health assessment, medication monitoring, individual and group counseling, mobile capacity to outreach and engage TAY. Contractors will be required to partner in the transformation of the system and advance MHS goals through their involvement in planning and use of data. Contractors shall be required to demonstrate knowledge and application of the MHSA Gap Analysis when describing the target TAY population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities.

System transformation is not possible without greater client and family participation, another system advancement with MHSA funds will be the addition of peer opportunities to provide role models and mentors for our TAY population. Our current system has no specific TAY age group staffing requirements, so the 'face' of our service is not that of the TAY age group.

Services shall be client centered and culturally competent, age and developmentally appropriate using evidence-based practices. These services shall utilize Copeland's, Wellness and Recovery Action Plan (WRAP) model to promote recovery. Training and technical assistance will also include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills.

Rehabilitation and recovery services will include dual diagnosis evidence-based practices e.g., Comprehensive Continuous Integrated System of Care (CCISC) model for the treatment of co-occurring disorders. CCISC is an

integrated and comprehensive treatment, training and administrative approach that supports the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis -specific and stage-specific treatment for each disorder.

This model is based on the following 8 clinical consensus best practice principles : 1) dual diagnosis is an expectation, not an exception and the interaction with the client shall be welcoming 2) the treatment relationship is empathic, hopeful, continuous 3) treatment services can be planned by using the four quadrant national consensus model for system level planning 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced 5) each disorder should be considered equally important and integrated dual primary treatment is required 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions 7) there is no one type of dual diagnosis program or intervention that is correct, treatment services are matched to client needs 8) outcomes are individualized

These services shall be provided through the sites of the 11 Bio-psychosocial Rehabilitation (BPSR) mental health clinics. These services shall be linked to the new MHSA TAY services to be provided with MHSA funds; TAY Clubhouse, TAY Intensive Case Management and TAY Dual Diagnosis Residential Treatment Center. In addition, specialized services linkages to community services for housing, employment, education, physical health or benefit counseling shall be utilized. These services will advance the MHSA goals of providing timely access to needed help, including during times of crisis by providing age and developmentally appropriate mobile outreach, engagement, mental health and rehabilitation services.

3) Describe any housing or employment services to be provided.

While these system development funds for TAY out patient expansion do not directly provide housing or employment, they will support TAY identifying and working toward housing and employment goals and will include linkages to a variety of supports related to housing (e.g., local Housing Authorities; listing of affordable housing) and employment (e.g., Employment Services program; Department of Rehabilitation; clubhouses). In addition the TAY will be provided with an employment assessment, job linkages, long term job support, job counseling and job coaching. Pre-employment and employment services will be offered as part of the array of rehabilitation services they will receive at the outpatient program. TAY employment support services will also include linkage to educational and vocational training programs

primarily through the MHSA TAY Clubhouse (TAY # 2) though clients will have the option of utilizing any of other County funded clubhouses where we provide employment support services.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This is not a Full Service Program.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Rehabilitation and recovery interventions are client directed and provided in the service array, to include: individualized wellness, relapse and recovery action plans, skill development, peer supports, social and recreational supports, supported employment, supported education and supported housing. Training and technical assistance will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills.

These components will advance MHSA goals by providing client directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, reduce homelessness, contact with the justice system and reduce inappropriate use of acute inpatient care and medical care.

Recovery goals are embedded in the SDMHS outpatient mental health and rehabilitation programs. BPSR programs are currently monitored on a number of client outcomes including timely access to services; decrease in re-hospitalization, client satisfaction, achievement of planned vocational, educational and residential goals. In addition, for those clients with dual diagnosis goals, existing programs provide stage-wise treatment and monitor clients for the advancement in stages of treatment for co-occurring disorders of mental illness and substance abuse. Recovery is a personal journey and for TAY clients this would mean identifying their needs, developing a direction for their future, learning skills required for healthy lifestyle changes and making advancement on their transition to independent living. These components will advance MHSA goals by providing client directed services that are individualized, reducing the effects of untreated mental

illness, increasing access to care for ethnically diverse individuals, reduce homelessness, contact with the justice system and reduce inappropriate use of acute inpatient and primary health care

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

SDMHS is expanding 11 BPSR Outpatient clinics (where licensed mental health workers provide mental health services in a clinic setting Monday-Friday, 8 to 5) by amending or reprocuring contracts to add specific services for TAY. The existing BPSR programs provide mental health assessment, medication monitoring, individual and group therapy in a recovery and rehabilitation model, dual diagnosis assessment and treatment, employment screening and job support in a limited capacity. These programs support the empowerment of mental health clients to participate in the community, develop more normal lifestyles and educate themselves on the opportunities for volunteer or paid employment they might consider. Our amendments or new contracts shall include the outreach service of a team, clinician and peer support staff, who will engage the TAY clients in the community to establish the relationship ensuring our TAY make the transition to Adult services. These TAY may come from Children's Mental Health Service providers, Children's Welfare Services or the law enforcement system.

In regions where our gap analysis identified a gap for the Latino TAY population (North Coastal, North Inland, Central and South Regions) contractors shall be required to provide staff who are bilingual/bicultural and Peer specialists who could engage these TAY who are unserved and provide more appropriate services for those underserved.

Our current provider for Asian/Pacific Islanders (UPAC) will receive additional funding to increase the services provided for Asian/PI TAY clients that will be more age appropriate and developmentally appropriate. This provider serves all regions for this specific population and their MHSA funding shall cover the hiring a specially trained clinician and peer staff (minimum of .5), for outreach services for this population.

The providers of this service shall be determined in 4 of our Regions by our competitive bidding process, as these services have been requested in the reprocurements (previously planned) of these regional services. In 2 Regions that have already been reprocured we shall amend their contracts to add these services. Our plan has proposed funds for each of the 11 sites to receive funds (these amounts shall vary by location and population identified in the gap analysis report) to provide a team of one Clinician (or .5 FTE) and Peer Specialist (or .5 FTE) with some psychiatric and nursing

support to engage the TAY population in outpatient services in an age appropriate manner and to outreach into the community where the TAY population are located.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

San Diego County Mental Health encourages programs to hire clients wherever feasible. Persons with client experience (or persons in recovery from substance abuse) shall be hired as peer specialists, who will promote successful outreach efforts to this population and provide other peer support activities. Some of the services that could be provided by these Peer Specialists include peer education, peer support groups, assisting team members as case aides, mentoring and role modeling. Additionally peers and family members shall be involved in volunteer roles to support whenever appropriate and with approval of our TAY clients. It is anticipated that clients of these services shall be linked (transportation provided) to many activities in the MHSA TAY Clubhouse (TAY-1) or any of our other County funded Clubhouses. Our training efforts include family's providing education services to others through our Family-to-Family education program. The program is expected to collaborate and link with other client-run organizations such as NAMI, the California Network of Mental Health Clients, and the local Mental Health Clients for Wellness and Recovery group.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. **Explain how they will help improve system services and outcomes for individuals.**

This program will collaborate with the San Diego Community College district (& other CC districts in County), (through the Disabled Student Services Department), adult education programs and the Department of Rehabilitation to provide educational and employment supports. By collaborating with multiple community based organizations such as The MHSA TAY Clubhouse shall be a primary partner with these outpatient service providers. Through the TAY clubhouse TAY clients shall have linkages to the Latino Federation, NAACP, Tribal Star, Asian Students Union and other specific diverse population student groups to provide role models and mentors.

The success of this program lies in forging collaborations and partnerships to address the multiple needs of the homeless TAY. Some of these strategies include: weekly meetings with the Sheriffs' Department and Juvenile system designees to identify TAY clients in need of intensive services, in-reach at these facilities for screening and assessment during

detention of TAY, care coordination with designated staff while client is in detention and discharge planning for re-entry into community. Additionally we propose care coordinate with other contract providers that their clients might need including mental or physical health, employment, drug and alcohol providers

Additionally by collaborating with Children's Welfare Services, Children's Mental Health Services and foster care services we shall help 16 & 17 year old TAY to avoid becoming homeless.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Cultural competence and sexual orientation and gender sensitivity are required expectations of our current providers, are integrated in our current service delivery system and will be a requirement in all MHSA programs as well. Services for these TAY will be provided in the required threshold languages of the county. Service providers will possess cultural awareness, knowledge and skills necessary to provide culturally competent services through experience, trainings or by participating in the new educational opportunities that MHSA will fund.

The program will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients in the geographic regions to be served, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County, will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

The Culturally Competent Clinical Practice Standards of SDCMHS: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The Practice Standards to be implemented in this program will be that the provider shall engage in a culturally competent community needs assessment and engage in community outreach to diverse communities based on the needs assessment. The program shall create an environment that is welcoming to diverse communities. The requirement that staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served with linguistic capacity and proficiency to communicate effectively with the population served. Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed. Training shall be provided to demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

Also staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.

Cultural factors shall be integrated into the clinical interview and assessment, and staff shall take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client. Additionally, Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.

When providing medications, Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing these services. Program shall also promote an environment that encourages staff to conduct self-assessments as a learning tool. Last but not least staff shall actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

The TAY Outpatient services under this workplan shall increase the services to TAY in general as this group is underserved or inappropriately served and all racial/ethnic groups & genders are underrepresented for TAY. This program shall provide outreach efforts directed to the homeless, justice system clients and those aging out of foster care. We currently have over 1,900 youths receiving mental health services in jail. Of the 11.5% of African American TAY receiving services, the majority are provided in jail or hospital settings. At this time 29% of the TAY receiving mental health services are Latino and the Latino poverty percentage is 41%, it is noted that the Asian/Asian Pacific Islanders are underrepresented across all age groups.

This TAY expansion service can outreach through MOU's with the justice system to increase successful referrals by connecting with this population prior to release from their facilities. This enhanced service shall have the resources to do outreach and engagement to this population in ways that our current outpatient services do not.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

In addition to the items in #9 , which include age & gender-sensitivity, our county offers a specific TAY training to providers on a regular basis on Sexual Identity Issues of Young Adults plus each of our cultural trainings contain a section on the sexual/gender differences of that specific culture. Assessment of clients includes sexual orientation (& domestic violence) with the requirement that appropriate treatment and/or referrals be provided. Research has indicated that the rate of psychiatric disorders for homosexually active people compared to heterosexuals is higher. Referrals and linkages where appropriate will be made to services that are gender-specific or relevant to needs relating to sexual orientation, such as referrals to the Rachel's Women's Center or the San Diego Lesbian, Gay, Bisexual and Transgender Community Center. Technical assistance and consultation will also be sought from these programs.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This program will be focused on in-county residents but could be accessed by individuals returning to county after out-of-county placement.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors Approval	December 2005
RFP posted (Programs North/Central & No Central)	February, 2006

Amendments completed (East & South sites)	by May, 2006
Contracts awarded (North/Central & No Central)	by May, 2006
Program staff hired and trained	July, 2006
Begin services to clients	July 2006
Review reports of programs	by January 31, 2007
Suggest amendments to contract	by March 1, 2007
Amend contract	by July 1, 2007
Continue to review and improve	by July 1, 2007

ADULT AND OLDER ADULT MENTAL HEALTH SERVICES

COMMUNITY SERVICES AND SUPPORTS EXHIBIT 4 OVERVIEW

Since 1999 Adult and Older Adult Mental Health Services (AOAMHS) has initiated a system redesign initiative in San Diego County. This transformation was initiated with the broad collaboration and partnership of multiple clients, advocates and community stakeholders. The 1999 Board of Supervisors approved System Redesign Plan was anchored in biopsychosocial rehabilitation and recovery (BPSR) practices. The plan integrated the philosophy, principles and practices of rehabilitation and recovery into an existing medical model of practice. The System Redesign Plan included a significant overhaul of the Adult and Older Adult System of Care (AOASOC) by reprocuring all outpatient mental health core services in each of the six Health and Human Services (HHSA) regions, and added system of care initiatives that included the development of older adult mental health services, transition age youth services, integrated co-occurring disorders services, and development of supported housing and employment services.

The following are examples of the AOASOC transformation to date and they include:

- ✓ From 1999 to 2004, the number of Clubhouses rose from 7 to 10, with a new emphasis on recovery and employment services added to contracts.
- ✓ Since 1999 intensive training has been provided to county and contracted organizational providers on biopsychosocial rehabilitation and recovery philosophy and practices, geriatric mental health, co-occurring disorders, transition age youth, supported housing and supported employment services.
- ✓ Since 1999, client and family participation in all aspects of the system of care has been increased with over 66 clients have been hired in the mental health system.
- ✓ Documentation of clients with co-occurring mental health and substance abuse disorders has risen from 19% of clients in FY 1999-2000 to 25% of clients in FY 2004-2005
- ✓ In FY 2000 - 2003 strategic plans and initiatives were developed for older adults, transition age youth, co-occurring disorders, housing and employment services.
- ✓ In FY 2000 -2001, San Diego County successfully obtained a three-year $10,000,000 competitive grant to develop AB2034 Integrated Homeless Services for homeless persons with a serious mental illness or co-occurring disorders. The AB2034 continues in operation to date.
- ✓ In FY 2001-2002, a new Older Adult Coordinator county position was added to the AOASOC to develop the system of care for older adults and the Older Adult Taskforce was established to inform and advise the Mental Health Director in that development.

- ✓ In FY 2001- 2005, core mental health services were reprocured in 4 of the 6 HHSA regions which integrated BPSR practices in the delivery of care by contractually mandating: mental health services for older adult, transition age youth, co-occurring disorders, housing, and employment service.

- ✓ In FY 2002- 2003, a partnership with UCSD created the Research Network Development Core (RNDC) for Older Adults with Psychosis, which has advanced research and clinical practices with older adults and facilitated the development of the older adult system of care.

- ✓ In FY 2003 –2004 in partnership with UCSD's RNDC we developed a four-part educational Wellness, Prevention and Education campaign for mental health stakeholders and the aging network that included educational segments on mental health and wellness in older adults, age appropriate integrated mental health assessment, medication adherence in older adults
and evidence based practices.

- ✓ In FY 2003 –2004 two Senior Peer Counseling projects where initiated. One in English and one for monolingual Spanish-speaking older adults.

- ✓ In FY's 2003- 2005, long term care bed capacity was reduced and additional community based intensive case management services for 45 clients was implemented.

- ✓ In FY 2003 –2005, Seven, Day Treatment programs were discontinued and Clubhouse services were augmented in four regions, which included the development of a new Clubhouse.

- ✓ In FY's 2003- 2005, long term care bed capacity was reduced and additional community based intensive case management services for 45 clients was implemented.

- ✓ In FY 2003 –2005, Seven, Day Treatment programs were discontinued and Clubhouse services were augmented in four regions, which included the development of a new Clubhouse.

- ✓ In FY 2004 - 2005 county operated outpatient clinics and case management services where competitively reprocured and BPSR integrated services as well as older adult, transition age youth, co-occurring disorders, homeless and employment services were required in the delivery of care.

- ✓ As of FY 2004-2005, over 25 mental health programs (including Children's and Adult/Older Adult Mental Health and Alcohol and Drug Services programs) have been trained in an integrated approach to treat co-occurring disorders.

- ✓ In FY 2005 - 2006 the last remaining two regions are in process of being reprocured with BPSR, older adult, transition age youth, co-occurring disorders, homeless and employment services mandated services.

- ✓ In FY 2005 – 2006 in partnership with UCSD, RNDC we have 22 active older adult research protocols and have completed the Older Adult Needs Assessment and the Utilization and Cost Analysis for Older Adults.

- ✓ In FT 2005 – 2006 wait times for a routine appointment has reduced from over 14 to less than 10 days on average.

The Mental Health Services Act (MHSA) provides an unprecedented opportunity to add new services and expand existing services for transition age youth, adults, older adults. We look forward to narrowing the gap for individuals, who have been unserved, underserved, inappropriately served and have experienced health care disparities- particularly those who are ethnically diverse in our community.

The Mental Health Services Act (MHSA) will increase and enhance services in the AOASOC in the following ways:

- ✓ Increase outpatient, mental health, rehabilitation and recovery services and intensive case management services for Transition Age youth (TAY), adults and older adults who have a serious mental illness, are ethnically diverse and experience health care disparities, are unserved, underserved and inappropriately served, and have been in the justice system, are high users of emergency care, and are isolated and homeless or at risk of homelessness.

- ✓ Provision of supportive housing to include an array of short-term emergency housing, transitional and permanent supportive housing.

- ✓ Provision of culturally and linguistically competent rehabilitation and recovery services and programs to include family education on mental illness and access to care, enhanced outpatient and rehabilitation services, enhanced employment services in clubhouses, supportive employment services, peer support services, and integrated primary health care and mental health services.

- ✓ Provision of age and developmentally appropriate services for TAY and older adult individuals with a serious mental illness.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Homeless Integrated Services and Supported Housing
Program Work Plan #: A-1		Estimated Start Date: July 2006

1a) Description of Program: This Full Service Partnership program will provide comprehensive individualized, integrated culturally competent services in North Inland, North Coastal, North Central & Central regions for homeless persons who have a serious mental illness and may also have co-occurring disorders of mental illness and substance abuse. The program will integrate outreach, engagement, 24/7 intensive case management/wraparound services, community-based mental health treatment services, working with the justice system as needed, and rehabilitation and recovery services (i.e., supported employment/education, supported housing, peer support, transportation support, expanding natural supports, empowerment), and probation services. This program advances the MHSA goals to reduce incarceration and institutionalization, to increase meaningful use of time and capabilities, to reduce homelessness and to provide timely access to needed help by providing intensive wraparound treatment, rehabilitation and case management services to at least 324 unduplicated adults each year, through provision of services following the SAMHSA Evidence-Based Practice of Assertive Community Treatment (ACT) in combination with provision of an array of housing options (e.g., Single Room Occupancy, transitional shelter, Board & Care, permanent housing). A continuum of housing options will be provided to include short-term housing, transitional and permanent supported housing. Note: This program will be divided into two components: (1) services for the Central and North Central regions; and (2) services for the North Inland and North Coastal regions.

1b) Priority Population: Services will be provided to adults age 25-59 years old who have a diagnosis of serious mental illness and are homeless or at risk of becoming homeless, and who are unserved or underserved or are high users of acute inpatient care and medical services. Priority for admission will be given to those persons with the most severe illness and the highest incidence of homelessness and/or County mental health service. In accordance with AB599, veterans ineligible for federal VA services may be eligible for this program. Special attention will be paid to persons who are unserved and not receiving mental health services, with an emphasis on active outreach to and engagement with these persons as well as to unserved persons with serious mental illness who are African-American or who are women.

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Regional ACT services, with two 112-person ACT Teams serving persons in the Central and North Central regions, and one 100-person ACT Team serving persons in the North Inland and North Coastal region; ✓ Community-based, integrated, comprehensive, individualized wraparound services, provided 24/7 by the ACT Teams; ✓ Probation officers will be embedded in the teams to address justice system issues and provide justice-related case management services; ✓ Services include outreach and engagement, mental health services, intensive case management, rehabilitation and recovery services, care coordination, skill development, supported education, supported employment, and housing supports; ✓ Staff will be trained to utilize recovery-oriented practice, including but not limited to Deegan's Intentional Care standards and Copeland's Wellness Recovery Action Planning (WRAP) ✓ Linkage and care coordination with physical healthcare providers; ✓ Staff to consumer ratio is approximately 1 to 10; ACT Team members share responsibility for the treatment, support and rehabilitation services; ✓ Includes comprehensive and integrated mental health and substance abuse services and individualized treatment/service plan with client centered treatment planning; ✓ 200 housing units (138 for Central and North Central Regions, and 62 for North Inland and North Coastal Regions) to be developed for clients in this program. An array of housing options, developed via one-time-only funds, will be provided to include a variety of short-term and long-term housing options: short-term stays at shelter, Single Room Occupancy (SRO), Board and Care (B&C), subsidized housing and/or master leasing; ✓ All services will serve clients with both mental illness and substance abuse disorders.	☒	☐	☐	☐	☐	☒	☐

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

San Diego County Mental Health Services (SDCMHS) will contract with a community-based organization to provide integrated mental health, rehabilitation and recovery services, utilizing Assertive Community Treatment (ACT) Team services to serve persons with serious mental illness and who are homeless. This service will cover the County's North Coastal, North Inland, North Central and Central geographic areas, and is charged to do 'whatever it takes' to support people in the community and help them work toward their recovery goals. ACT is an evidence-based practice that has repeatedly demonstrated its effectiveness with people who have serious mental illness who have not been adequately served by the usual service system. SAMHSA's ACT Implementation Resource Kit (2003) describes:

> "Assertive community treatment (ACT) is a way of delivering comprehensive and effective services to individuals who are diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. At the heart of ACT is a trans-disciplinary team of 10 to 12 practitioners who provide services to approximately 100 people. Services are delivered directly by the team as opposed to being brokered from other agencies or providers. To ensure that services are highly integrated, team members are cross-trained in each other's areas of expertise to the maximum extent possible. Team members collaborate on assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure each person receives the services he or she needs to support his or her recovery from mental illness.
>
> The course of recovery from severe mental illness and what it means to have a life that is not defined by a severe mental illness differs among people. Consequently, ACT services are highly individualized and there are no arbitrary time limits on the length of time an individual receives services. Most services are provided in vivo, that is, in the community settings where problems may occur and support is needed rather than in staff offices or clinics. By providing services in this way, people get the treatment and support they need to address the complex, real world problems that can hinder their recovery. Each person's status is reviewed daily by the team so the nature and intensity of services can be adjusted quickly as needs change. At times, team members may meet with a person several times a day, but as the individual's needs and goals change, the nature and frequency of contacts with the individual also change."

Services to be provided include outreach and engagement, 24/7 intensive case management/wraparound services, community-based outpatient mental health services (including medication management, individual therapy, and group

therapy as needed), rehabilitation & recovery services (including skill and resource development in acquiring and sustaining housing/employment/educational/social goals), supported employment, supported education, and peer support services. Program will serve 100 clients in North County, and 224 clients in the Central/North Central region of San Diego, and the vast majority of services will be delivered through outreach to the client. Referrals will primarily come from programs that serve the homeless, including the police, and extensive outreach and engagement with persons who are homeless is a core component of connecting with clients.

The Comprehensive Continuous Integrated System of Care (CCISC) treatment model will be integrated with the ACT Team model and will be used for clients with co-occurring disorders of mental illness and substance abuse. CCISC is an integrated and comprehensive treatment, training and administrative approach that supports the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis-specific and stage-specific treatment for each disorder. This model is based on the following eight clinical consensus best practice principles: 1) dual diagnosis is an expectation, not an exception, and the interaction with the client shall be welcoming; 2) the treatment relationship is empathic, hopeful, continuous; 3) treatment services can be planned by using the four quadrant national consensus model for system level planning; 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced; 5) each disorder should be considered equally important and integrated dual primary treatment is required; 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions; 7) there is no one type of dual diagnosis program or intervention that is correct, and treatment services are matched to client needs; and 8) outcomes are individualized.

One-time funds are included in the first year for training and materials costs associated with model implementation and training, including technical assistance and consultation on ACT, Copeland's Wellness and Recovery Action Plan and Deegan's Intentional Care Guidelines. These components will advance MHSA goals by providing client-directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, reducing homelessness, reducing contact with the justice system and reducing inappropriate use of acute inpatient care. In addition, this program will advance rehabilitation and recovery practices that assist clients in their recovery, in self-sufficiency and in seeking and sustaining employment. Six weeks of program start-up funds are included in the budget request.

Staff will reflect the evidence-based practice model's recommended staffing pattern, and will include a team leader, a program assistant, psychiatrist, and a variety of mental health professionals that will include the specialty functions of

nursing, employment specialist, peer specialist, substance abuse specialist. At least six FTE peer specialists will be part of this team. Approximately one-third of the staff is expected to be bilingual. The program will have a Program Advisory Group (PAG) that consists of at least 51 percent clients to advise the program on the implementation of recovery-oriented services.

3) Describe any housing or employment services to be provided.

In Allness and Knoedler's "A Manual for ACT Start-up (2003)," they state, "One of the most important needs for all persons is safe, comfortable, and affordable housing. In traditional treatment, persons with severe and persistent mental illnesses live in institutions or in specialized housing. In the ACT model, persons with severe and persistent mental illnesses can successfully live in normal housing with frequent and consistent team contact. The ACT team helps clients find and reside in the kind of housing situations which best meet their needs at any particular time." Housing specialists are embedded in the ACT Team model.

According to the San Diego Gap Analysis, it is estimated that approximately 4,000 homeless individuals with serious mental illness reside in San Diego County; over 60 percent of these people may have co-occurring disorders of mental illness and substance abuse. It is estimated that there are approximately 2,765 adults per year with serious mental illness who were homeless or may have been homeless during the year and were underserved or inappropriately served by the mental health system. The highest concentration of homeless persons is in the Central and North Central regions and in the North County regions of San Diego. This program will address homeless needs in these regions. Based on statistics taken from the InSyst system, African Americans who are homeless, are overrepresented in mental health services. The MHSA supportive housing program will be required to address this disparity by ensuring that housing services are provided to African Americans. As affordable housing for persons with very low income is a huge challenge in San Diego, the Contractor will develop an array of supported housing that will include approximately 200 units (138 units in the Central and North Central Regions, and 62 units in the North Inland and North Coastal Regions) for clients in this program. Housing options that the Contractor may develop include: temporary stay in short-term housing; transitional supported housing to include a variety of short-term and long-term housing options including short-term stays at shelter, Single Room Occupancy (SRO), Board and Care (B&C); subsidized housing; and/or master leasing. Multiple approaches will be considered (e.g., scattered housing, clustered housing, and mixed use housing). One-time funds ($2,640,000) will be used to develop the housing capacity during the three years of this program. Housing development strategies will be shared and efforts will be coordinated among the Full Service Partnership programs (A-1, A-2, TAY-1, and OA-1). Capital Facilities funding, when available, will be considered for ongoing permanent housing capacity development.

The ACT Teams will have employment services provided by employment specialists embedded in the teams and will provide an array of supportive employment services including job readiness, job supports and job placement. SAMHSA's ACT Implementation Resource Kit (2003) states: "ACT emphasizes work and vocational expectations for all consumers, while accepting individual differences in capacity and interest in competitive employment…The team's employment specialists are responsible for providing the majority of employment services. They are also responsible for directing and teaching other team members to participate in carrying out individual consumer employment plans. Persons with severe mental illnesses rarely lose jobs because they do not have the skills for the job. More often, jobs are lost because mental illness and related symptoms and behavior affect job performance. For this reason, the assessment process includes a careful review, not only of the consumer's education and past work experience, but also of the specific behaviors or other issues that have been problematic on the job. Initially, many consumers indicate that they do not want to work or that they are unable to work. In addition, because staff cannot predict how well a person is going to do in employment, they may be hesitant to help consumers find jobs. To overcome both consumer and staff resistance or apprehension, it is critical for the employment specialist and all the team members to work together to encourage, support, and provide consumers with opportunities to try work." Some clients may want to access other employment supports, such as the Department of Rehabilitation or the Regional Clubhouses, and the ACT Team will support those efforts.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Average cost per client/per year without the housing is $12,000. $2,640,000 in one-time funds will be utilized to develop and subsidize 200 housing units for clients in this program at a cost per client of $13,200.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Persons with serious mental illness who are homeless usually have experience with tremendous loss and trauma, and the focus on resiliency is critical to help them travel the path of recovery. This service will be recovery-oriented and strengths-based. Probation services will work closely with the team, to address the complex issues that may be involved in resolving outstanding justice system issues that pose barriers to recovery.

Rehabilitation and recovery interventions are client-directed and embedded with the service array to include: wellness and resiliency focus, individualized wellness and recovery action plan (Copeland's WRAP), skill development, peer supports,

social and recreational supports, supported employment, supported education and supported housing. One-time funds are included for training and technical assistance, which will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills. The ACT Teams will incorporate peer specialists who can serve as role models, and will provide support in the critical areas of housing, work, school, relationships, recreation and meaningful activities. Training on and technical assistance with the ACT model will also occur, and will incorporate the values of empowerment and recovery in the delivery of services. Program evaluation, outcomes, and client satisfaction surveys as well as client focus groups will be some of the strategies that the program will use to ensure adherence to recovery principles and practices. In addition the Program Advisory Group (PAG) will oversee, monitor and provide input and feedback on the implementation of this program.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program, and the contractor will be identified through the Request for Proposal process. While it will provide the bulk of services directly to its clients, it will also provide referrals and establish linkages to relevant programs and services, such as local clubhouses and primary care medical providers.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Contractor shall assure that ACT Team staff includes qualified individuals with experience as mental health clients or family members of mental health clients, and shall employ a minimum of six FTE staff (these could be shared positions of 10 or more hours per week) to serve as ACT Team Peer Specialists. Contractor will positively consider identified personal client and/or family mental health experience as valuable experience for persons to be hired in any staff position. Peer support specialists can be tremendously valuable in promoting hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. The program will encourage its clients to link with client-operated services, including local clubhouses and the to-be-established MHSA Client-Operated Peer Support Services Program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Our experience with the AB2034 Homeless Integrated Services program has demonstrated successful stakeholder collaboration with multiple community-based organizations that include: homeless providers, mental health providers (including clubhouses), justice and public safety sector entities, housing providers, the business community, faith-based organizations and health providers. The success of this program lies in forging those same collaborations and partnerships to address the multiple needs of the homeless. By collaborating and partnering there will be system improvements in the delivery of care, in the reduction of inappropriate use of services and a reduction in costs for the community. Such collaborations include the Homeless Outreach Team (HOT), the Psychiatric Emergency Response Team (PERT), Inpatient Units and Emergency Room Units, the Sheriff's Department, the San Diego Police, and the Probation Department. Homeless providers that this program will partner with include St. Vincent de Paul, the Rescue Mission, Veteran's Services, Alpha Project, Rachel's Women Center, and Volunteers of America. This program will also collaborate and work with the MHSA Housing Consultant Contractor to identify and develop the array of housing options mentioned above.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

While it is critically important to recognize the individual differences and unique needs of every person served, persons with serious mental illness who have been homeless often share experiences of poverty, victimization, trauma and loss of valued role. Cultural competence and understanding of differences are required expectations of our current providers and are integrated in our current service delivery system and will be a requirement of this program as well. At least a third of the staff is expected to be bilingual, and interpreter services will be obtained as necessary. The ACT Team model has demonstrated effectiveness with persons with serious mental illness and with persons who are homeless, and is seen as an excellent model for service. Staff will possess cultural awareness, knowledge and skills necessary to provide culturally competent services, particularly to eligible African-Americans and women who are unserved, underserved or inappropriately served, as is recognized that African Americans tend to be inappropriately served (e.g., more likely to receive a diagnosis of schizophrenia; receiving a higher rate of mental health services in jail, and fewer outpatient services in several regions, than predicted by prevalence data) and women tend to be underserved by our mental health

system. Our gap analysis notes that “African Americans who are homeless are overrepresented in mental health services,” and this program will address this disparity through active outreach to African Americans who are homeless and have serious mental illness.

Contractor shall assure that ACT Team staff includes qualified individuals with experience as mental health clients or family members of mental health clients, and shall employ a minimum of six FTE staff (these could be shared positions of 10 or more hours per week) to serve as ACT Team Peer Specialists. The Contractor will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients in the geographic regions to be served, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County (Spanish, Vietnamese and Arabic), will arrange for language translation services when staff do not have the capability to speak a client’s language, using the County’s contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

The Culturally Competent Clinical Practice Standards of SDCMHS are to: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels. The Practice Standards that the program shall implement are:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
9) Cultural factors are integrated into the clinical interview and assessment.
10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
14) Staff actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The winning proposal's curriculum and program must evidence sensitivity to individual and cultural differences, including sexual orientation and gender, and training in these areas will be provided to staff. Referrals and linkages where appropriate will be made to services that are gender-specific or relevant to needs relating to sexual orientation, such as referrals to the Rachel's Women's Center or the San Diego Lesbian, Gay, Bisexual and Transgender Community Center.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This service will be provided in San Diego County. However, clients from San Diego currently residing in out-of-county long-term care facilities whose discharge plan indicates the need for supported housing and who would otherwise be homeless upon their return to San Diego County will be given priority for admission to this program.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors approval	December 2005
Requests for Information issued	December 2005
Request for Proposals issued	January 2006
Contract awarded	July 2006
Program manager hired	July 2006
50% of program staff hired	July-August 2006
Staff trained	July-August 2006
Begin services to clients	August 2006
Full caseload established	February 2007
Serve an average caseload of 324 persons	Throughout FY 2007-08

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Justice Integrated Services & Supported Housing
Program Work Plan #: A -2		Estimated Start Date: July 2006

1a) Description of Program: This Full Service Partnership program will provide countywide comprehensive, individualized, integrated culturally competent mental health services for individuals with a serious mental illness who may also have a dual diagnosis and have been previously in the justice system, received mental health services while incarcerated, and /or are re-entering the community from the justice system. Components of this integrated and comprehensive program include diversion and reentry services, utilizing 24/7 intensive case management/wraparound services, community-based outpatient services, rehabilitation and recovery services (i.e., supported employment/education, supported housing, peer support, transportation support), and probation services.

This program advances the MHSA goals to reduce incarceration and institutionalization, to increase meaningful use of time and capabilities, to reduce homelessness and to provide timely access to needed help by providing intensive wraparound treatment, rehabilitation and case management services to at least 111 unduplicated adults each year, through provision of services following the SAMHSA Evidence-Based Practice of Assertive Community Treatment (ACT) in combination with provision of an array of housing options (e.g., Single Room Occupancy, transitional shelter, Board & Care, permanent housing). A continuum of housing options will be provided to include short-term housing, transitional and permanent supported housing.

1b) Priority Population: Services will be provided to adults age 25-59-year-old who have a diagnosis of serious mental illness and who have active or recent criminal justice involvement. Priority for admission will be given to those persons with the most severe illness and the assessed highest need for an intensive level of community-based mental health service. Special attention will be paid to persons who are unserved and not receiving mental health services (e.g., persons who have involvement with the justice system and are seriously mentally ill but receiving no mental health treatment), with a major emphasis on active outreach to and engagement with these persons as well as to unserved and underserved adults with serious mental illness and criminal justice involvement who are African-American or who are women. In accordance with AB599, veterans ineligible for federal VA services may be eligible for this program.

1d) Fund Type	**1d)** Age Group

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	O E	C Y	TAY	A	OA
1c) Diversion and re-entry to community based mental health services; ACT-provided 'in-reach' care coordination services to persons with serious mental illness with involvement with the justice system, both in detention and after release from detention; ✓ One ACT Team will be formed to serve an average caseload of 111 persons with serious mental illness ✓ Countywide services are community-based, integrated, with individualized wraparound services provided 24/7 by the ACT Team; ✓ Services include outreach and engagement, mental health services, intensive case management, rehabilitation and recovery services, care coordination, skill development, supported education, supported employment, and housing supports; ✓ Staff will be trained in and utilize recovery-oriented practice, including but not limited to Deegan's Intentional Care standards and Copeland's Wellness Recovery Action Planning (WRAP) ✓ Linkage & care coordination to physical healthcare providers/hospital ER's; ✓ Staff to consumer ratio is approximately 1 to 10; ACT Team members share responsibility for the treatment, support and rehabilitation services; ✓ Probation Officer will be embedded in the team to facilitate re-entry and management of justice-related issues; ✓ Includes comprehensive and integrated mental health and substance abuse services and individualized treatment/service plan with client involvement in treatment planning; ✓ The program will serve clients with both mental illness and substance abuse disorders; ✓ An array of 100 housing options, developed via one-time-only funds, will be provided to include: short-term stays at shelters, Single Room Occupancy (SRO), Board and Care (B&C), subsidized housing and/or master leasing.	☒	☐	☐	☐	☐	☒	☐

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

San Diego County Mental Health Services (SDCMHS) will contract with a community-based organization to provide integrated mental health, rehabilitation and recovery services, utilizing countywide Assertive Community Treatment (ACT) Team services to serve persons with serious mental illness who have involvement with the justice system. The program will do 'whatever it takes' to support people in the community and help them work toward their recovery goals. ACT is an evidence-based practice that has repeatedly demonstrated its effectiveness with people who have serious mental illness who have not been adequately served by the usual service system. SAMHSA's ACT Implementation Resource Kit (2003) describes:

> "Assertive community treatment (ACT) is a way of delivering comprehensive and effective services to individuals who are diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. At the heart of ACT is a trans-disciplinary team of 10 to 12 practitioners who provide services to approximately 100 people. Services are delivered directly by the team as opposed to being brokered from other agencies or providers. To ensure that services are highly integrated, team members are cross-trained in each other's areas of expertise to the maximum extent possible. Team members collaborate on assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure each person receives the services he or she needs to support his or her recovery from mental illness.
>
> The course of recovery from severe mental illness and what it means to have a life that is not defined by a severe mental illness differs among people. Consequently, ACT services are highly individualized and there are no arbitrary time limits on the length of time an individual receives services. Most services are provided in vivo, that is, in the community settings where problems may occur and support is needed rather than in staff offices or clinics. By providing services in this way, people get the treatment and support they need to address the complex, real world problems that can hinder their recovery. Each person's status is reviewed daily by the team so the nature and intensity of services can be adjusted quickly as needs change. At times, team members may meet with a person several times a day, but as the individual's needs and goals change, the nature and frequency of contacts with the individual also change."

Services to be provided include outreach and engagement, 24/7 intensive case management/wraparound services, community-based outpatient mental health services (including medication management, individual therapy, and group therapy as needed), rehabilitation & recovery services (including skill and resource development in acquiring and sustaining housing/employment/educational/social goals, supported employment, supported education, and peer support

services. The program will serve 111 clients throughout the County, and the vast majority of services will be delivered through outreach to the client. Referrals will primarily come from the justice system's jails and probation office, and extensive outreach and engagement with persons who are currently or were recently in detention is a core component of connecting with clients.

The Comprehensive Continuous Integrated System of Care (CCISC) treatment model will be integrated with the ACT Team model and used for clients with co-occurring disorders of mental illness and substance abuse. CCISC is an integrated and comprehensive treatment, training and administrative approach that supports the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis-specific and stage-specific treatment for each disorder. This model is based on the following eight clinical consensus best practice principles: 1) dual diagnosis is an expectation, not an exception, and the interaction with the client shall be welcoming; 2) the treatment relationship is empathic, hopeful, continuous; 3) treatment services can be planned by using the four quadrant national consensus model for system level planning; 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced; 5) each disorder should be considered equally important and integrated dual primary treatment is required; 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions; 7) there is no one type of dual diagnosis program or intervention that is correct, and treatment services are matched to client needs; and 8) outcomes are individualized.

One-time funds are included in the first year for training and materials costs associated with model implementation and training, including technical assistance and consultation on ACT, Copeland's Wellness and Recovery Action Plan and Deegan's Intentional Care Guidelines. These components will advance MHSA goals by providing client-directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, reducing homelessness, reducing contact with the justice system and reducing inappropriate use of acute inpatient care. In addition, this program will advance rehabilitation and recovery practices that assist clients in their recovery, in self-sufficiency and in seeking and sustaining employment. Six weeks of program start-up funds are included in the budget request.

Staff will reflect the evidence-based practice model's recommended staffing pattern, and will include a team leader, a program assistant, psychiatrist, and a variety of mental health professionals that will include the specialty functions of nursing, employment specialist, peer specialist, substance abuse specialist. At least two FTE peer specialists will be part of this team. Approximately one-third of the staff is expected to be bilingual. The program will work extremely closely with

the Sheriff's Department and the Probation Department, in order to assure effective partnership relating to clients' justice system involvement. The program will have a Program Advisory Group (PAG) that consists of at least 51 percent clients to advise the program on the implementation of recovery-oriented services.

3) Describe any housing or employment services to be provided.

Affordable housing for persons with very low income is a huge challenge in San Diego, and many people leaving jail find themselves without housing. Housing specialists are embedded in the ACT Team model, and the ACT Team will aggressively work to help clients obtain housing that reflects their needs and preferences. Therefore, housing will be a key component of this program, and the Contractor will develop an array of supported housing that will include approximately 100 units for clients in this program. Housing options that the Contractor may develop include: temporary stay in short-term housing, transitional supported housing to include a variety of short-term and long-term housing options including: temporary stay in short-term housing; transitional supported housing to include a variety of short-term and long-term housing options including short-term stays at shelter, Single Room Occupancy (SRO), Board and Care (B&C); subsidized housing; and/or master leasing. Multiple approaches will be considered (e.g., scattered housing, clustered housing, and mixed use housing). One-time funds ($1,320,000) will be used to develop the housing capacity during the three years of this program. Housing development strategies will be shared and efforts will be coordinated among the Full Service Partnership programs (A-1, A-2, TAY-1, and OA-1). Capital Facilities funding, when available, will be considered for ongoing permanent housing capacity development.

The ACT Teams will have employment services provided by employment specialists embedded in the teams and will provide an array of supportive employment services including job readiness, job supports and job placement. SAMHSA's ACT Implementation Resource Kit (2003) describes: "ACT emphasizes work and vocational expectations for all consumers, while accepting individual differences in capacity and interest in competitive employment…The team's employment specialists are responsible for providing the majority of employment services. They are also responsible for directing and teaching other team members to participate in carrying out individual consumer employment plans. Persons with severe mental illnesses rarely lose jobs because they do not have the skills for the job. More often, jobs are lost because mental illness and related symptoms and behavior affect job performance. For this reason, the assessment process includes a careful review, not only of the consumer's education and past work experience, but also of the specific behaviors or other issues that have been problematic on the job. Initially, many consumers indicate that they do not want to work or that they are unable to work. In addition, because staff cannot predict how well a person is going to do in employment, they may be hesitant to help consumers find jobs. To overcome both consumer and staff resistance or apprehension, it is critical for the employment specialist and all the team members to work together to encourage,

support, and provide consumers with opportunities to try work." There will often be additional obstacles to employment for people with past criminal convictions, and the Team will work with them to face these extra challenges. Some clients may want to access other employment supports, such as the Department of Rehabilitation or the twelve Clubhouses throughout the County, and the ACT Team will support those efforts.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Average cost per client/per year without the housing is $12,000. $1,320,000 in one-time funds will be utilized to develop and subsidize 100housing units for clients in this program at a cost per client of $13,200.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Persons who have serious mental illness and are involved with the criminal justice system face some major challenges in their path of recovery, and this program will do whatever it takes to help each person identify their goals and work toward achieving them. Services will be recovery-oriented and strengths-based. Probation services will work closely with the team, to address the complex issues that may be involved in resolving outstanding justice system issues and minimizing reincarceration.

Rehabilitation and recovery interventions are client-directed and embedded with the service array to include: wellness and resiliency focus, individualized wellness and recovery action plan (Copeland's WRAP), skill development, peer supports, social and recreational supports, supported employment, supported education and supported housing. One-time funds are included for training and technical assistance, which will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills. The ACT Teams will incorporate peer specialists who can serve as inspirational role models, and will provide support in the critical areas of housing, work, school, relationships, and recreation. Training on and technical assistance with the ACT model will also occur, and will incorporate the values of empowerment and recovery in the delivery of services. Program evaluation, outcomes, and client satisfaction surveys as well as client focus groups will be some of the strategies that the program will use to ensure

adherence to recovery principles and practices. In addition the Program Advisory Group (PAG) will oversee, monitor and provide input and feedback on the implementation of this program.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program, and the contractor will be identified through the Request for Proposal process. While it will provide the bulk of services directly to its clients, it will also provide referrals and establish close linkages to relevant programs and services, such as local clubhouses and primary care medical providers.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Contractor shall assure that ACT Team staff includes qualified individuals with experience as mental health clients or family members of mental health clients, and shall employ a minimum of two FTE staff (these could be shared positions of 10 or more hours per week) to serve as ACT Team Peer Specialists. Contractor will positively consider identified personal client and/or family mental health experience as valuable experience for persons to be hired in any staff position. Peer support specialists can be tremendously valuable in promoting hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. The program will encourage its clients to link with client-operated services, including local clubhouses and the to-be-established MHSA Client-Operated Peer Support Services Program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. **Explain how they will help improve system services and outcomes for individuals.**

Our experience with the AB2034 Homeless Integrated Services program has demonstrated successful stakeholder collaboration with multiple community-based organizations that include: homeless providers, mental health providers (including clubhouses), justice and public safety sector entities, housing providers, the business community, faith-based organizations and health providers. The success of this program lies in forging those same collaborations and

partnerships to address the multiple needs of the persons with serious mental illness who are involved with the justice system. By collaborating and partnering there will be system improvements in the delivery of care, in the reduction of inappropriate use of services and a reduction in costs for the community with expected decreased detention time and increased time in the community. Such collaborations include the Psychiatric Emergency Response Team (PERT), Inpatient Units and Emergency Room Units, the Sheriff's Department, the San Diego Police, and the Probation Department. Extensive collaboration, due to the special nature of this program, will occur with the San Diego Sheriff's Department and the San Diego Probation Department. This program will also collaborate and work with the MHSA Housing Consultant Contractor to identify and develop the array of housing options mentioned above, resulting in avoidance of, or decrease in, homelessness.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Persons who have serious mental illness and significant experience with the criminal justice system need to be recognized both as individuals and as persons who may share some experiences of loss of dignity, loss of valued role, and trauma. Persons who have been in detention may have developed patterns of behavior that do not serve them well in their efforts toward recovery. Cultural competence and understanding of differences, including sexual orientation and gender, are required expectations of our current providers and are integrated in our current service delivery system and will be a requirement in all MHSA programs as well. At least a third of the staff are expected to be bilingual, and interpreter services will be obtained as necessary. The ACT Team model has demonstrated effectiveness with persons who have serious mental illness and are involved with the justice system, and is seen as an excellent model for service. Staff at this program will possess cultural awareness, knowledge and skills necessary to provide culturally competent services, particularly to eligible African-Americans and women who are unserved, underserved or inappropriately served, as is recognized that African Americans tend to be inappropriately served (e.g., more likely to receive a diagnosis of schizophrenia; receiving a higher rate of mental health services in jail, and fewer outpatient services in several regions, than predicted by prevalence data) and women tend to be underserved by our mental health system. Our gap analysis notes that "the number of African Americans in jail is notably higher than other groups, and the number of African Americans receiving mental health services in jail is also higher, yet many of them do not receive mental health services when they are released from jail, indicating that many of them may be underserved or inappropriately served. The number of females receiving mental health services while in jail Is not consistent with predicted prevalence rates, indicating that more females may need to be assessed for mental illness while in jail, as well as receiving services to assist them with re-entry to the community."

Contractor shall assure that ACT Team staff includes qualified individuals with experience as mental health clients or family members of mental health clients, and shall employ a minimum of two FTE staff (these could be shared positions of 10 or more hours per week) to serve as ACT Team Peer Specialists. The Contractor will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County (Spanish, Vietnamese and Arabic), will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

The Culturally Competent Clinical Practice Standards of SDCMHS are to: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels. The Practice Standards that the program shall implement are:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff are able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
9) Cultural factors are integrated into the clinical interview and assessment.

10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
2) Staff actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The winning proposal's curriculum and program must evidence sensitivity to individual and cultural differences, including sexual orientation and gender, and training in these areas will be provided to staff. Referrals may be made to services that are gender-specific or relevant to needs relating to sexual orientation, such as referrals to the Rachel's Women's Center or the San Diego Lesbian, Gay, Bisexual and Transgender Community Center.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This is generally not applicable, as this service will be provided in San Diego County to persons with involvement with the local justice system. However, clients from San Diego County currently residing in out-of-county judicial facilities whose discharge plan indicates the need for supported housing and who meet the priority eligibility criteria for this program will be considered for admission to this program.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors approval	December 2005
Requests for Information issued	December 2005
Request for Proposals issued	January 2006
Contract awarded	July 2006
Program manager hired	July 2006
50% of program staff hired	July-August 2006
Staff trained	July-August 2006
Begin services to clients	August 2006
Full caseload established	February 2007
Serve an average caseload of 111 persons	Throughout FY 2007-08

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Client-Operated Peer Support Services
Program Work Plan #: A-3		Estimated Start Date: July 2006

1a) Program Description: This client-driven and client-operated program will provide countywide culturally competent peer education, peer advocacy, employment support services, skill development classes and social/recreational activities delivered by peer counselors. These services will be delivered in a variety of settings, including but not limited to clubhouses, outpatient clinics, Board & Care facilities, locked long-term care facilities, and community centers. These services will expand persons' networks of supportive relationships, and will provide individuals with assistance in a wide variety of areas, including education, employment, recreation, housing, and relationships with families, friends and service providers, and will support alternatives to institutionalization.

Goals of the program include: fostering transformation of the system through client-driven services empowering people with serious mental illness by facilitating and supporting peers with an increased 'voice and choice,' thereby decreasing isolation; increasing empowerment; increasing self-identified valued roles; and increasing self-sufficiency.

1b) Priority Population: Persons served will be persons age 18 and over with a diagnosis of severe mental illness who are interested in support, rehabilitation and recovery services provided by peers. Unserved and underserved individuals will be served through this program, and will include transition-age youth (age 18 and over), adults and older adults. Outreach and culturally relevant peer interventions are a core element of this program, and particular outreach will be made to Latinos and Asian/Pacific Islanders who are unserved and underserved (according to our gap analysis) and to persons who are living in locked facilities and Board & Care facilities. In accordance with AB599, veterans ineligible for federal VA services may be eligible for these services.

	Fund Type			Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Staff will be assigned to each of the six County regions to provide a variety of individual and group peer support services; ✓ Staff will be composed of persons who have had the experience of coping with a mental illness; ✓ Staff will be trained in Deegan's Intentional Care standards, to ensure that services are recovery-oriented and empowerment-building; ✓ Services will be provided on an outreach basis to sites such as clubhouses, outpatient clinics, Board & Care facilities, community centers and locked long-term facilities; ✓ Services will focus on rehabilitation and recovery; ✓ Services will be language specific and culturally relevant and culturally competent; ✓ Collaboration will occur with local consumer advocacy groups, and expanded networking/ collaboration will improve linkages and outcomes; ✓ Use of specific curricula/models may include Copeland's Wellness Recovery Action Planning, the Boston University's Recovery curriculum, SAMHSA's Illness Management & Recovery toolkit, and/or other best practices approaches.	☐	☒	☐	☐	☐	☒	☐

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

Implementation of this service is seen as an important element in the continuing transformation of San Diego County Mental Health Services (SDCMHS) services, and builds upon our System Redesign efforts (begun in 1999) to incorporate client-centered, recovery-oriented services throughout our service system. SDCMHS will contract with a community-based organization to operate Client-Operated Peer Support Services for adults (age 18 and over) with serious mental illness. Client-Operated Peer Support Services will support transformation of our system of care through expansion of the client/consumer network of supportive relationships, and will provide people with mental illness assistance in a wide variety of areas. This client-driven program will be operated by people who have experience with their own mental illness, and will provide a cadre of peer support specialists (all of whom will have personal client/consumer experience) for outreach to clients throughout San Diego County. Support services provided will be based on the needs of the particular group or individual, and may include a variety of supports related to housing, employment, education, recreation, money, transportation, relationships with families, friends and service providers, and alternatives to institutionalization. Services will help the person develop increased mastery and valued role/s in their life, and will provide assistance with both skill development and resource development.

Services will be provided in both group and individual formats, and it is expected that at least 1400 unduplicated persons with serious mental illness will be served during the course of a year. Some may be served just once, while others may have repeated contacts with the peer support specialist/s.

Peer support specialists can be tremendously valuable in promoting hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. One-time funds are included for training and technical assistance, and six weeks of program start-up funds are included in the budget request.

Training and technical assistance will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills. Responders to the Request for Proposals (RFP) will be encouraged to identify other client/consumer-developed, recovery-oriented best practice tools and approaches that they recommend for use in this service, and the final model will incorporate the winning proposal's recommendations.

The closest programs to this model that we currently have are the clubhouses, but many people do not choose to (or because of where they live, such as a locked long-term facility, cannot) affiliate with a clubhouse. This program will collaborate with area clubhouses, but will focus much of its efforts beyond the clubhouses to reach out to sites such as clinics, Board & Care facilities, locked long-term care facilities and community centers. The program will also collaborate with local groups such as the California Network of Mental Health Clients, Mental Health Clients for Wellness and Recovery, and NAMI's local chapters.

Specific outreach and engagement will occur with unserved and underserved groups of consumers who are Latino or Asian/Pacific Islander. Services will be provided when needed in Spanish and/or in relevant threshold language (Vietnamese, Arabic). The program will have a Program Advisory Group (PAG) that consists of at least 75 percent clients to advise the program on the implementation of recovery-oriented services.

Services will be available to persons with a diagnosis of mental illness. The program base may be located anywhere in the County, as services will primarily be delivered on an outreach basis, and hours of program operation will be based on client need and are therefore expected to include some evening and weekend hours.

3) Describe any housing or employment services to be provided.

While this program does not directly provide housing or employment services to peers, it will support people identifying and working toward housing and employment goals and will include assistance and linkages to a variety of supports related to housing (e.g., local Housing Authorities; listing of affordable housing, Section 8 and other supportive housing) and employment (e.g., Employment Services program; Department of Rehabilitation; clubhouse employment services, and the MHSA Employment program).

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Not applicable, as this program is a System Development initiative, not a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. **Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

This program will be operated by people who have experience with their own mental illness and will provide a cadre of peer support specialists (all of whom will have personal client/consumer experience) who will provide outreach to clients throughout San Diego County. Support services provided will be based on the needs of the particular group or individual, and may include a variety of supports related to housing, employment, education, recreation, money, transportation, relationships with families, friends and service providers, and alternatives to institutionalization. Services will help the person develop increased voice and choice in his/her life, and will provide assistance with both skill development and resource development. Peer support specialists can share their recovery efforts and model the importance of recovery and resilience in managing challenges to recovery through incorporating their own experiences into their work with clients.

One-time funds are included for training and technical assistance, and will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills. Responders to the Request for Proposals (RFP) will be encouraged to identify other client/consumer-developed, recovery-oriented, wellness-based best practice tools and approaches that they recommend for use in this service, and the final model will incorporate the winning proposal's recommendations.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable, as this is a new service. However, this service will substantially transform the system of care through establishment of the first non-clubhouse peer support services model funded by SDCMHS, and is expected to complement elements of the existing array of options, including clubhouses and client advocacy organizations, by providing client-driven peer support services designed to reach out to and engage persons in a variety of settings.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

This program is a client-driven service that will be operated by people who have experience with their own mental illness, and will provide a cadre of peer support specialists (all of whom will have personal client/consumer experience) for outreach to clients throughout San Diego County. A sample budget is shown in Exhibit 5b; the final program may vary

based on the details of the best proposal received, but will maintain staffing by persons with personal client/consumer experience. The program is expected to collaborate and link with other client-run organizations, including local clubhouses, local NAMI chapters, the California Network of Mental Health Clients, and the local Mental Health Clients for Wellness and Recovery group and other existing Program Advisory Groups (PAG).

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system and outcomes for individuals.

This program will collaborate with area clubhouses, but will focus much of its efforts beyond the clubhouses to reach out to sites such as outpatient mental health clinics, Board & Care facilities, locked long-term care facilities and community centers, and will also collaborate with local groups such as the California Network of Mental Health Clients, Mental Health Clients for Wellness and Recovery, and local NAMI chapters. It will make special effort to link with Latino and Asian-Pacific Islander communities in order to effectively engage with persons of those ethnicities.
As a primarily outreach-based service, this program will be linking with and working closely with many other services in the community. For example, it is expected to hold individual and group meetings at other provider sites (e.g., Board & Cares, locked long-term facilities, clubhouses, outpatient clinics), as part of its outreach efforts and multiple bases of operation throughout the community. It will work with various providers of services to persons who may need extra outreach efforts, such as those persons living in locked long-term facilities or in Board & Cares, to establish connections with those persons. It will also publicize its efforts through the SDCMHS Network of Care website to advertise the availability of peer support services. Special efforts to engage with the unserved/underserved communities of Latinos and Asian/Pacific Islanders will occur, and it is expected that the program will make special connections with specialized services for those populations such as the Maria Sardiñas Center and Casa del Sol Clubhouse (both serving many Hispanics with mental illness in the South Bay area) and the Union of Pan-Asian Communities (UPAC) mental health services. The program will make referral for a wide variety of services as needed and wanted by the person, including referral to services that can assist with employment, housing, finances, social support, education, and wellness.

Each year the program shall provide services to 1400 unduplicated persons with serious mental illness.
Outcomes for individuals include positive change in status in identified areas (e.g., education, employment, benefits management, recreation, housing, relationships with families/friends/service providers) due to involvement with the program. 25% of clients served for six or more contacts shall demonstrate improvement in at least one identified area, via client satisfaction survey or other approved measurement tool.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Cultural competence and understanding of differences, including sexual orientation and gender, are required expectations of our current providers, are integrated in our current service delivery system, and will be expected of this program. Service providers will possess cultural awareness, knowledge and skills necessary to provide culturally competent services.

People with personal experience of their own mental illness will staff this program, in order to best connect with the population to be served—that is, adults with serious mental illness. The winning proposal's curriculum and program must evidence sensitivity to individual and cultural differences. Special efforts will be targeted at outreach to persons of Latino and Asian-Pacific Islander backgrounds to address inequities in accessing services identified in the gap analysis, and the provider will work closely with members of those communities to ensure active and effective outreach efforts. Specific collaboration strategies will used to effectively connect with persons who are Latino and Asian-Pacific Islander, and will include outreach to specific service agencies, such as Maria Sardiñas Center in the South Bay (serving primarily Hispanic persons) and Union of Pan Asian Communities (serving Asian/Pacific Islanders throughout the County). It is expected that at least 33% of staff will be bilingual.

The program will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County, will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender- sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The winning proposal's curriculum and program must evidence sensitivity to individual and cultural differences, including sexual orientation and gender, and training in these areas will be provided to staff. Referrals may be made to services

that are gender-specific or relevant to needs relating to sexual orientation, such as referrals to the Rachel's Women's Center or the San Diego Lesbian, Gay, Bisexual and Transgender Community Center.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This service will be provided in San Diego County. However, clients from San Diego currently residing in out-of-county long-term care facilities may establish contact with this program as part of their discharge planning efforts.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors approval	December 2005
Request for Information issued	February 2006
Request for Proposals issued	April 2006
Contract awarded*	July 2006
Program manager hired	July 2006
50% of program staff hired	August 2006
75% of staff hired	August - September 2006
Staff trained	August - September 2006
Begin services to clients	August - September 2006
Services provided to at least 500 unduplicated persons	January 2007
Services provided to at least 1400 unduplicated persons	June 30, 2007
Services provided to at least 1400 unduplicated persons	FY 2007-08

*Note that the Exhibit 5b budget and staffing detail is a sample of a possible program design; final budget and staffing detail will be determined by the proposal deemed to be the best value to the County.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Family Education Services
Program Work Plan #: A-4		Estimated Start Date: July 2006

1a) Program Description: Family Education Services will provide family-driven countywide family education about major mental illness, stigma reduction and resources to improve access to care. It will promote integration of family education services throughout the County and will support transformation of our system of care through promotion of increased family involvement. Family education curriculum will be provided in English, Spanish, Vietnamese and Arabic, with non-English curriculum developed as part of the program. The program will ensure provision of 20 class series each year of family education, providing education and support for families who have relatives with mental illness. The class series is expected to consist of an approximately 10-12 week course, taught by families, and will increase family members' coping skills and support family members' increased involvement and partnership with the mental health system, improving their ability to effectively support their loved one and to promote networks of supportive relationships.

1b) Priority Population: Persons served will be family members or significant others of adults (including transition-age youth and older adults) with a serious mental illness. Family members will be actively recruited through publicity, at existing mental health clinics and word-of-mouth. Classes for both English-language and Spanish-language speakers will be available within Fiscal Year (FY) 2006-07, and part of this project supports development and presentation of the curriculum for Vietnamese- and Arabic-language speakers by the end of FY 2007-08.

	1d) Fund Type			**1d)** Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ This family-driven program will utilize an established, culturally competent family education curriculum with evidence supporting it as a promising or best practice; ✓ Family members will be the teachers of the curriculum; ✓ Staffing (volunteers and paid staff) of the program will primarily consist of family members of persons with serious mental illness; ✓ Linkage with San Diego Alliance Mentally Ill (SDAMI) will ensure provision of family education classes throughout our system of care; ✓ Provision of classes in all current threshold languages will occur by the end of FY 07-08; ✓ Development of culturally competent curriculum in Spanish, Vietnamese	☐	☒	☐	☐	☐	☒	☐

and Arabic in collaboration with those communities, so that future classes will be available to family members whose primary language is Spanish, Vietnamese or Arabic; ✓ Collaboration with mental health services including client-driven organizations such as clubhouses will foster support of family members' involvement with these family education classes; ✓ Active outreach will be made to families by providers, clients and other family members and friends to promote attendance at these classes, through publicity and word-of-mouth; ✓ Review of feedback from classes to assess whether different or additional family education services may be needed. ✓ Provider will coordinate at last two sessions annually of the 'Schizophrenia Education' class series, open to all family and friends of persons diagnosed with schizophrenia.							

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

San Diego County Mental Health Services (SDCMHS) will contract with a community-based organization to provide a series of educational classes using an established family education curriculum to provide education and support for families who have relatives with serious mental illness. Classes will be held throughout the County, with a minimum of two class series to be held in each of the County's six geographic regions. Classes will be held in English and Spanish in the first year. A critical component of this program is to ensure development of culturally competent curriculum for primary speakers of Spanish, Vietnamese and Arabic. Active outreach to family members to inform them of the classes and to encourage them to attend will occur by promotion among providers, clients, family members and friends the availability of educational classes.

Each class series is expected to be composed of approximately 10-12 classes, held over a period of approximately three months, and curriculum that has some evidence as a best practice is the preferred model. These classes, taught by family members, will increase family members' coping skills and support increased involvement and partnership with the mental health system, thereby helping family members support their loved one and promote networks of supportive relationships. It is expected that approximately 15-20 people will sign up for each class series, and that approximately 12 of these people will complete the 10-12 week series. Therefore, the program is expected to serve the 240 people/year

who complete the class series. This program will not have traditional office hours and its home base may be located anywhere as services will be delivered via classes and will be provided throughout the County. This family-driven program advances the MHSA goals through promoting networks of supportive relationships. Six weeks of program start-up funds are included in the budget request.

Linkage with local NAMI chapters will occur to ensure that there is coordination between this program and NAMI's family support services, and NAMI is expected to be a key partner in promotion of this program. This program will establish linkages with the multiple mental health provider agencies throughout the County, including but not limited to outpatient mental health clinics, clubhouses, 11 psychiatric hospitals, long-term care facilities and private providers. Through the classes, family members will be provided with information about how to access the mental health system and resources for persons with serious mental illness, including mental health, housing, employment, education, social, recreation and crisis services.

This program will also assume responsibility for coordinating at least two sessions each year of the 'Schizophrenia Education' class series (developed by Christopher Amenson, Ph.D., of Pacific Clinics, a large mental health provider based in Pasadena), open to all family and friends of persons diagnosed with schizophrenia. San Diego County Mental Health Services has purchased the rights to present this program within San Diego County, and will make it available to San Diego partners who volunteer to co-sponsor and present it.

3) Describe any housing or employment services to be provided.

The program will not directly provide housing or employment services. However, it will have information about housing and employment resources, and will provide basic information about housing and employment as part of the information provided through the classes. Class participants will be referred to specific resources (e.g., local Housing Authorities, Department of Rehabilitation, Clubhouses, Employment Services programs) as needed.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Not applicable, as this program is a System Development initiative, not a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. **Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

A core recommendation of the *President's New Freedom Commission on Mental Health (2003)* is involvement of families fully in orienting the mental health system toward recovery. The *Mental Health: A Report of the Surgeon General (1999)* cited Ruth Ralph as identifying external factors as a dimension of recovery reported by people with serious mental illness; "External factors include interconnectedness with others; the supports provided by family, friends, and professionals; and having people who believe that they can cope with and recover from their mental illness" (Ralph*, Recovery in Mental Illness,* 2005). Family support and family involvement are critical components of recovery for many people.

This program will provide family-directed education and support built around goals and tools to help family members become better able to understand, cope with and respond to issues that arise due to a loved one's mental illness, and thereby promotes the natural supports of family with a focus on recovery and resilience, concepts that apply to both persons with serious mental illness and their families. SDMHS will review the proposed curriculum to ensure that the values of recovery and resiliency are integrated throughout the curriculum, and will seek input about the curriculum from NAMI members. SDMHS will expect the program to closely work with members of the identified ethnic communities (reflecting primary speakers of Spanish, Vietnamese and Arabic) to adapt and/or develop culturally competent curriculum for these communities.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program, and the provider will be identified by a Request for Proposal (RFP) process. SDCMHS does not currently fund any family education services for family members of adults with serious mental illness, beyond providing some copying services to the local NAMI chapters. Provision of SDCMHS funding for family education services will establish a solid funding base for countywide presentation of family education services, and will be integrated with other family education and support services provided by SDAMI but not funded by SDCMHS.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

This is a family-run program; all trainers and participants are family members. A 'train-the-trainer' component will support family members who become trainers. Trainers may either be volunteers or paid for their time, depending on the winning proposal's model; the sample budget reflects a model that has volunteer trainers. It is expected that all paid staff of this program will be family members of persons with serious mental illness. Clients and family members will be key components to effective outreach strategies, and the program will closely link with SDAMI and the 12 clubhouses throughout the County.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The success of this program will depend on strong collaboration with San Diego's NAMI organizations and other consumer/family groups and organizations such as outpatient mental health clinics and contracted clubhouses. The family education program will build collaboration between mental health services and families, helping family members learn how to navigate, advocate and become partners with the service system. These relationships improve individual and system outcomes.

Specific collaboration strategies will be needed to effectively connect with Hispanic, Vietnamese and Arabic family members. Outreach to specific service agencies, such as Maria Sardiñas Center in the South Bay (serving primarily Hispanic persons), Union of Pan Asian Communities (serving Asian/Pacific Islanders throughout the County, including a large Vietnamese population), and East County mental health centers and Chaldean community leaders in East County (where many of the people whose primary language is Arabic live).

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Cultural competence and understanding of differences, including sexual orientation and gender, are required expectations of our current providers, are integrated in our current service delivery system, and will be expected of this program. Service providers will possess cultural awareness, knowledge and skills necessary to provide culturally competent services.

Family members of persons with serious mental illness are expected to staff this program, in order to best connect with the population to be served—that is, family members of adults with serious mental illness. The winning proposal's curriculum and program must evidence sensitivity to individual and cultural differences. Special efforts will be targeted at developing culturally competent curriculum for primary speakers of Spanish, Vietnamese and Arabic, and the provider will work closely with members of those communities to ensure relevant adaptation of the curriculum and training bilingual, bicultural family members to present the curriculum.

The program will ensure that staff (whether volunteer or paid) are culturally competent to serve the culturally diverse backgrounds of the clients, and will provide a Human Resource Plan for recruiting, hiring and retaining staff (volunteer or paid) reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff relevant to provision of the family education services in Spanish, Vietnamese and Arabic. SDMHS will expect the program to closely work with members of the identified ethnic communities (reflecting primary speakers of Spanish, Vietnamese and Arabic) to adapt and/or develop culturally competent curriculum for these communities.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The winning proposal's curriculum and program must evidence sensitivity to individual and cultural differences, including sexual orientation and gender. Referrals may be made to services that are gender-specific or relevant to needs relating to sexual orientation, such as referrals to the Rachel's Women's Center or the San Diego Lesbian, Gay, Bisexual and Transgender Community Center.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable, as these classes will be available to San Diego County residents.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors approval	December 2005
Request for Information issued	February 2006
Request for Proposals issued	April 2006
Contract awarded*	July 2006
Program coordinator hired	July 2006
Trainers recruited and trained	July-September 2006
Classes in English start	by October 2006
Classes in Spanish start	by April 2007
Classes in Vietnamese start	within Fiscal Year 2007-08
Classes in Arabic start	within Fiscal Year 2007-08

*Note: Attached budget is a sample only (and reflects a model that would utilize volunteers as trainers); the final budget and staffing detail will be based on the winning proposal, although staffing (volunteer and paid) of this program is expected to be primarily family members.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year**: 2005-06; 2006-07; 2007-08	**Program Work Plan Name:** Clubhouse Enhancement and Expansion for Employment Services
Program Work Plan: A-5		**Estimated Start Date:** April 1, 2006
1a) A brief description of the program: I. Clubhouse Enhancement and expansion services provides expanded capacity for social and community rehabilitation activities for 500 underserved adults with a serious mental illness in ten existing member-run Clubhouse programs and two other Clubhouses to become partially-funded by San Diego County. II. Clubhouse Expansion for Employment Services: Provides underserved adults who have serious mental illness with employment screening, job supports and job placements in twelve (12) member-run Clubhouse programs		
1b) Identification of the age and situational characteristics of the priority population to be served in this program: Underserved adults age 18 and over with serious mental illness who are in need of skill development to increase their self sufficiency and skills to integrate in the community and who have previously been unable to work; due to the severity of the		

illness lacked motivation and hope, who are choosing to improve their social and vocational skill sets for improving their quality of life in the community and can benefit from peer support. In accordance with AB599, veterans are eligible for this program. Special emphasis on active outreach to underserved persons with serious mental illness who are African-American, Latino, Asian-American/Pacific Islanders, Native Americans or who are women.									
	1d) Fund Type				**1d)** Age Group				
1c) Identification of strategies for which you will be requesting MSHA funds for this program. 1d) Identification of the finding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a program.	FSP	Sys Dev	O E	OTO	C Y	TA Y	A	O A	A L L
✓ <u>Clubhouse Enhancement</u>: The member operated Clubhouse programs will provide opportunities for skill development, social rehabilitation and symptom management through an array of meaningful peer-led educational, support groups and community activities to include illness and symptom management, recovery groups, cultural and sports activities; recreational outings; and self-help advocacy groups. Peer Specialists will assist and support members to engage in volunteer, social rehabilitation and community activities. ✓ <u>Clubhouse Expansion for Employment Services</u>: The member operated Clubhouse program will provide employment screening and job placement through onsite and/or offsite volunteer and/or paid vocational opportunities of member's choosing. The program will also provide ongoing job supports via activities within a network of supportive relationships of peer staff, members who are employed and others who are seeking employment. Benefits counseling will also be provided. ✓ Peer Employment Specialists will assist and support members to engage in paid vocational activities annually by activities such as: identifying group and individual employment opportunities in the community; negotiating with employers for entry-level positions that will be filled by the Clubhouse program on a rotating basis; accompanying members to on-the-job training; substituting for the member at work on days they miss work; identifying and problem-solving work-related issues that impede continuing employment such as transportation. ✓ Four of the 12 Clubhouse programs will maintain or become International	☐	☒	☐	☐	☐	☐	☒	☐	☐

Center for Clubhouse Development (ICCD) - certified within the next three years and will follow the 36 standards of practice from the ICCD; all remaining Clubhouse programs may employ many ICCD standards along with engagement and other strategies.									

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

MHSA goals of providing employment, vocational training, pre-employment activities, education, a network of supportive relationships and meaningful use of time and capabilities will be advanced by augmenting the budgets of each of twelve (12) Clubhouse programs. San Diego County Mental Health Services (SDCMHS) via a competitive bidding process is reprocuring six of the existing clubhouses. Four other Clubhouses will have their current contracts amended and lastly, two additional Clubhouses, sponsored by hospital partners and not previously funded by the County will be provided funding to expand their services. The result will be expanded services of all of the twelve Clubhouses that are currently located in the 6 HHSA regions of San Diego.

Four of the Clubhouses in the Central and South regions will achieve ICCD certification within three years or maintain certification recently achieved. ICCD certification is a proven evidence based practice for creating opportunities for people living with mental illness to be respected members of society. “ICCD clubhouses are founded on the realization that recovery from serious mental illness must involve the whole person in a vital and culturally sensitive community. A clubhouse community offers respect, hope, mutuality and unlimited opportunity to access the same worlds of friendship, housing, education and employment as the rest of society.” At least three Clubhouses primarily serve specific ethnic groups: North Central Region: East Wind- Monolingual Asian-American/ Pacific Islanders; Central Region: Friendship Clubhouse- African-Americans; South Region: Casa Del Sol -Latinos. These Clubhouses reflect major ethnic groups in their respective communities and will enhance their efforts to reduce ethnic disparities in offering Clubhouse services. The East Corner Clubhouse and North County Clubhouses will provide active outreach for Native Americans in their regions to include collaboration with Indian health providers and tribal organizations. Central Region Clubhouses will similarly outreach to Native American Urban Indians by connecting with the San Diego Urban Indian Center and tribal organizations.

3) Describe any housing or employment services to be provided.

The Clubhouses do not provide housing directly for members but will provide information on applying for Section 8 housing subsidies and other available housing programs or shared housing opportunities.

Each member will be asked to identify a personal goal of their own choosing upon enrolling into a Clubhouse. Volunteer work and paid work opportunities will be identified and developed within and outside the Clubhouse setting to the fullest extent possible. This will provide members with an array of choices ranging from volunteer work within the Clubhouse; transitional temporary jobs; to paid competitive positions in the community. New Clubhouse members arrive at all points along the continuum of recovery. Some are eager to move into the work force. Others are uncertain of their abilities. Members are invited to volunteer within the Clubhouse to build confidence in themselves through achievement.

Non-ICCD Clubhouses will provide vocational and educational support such as: temporary employment positions for skill advancement; volunteer activities that may include: plan, purchase, prepare and serve meals; assess and conduct building maintenance and minor repairs; answer phones; greet, track visitors, and orient new members; help plan recreational outings and parties; conduct a member 'bank' that also sells bus passes and stamps for members convenience; teach a class or skill the member possesses; or facilitate an interest group. For those who choose an employment goal, their preferences will be determined so that they can target their job search. An ongoing job support club or Employment Dinner will be available to share success stories; offer mentoring, discuss appropriate job behaviors and problem-solve difficult job situations. English as Second Language (ESL) classes will be offered on site at East Wind Clubhouse to improve English proficiency for monolingual Asians/Pacific Islanders. Clubhouses will link with the Department of Rehabilitation as needed to assist members to obtain their services and funds for clothing, uniforms or other supplies needed to begin a job.

ICCD Clubhouses provide comprehensive employment services for members in three levels of employment: Supported; Transitional and Independent employment:

> Supported Employment services will assist members through the various steps of job searching such as: reviewing newspaper, penny-saver and internet job ads; networking interviews; and resume writing including scan-able resumes. Interviewing practice to include appropriate dress, telephone courtesy, punctuality and negotiating salary will be discussed and role-played as needed. An Employment specialist will assist with job linkage, job development and job placement by outreach to the business community. Transitional Employment positions are developed and provided as follows: The specialists will approach, for example, businesses in the service and retail industries and offer them a win-win approach to keep their entry-level vacancies filled: in exchange for providing a fulltime position to the Clubhouse that is paid no less than the prevailing minimum wage, Clubhouse staff train alongside members who are recruited to

fill the position at half or fulltime; and Clubhouse staff commit to performing on the job whenever a member is absent. In this way, the employer is assured that the work will always be attended.

Independently employed members continue to have available all clubhouse supports and opportunities including advocacy for entitlements, and assistance with housing, clinical, legal, financial and personal issues, as well as participation in evening and weekend programs.

4) Pease provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A- This is System Development program, not FSP.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

All Clubhouse programs will be recovery-oriented, culture and strengths-based. One-time funds are included for training and technical assistance, which will include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills.

The Clubhouses will incorporate peer specialists who can serve as role models and mentors, and will provide support in the critical areas of work, school, relationships, recreation and meaningful activities. Recovery will be reinforced through the role models and mentorship provided when peers achieve or maintain education, employment and community goals. Key staff in this program shall be those peers who improve and begin to provide support (either volunteer or paid) for new peers. Support and celebration of goals will be a regular part of the activities in the Clubhouse in order to reinforce these goals. Clubhouse newsletters document members' community outreach to those less fortunate, mutually shared Clubhouse activities and educational and employment adventures and successes. Employment and educational activities of members are tracked by each Clubhouse. Program evaluation, outcomes, and member satisfaction surveys that also gauge increased self-sufficiency and empowerment will be some of the strategies that the program will use to ensure

adherence to recovery principles and practices. In addition the Member Advisory Board (MAB) will oversee, monitor and provide input and feedback on the implementation of expansion of services in each Clubhouse program.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

The eight Clubhouses that are not becoming ICCD certified will add new groups to assist members in new ways. These Clubs assist members with peer-led groups to develop wellness goals and crisis planning through the use of the Wellness Recovery Action Plan guide developed by Copeland. The Friend-to-Friend Clubhouse for Homeless will offer programming to members for Anger Management classes and peer-led recovery groups for co-occurring mental health and substance abuse disorders. Members will be linked to new mental health services that offer housing resources (A-1, A-2 and TAY-1). The East Wind Clubhouse will provide mental health education and vocational services to members to decrease stigma, improve coping skills and employability. While additional services will be provided to the Hmong, Cambodian and Vietnamese members now served, additional staff will be hired to provide these services in Asian languages not currently being served at the Clubhouse, such as Korean or Tagalog. Casa Del Sol will add more bilingual Spanish peer staff to assist members. All Clubhouses will be adding peer staff who will be trained to assist with duties described above. Clubhouses will be adding more recovery and vocational supports so that members understand that the Clubhouse activities are a tool to recovery in the best possible sense and not simply a recreational destination.
With the addition of MHSA funding, ICCD certification will become a contractual requirement for Clubhouses for the first time albeit in four of the twelve Clubhouses. Two of these Clubhouses have recently obtained this certification and will be able to expand their ICCD program so that more members reach educational and employment goals. Two others will be developing programming that sets up the ‘work-ordered day’ model and will, of necessity, discontinue token economies as a means of motivating members; decrease or move support groups to the end of the day so that members are focusing on work type tasks during the day; and develop transitional employment positions in the community. Other Clubhouse programs will be developing Clubhouse businesses that members operate such as: food catering; coffee cart; snack bar; dog grooming; tailoring; minor repairs and hauling; apartment managing; or thrift shops. Several Clubhouses may be remodeling or moving to accommodate increased programming or new businesses. Clubhouses will be a primary source of candidates to be hired in other Clubhouses and in case management or outpatient clinic programs (See A-1, A-2 and A-8).

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Contractor shall assure that Clubhouse staff includes qualified individuals with experience as mental health clients or family members of mental health clients in any or all staff positions for which they qualify, and shall employ an additional minimum of 1.0 FTE staff per Clubhouse (can be shared position of 10 or more hours per week) to serve as Peer Specialists. Peer specialists will promote hope for recovery by sharing their recovery efforts and modeling the importance of resilience in managing challenges to recovery. Peer specialists will provide job support in the ICCD Clubhouses by training on the job alongside the member. Peer staff will orient new members, teach tasks within the Clubhouse; assist support and advocacy groups; participate in all aspects of Clubhouse functioning. Clubhouses are expected to be Member-run programs and each Clubhouse will develop a Member Advisory Group (MAG) to evaluate and monitor the implementation and expansion of services.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Clubhouses will collaborate with local institutions, businesses and companies to identify volunteer opportunities and paid employment positions for their members. Collaboration will include companies such as the City of San Diego City Works program, TJ Maxx, PetCo Park, COVANCE, and the San Diego SHARE program (who currently work with our clubhouses) and explore other businesses for more opportunities for Clubhouse members. Collaborations with ethnic student unions at our colleges/universities in San Diego shall be encouraged such as Asian American Student Union and Hispanic Federation. Every Clubhouse participates in the Systemwide Clubhouse Directors meeting where they share ideas, activities that are successful and less than successful to support one another.

The San Diego Urban Indian Center representatives will be invited to meet with the Clubhouse Directors and tour the individual Clubhouses to develop an awareness of Clubhouse services for their clients with serious mental illness. The Clubhouses will collaborate with community college districts, adult education programs and the Dept. of Rehabilitation to provide educational training and employment supports.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Cultural competence and understanding of differences are required expectations of our current providers and are integrated in our current service delivery system and will be a requirement of Clubhouse programs as well. Services in the clubhouses shall be provided in the languages of the specific community to be served. The East Wind Clubhouse offers services in Hmong, Vietnamese and Cambodian and will hire staff for Korean, Tagalog or other Asian languages as indicated. Casa Del Sol Clubhouse offers services in Spanish. Friendship Clubhouse will expand services to the African-American community it serves. All Clubhouses will be required to provide active outreach to underserved populations. They will reach potential members by visiting hospitals, outpatient clinics, Board and Cares, Long-term Care facilities and others. They will set up booths at neighborhood ethnic festivals and health fairs and outreach to religious and/or other organizations and providers. Service providers will possess cultural awareness, knowledge and skills necessary to provide culturally competent services, particularly to African-Americans, Latino, Asian-American/Pacific Islanders and women. The Clubhouse programs will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the members in the geographic regions to be served, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at least the threshold languages for the County, will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan. Providers will promote an environment that encourages staff to conduct self-assessment as a learning tool; and seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The Clubhouse program must evidence sensitivity to individual and cultural differences, including sexual orientation and gender, and training in these areas will be provided to staff. Referrals and linkages where appropriate will be made to and from services that are gender-specific or relevant to needs relating to sexual orientation, such as Rachel's Women's Center; Stepping Stone; and the San Diego Lesbian, Gay, Bisexual and Transgender Community Center. These programs will be provided with a Clubhouse list and invited to tour and become familiarized with Clubhouse services that may benefit their clientele.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This service will be provided in San Diego County. However, clients from San Diego currently residing in out-of-county long-term care facilities whose discharge plan indicates the need for social and/or educational or vocational activities or supports would be immediately welcomed to become a new member of any Clubhouse they choose.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors approval	December 2005
Requests for Information issued	December 2005
Request for Proposals issued	January 2006
Amendments executed	April 2006
Contracts awarded	April 2006
Program staff hired	April 2006
Staff trained	April - June 2006
Begin services to members	April 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Supported Employment Services
Program Work Plan #: A-6		Estimated Start Date: July 2006

Program Description: This program will provide supported employment services, with the annual goal of helping 60 people with Serious Mental Illness (SMI) become competitively employed, offering job screening, job preparation, job development, job supports, job coaching and job placements, employment opportunities and supports for educational / vocational training. The program will use the model of Substance Abuse Mental Health Services Administration (SAMHSA) Evidence-Based Practice of Supported Employment. This program will provide specific employment opportunities, and will also support educational and vocational training opportunities.

Priority Population: Persons served will be persons age 18 and over with a diagnosis of serious mental illness who reside in the Central or North Central geographic region of San Diego County and are interested in becoming competitively employed. Priority will be given to those persons who need more long-term job coaching and support than is available through other supported employment services in our system, (a cooperative program between Mental Health and the Dept. of Rehabilitation) or through our MHSA clubhouse supported employment expansion. In accordance with AB599, veterans ineligible for federal VA services may be eligible for this program.

	Fund Type			Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ The program will use SAMHSA's Evidence-Based Practice of Supported Employment; ✓ The program will incorporate SAMHSA's six principles of Supported Employment:1) Eligibility is based on consumer choice; 2) Supported employment is integrated with treatment; 3) Competitive employment is the goal; 4) Job search starts soon after a consumer expresses interest in working; 5) Follow-along supports are continuous; 6) Consumer preferences are important; ✓ Employment Specialists (with caseloads of 20-25 each at any point in time) will help at least 60 people a year to become competitively employed; ✓ Hiring of staff who have personal experience with mental illness is required;	☐	☒	☐	☐	☐	☒	☐

✓ Hiring of bilingual, bicultural staff is required; ✓ Specific outreach and engagement efforts will be made for Latino or Asian/Pacific Islanders. ✓ Staff will be trained in Deegan's Intentional Care guidelines to help ensure recovery-oriented and empowerment-building practice, and in Copeland's Wellness Recovery Action Planning (WRAP) model to be able help people do an employment-related WRAP when applicable. ✓ Staff will be trained in Benefits Counseling, to help people identify how earned income may affect their benefits and to best handle reporting requirements.							

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

San Diego County Mental Health Services (SDCMHS) will contract with a community-based organization to provide a Supported Employment Services program to serve persons age 18 and over with a diagnosis of serious mental illness who are interested in becoming competitively employed, utilizing a comprehensive approach that is community-based, client and family driven and culturally competent. The program advances the goals of the MHSA as employment is a valuable path to recovery for many people. This program provides an array of job supports to help the person with serious mental illness who needs a wide array of long-term job supports to obtain competitive employment, and will build on the person's strengths to help them achieve this goal.

The Supported Employment Services program will be expected to seek other funding to allow expansion and thereby continue long-term support of some of its clients while being able to serve new clients and meet the annual service goals. One-time funds are included in the first year both for training and six weeks of program start-up costs. The provider will follow the evidence-based practice outlined in SAMSHA's *Supported Employment Implementation Resource Kit*. As defined by the Kit, "the definition of competitive employment includes the following: pays at least minimum wage; the employment setting included co-workers who are not disabled; the position can be held by anyone, that is, one does not need to be a member of a population with a disability to hold the job." Following these guidelines, the goal is to assist individuals find and keep competitive jobs, leading to recovery and independence.
One-time funds are included for training and technical assistance, and six weeks of program start-up funds are included in the budget request. Training and technical assistance will include training on Deegan's 'Intentional Care' standards,

which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills that can be utilized by some persons to support their efforts to obtain and keep employment.

The closest program to this model that we currently have [a cooperative Dept. of Mental Health/Dept. of Rehabilitation (DMH/DOR) program] provides support for only 90 days after the person obtains employment, due to DOR regulations. The proposed program will have no time limit for services, and provision of unlimited job supports will make supported employment a viable option for many more people with serious mental illness who are interested in work but need more long-term job support to maintain that employment. Some/all Employment Specialists will have experience as a client/consumer and/or as a family member, as such experience is seen as an asset to their qualifications.

The provider will be located in central San Diego to allow easy access to persons living in the Central and North Central geographic regions of San Diego County. The hours shall be flexible to allow evening and/or weekend hours as needed by the clients. The program will serve 60 clients per year with three employment specialists assisting the clients in competitive employment. Each employment specialist will have an active caseload of 20-25 at any point in time. The program will also have a Program Advisory Group (PAG) that consists of at least 51 percent clients to advise the program on the implementation of recovery-oriented services, and will work closely with existing providers, including the DMH/DOR Cooperative Program, clubhouses, and the client community to identify people who may be served by this program.

3) Describe any housing or employment services to be provided.

The Supported Employment Services primary focus is employment. The services include a rapid job search to assist clients in obtaining a job as soon as interest is expressed, finding individualized jobs based on the client's strengths, preferences and work experience, and indefinite follow-up support as needed. Housing services will include referrals to housing specialists such as the Department of Housing and Community Development or local Housing Authorities.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This program is a System Development initiative, and is not a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. **Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

The *President's New Freedom Commission on Mental Health (2003) states,* "The low rate of employment for adults with mental illnesses is alarming. People with mental illnesses have one of the lowest rates of employment of any group with disabilities - only about 1 in 3 is employed. The loss of productivity and human potential is costly to society and tragically unnecessary. High unemployment occurs despite surveys that show the majority of adults with serious mental illnesses want to work - and that many *could* work with help." Supported Employment Services will advance the goals of recovery for adults by allowing for a meaningful use of time and work, which is a path to recovery for many people with a severe mental illness diagnosis. To ensure the values of recovery are promoted and continually reinforced, all staff will be trained in Deegan's Intentional Care guidelines and in Copeland's Wellness Recovery Action Planning (WRAP) model to help ensure recovery-oriented and empowerment-building practice. Deegan's Intentional Care guidelines enforce recovery-oriented and empowerment-building practices, while Copeland's Wellness Recovery Action Planning model provides staff a tool to help clients develop an employment-related WRAP when relevant. Staff will also be trained in benefits counseling to help clients identify how earned income may affect their benefits and how to best handle reporting requirements.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program. The most similar program we currently have (a cooperative DMH/DOR program) provides support for only 90 days after the person obtains employment, due to DOR regulations. The proposed program will have no time limit for services, and provision of unlimited job supports will make supported employment a viable option for more people with SMI who are interested in work but need more long-term job support to maintain employment. The provider will be determined through a Request for Proposal process.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Some or all Employment Specialists may have experience as a client/consumer and/or as a family member, as such experience is seen as an asset to their qualifications. A requirement of providers is that at least one Full Time Equivalent (FTE) out of the 3.5 FTE Employment Specialists be a client and/or family member; the FTE position may be shared

among multiple client/family members. The program will also have a Program Advisory Group (PAG) that consists of at least 51 percent clients to advise the program on the implementation of this program and its recovery-oriented services.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program will work closely with existing mental health providers (including the DMH/DOR Cooperative Program) and relevant sectors of the business community (depending on the person's area of employment interest) to identify potential job opportunities for clients. The provider will collaborate with and provide linkages to relevant services as defined in the client's individual employment plan, including mental health providers, primary health care providers, culturally-specific community based organizations, family support services, and alcohol and drug programs. The provider will also work closely with each client's identified care coordinator.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Cultural competence and understanding of differences, including sexual orientation and gender, are required expectations of our current providers, are integrated in our current service delivery system, and will be expected of this program. Service providers will possess cultural awareness, knowledge and skills necessary to provide culturally competent services. The program shall assure that staff includes qualified individuals with experience as mental health clients or family members of mental health clients.

The winning proposal's curriculum and program must evidence sensitivity to individual and cultural differences. Special efforts will be targeted at outreach to persons of Latino and Asian-Pacific Islander backgrounds to address inequities in accessing services identified in the gap analysis, and the provider will work closely with members of those communities to ensure active and effective outreach efforts. Specific collaboration strategies will used to effectively connect with persons who are Latino and Asian-Pacific Islander, and will include outreach to specific service agencies such as the Union of Pan Asian Communities (serving Asian/Pacific Islanders) and Southeast Mental Health Center (which serves many Latino persons). It is expected that at least 33% of staff will be bilingual.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The winning proposal's program must evidence sensitivity to individual and cultural differences, including sexual orientation and gender, and training in these areas will be provided to staff. Referrals and linkages may be made to services that are gender-specific or relevant to needs relating to sexual orientation, such as referrals to the Rachel's Women's Center or the San Diego Lesbian, Gay, Bisexual and Transgender Community Center.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable, as this service will be for persons residing in San Diego County.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors Approval	December 2005
Issue Request for Information to solicit service provider/s	February 2006
Release Request for Proposals	April 2006
Identify service provider and initiate contract	July 2006
Program manager hired	July 2006
75% of staff hired	July - August 2006
Staff trained	July-September 2006
Begin services to clients	August 2006
Sixty clients to have obtained competitive employment	June 30, 2007
Sixty more clients to have obtained competitive employment	FY 2007-08

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year**: 2005-06, 06-07 & 07-08	**Program Work Plan Name:** Mental Health and Primary Care Services Integration
Program Work Plan: A - 7 (also links with CY 4.1 and OA-3		**Estimated Start Date: April 1, 2006 (Contract execution date)**

1a) A brief description of the program: MHSA funds will be used to pay for mental health assessment and treatment services to children/youth and their families at various community health clinic settings across San Diego County that also provide mental health services. Services will be coordinated and managed through a master contract with the Council of Community Clinics and will be open to all community clinics within San Diego County willing to abide by the terms of the contract. All contracted clinics will be either Federally Qualified Health Centers (FQHCs) or Indian Health Services (IHS) clinics.

1b) Identification of the age and situational characteristics of the priority population to be served in this program: Adults, who are seriously mentally ill (SMI), and their families who have been identified by the gap analysis, community input and the MHSA Adult Workgroup as being un-served. Prospective clients are currently receiving physical health care services at community clinics but are not currently receiving needed mental health assessment and treatment services because they are uninsured.

	1d) Fund Type				**1d)** Age Group				
1c) Identification of strategies for which you will be requesting MSHA funds for this program. 1d) Identification of the finding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a program.	FSP	Sys Dev	O E	OTO	C Y	TA Y	A	O A	A L L
1c) ✓ Integrated physical and mental health services by providing services via primary care community clinics. Will provide mental health assessment, information, referral and brief mental health services; ✓ Model supports collaboration between mental health and primary care and other physical care providers to improve integrated services; ✓ Community based program to increase access to care in a normative setting for those who may be more responsive to services in health care settings; ✓ Individualized, culturally competent, and strength based assessment and treatment plans with adult/families who actively involved in the development	☐	☐	☒	☐	☐	☐	☒	☐	☐

of the treatment plan; ✓ Community clinics are located across San Diego County in rural, urban, and suburban communities and neighborhoods; ✓ Community clinics serve a broad diverse population. Individual clinics may serve ethnic groups representative of the community and neighborhood in which they are located; ✓ Training on wraparound principles and approach, domestic violence and co-occurring disorders (CCISC model) will be provided to clinical staff; ✓ Services will screen for dual diagnosis and, at a minimum, include screening, assessment, and referral, a wellness, strength-based and resilience focus, wraparound approach, assess for domestic violence, address in treatment or refer for services when appropriate, and will adhere to San Diego County's Cultural Competence standards; Training to Primary Care providers regarding the mental health system will be developed. Note: this is not funded under this project Work Plan but will be covered under separate One Time Only Training funds.									

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

The County of San Diego is proposing to utilize the many community clinics in San Diego County to provide mental health treatment services to adults, children and adolescents and their families. Services will be targeted toward uninsured families. The Service modality will be coordinated through a master agreement with the Council of Community Clinics to manage the authorization of care and provide general system management. The Council of Community Clinics will develop sub-contracts with individual clinic providers and reimburse for services provided by staff of the participating clinic organizations on a fee-for-service basis and authorize treatment and payment for necessary medications. The Council of Community Clinics represents the consortium of community clinics and Indian Health Services providers in San Diego County. The Council of Community Clinics was selected as the provider and coordinator of this program because they already serve in this role for the County for specialist care for Ryan White funds for the County of San Diego Office of AIDS Coordination and for dental services for San Diego County's First Five Commission.

San Diego County elected to pursue this program model because there are already 13 clinic organizations (9 community clinics and 4 Indian Health Services' provides) that offer mental health services at 27 different locations throughout San

Diego County. At this point, it has not been determined exactly how many of the clinics will participate in the program although all clinics have expressed a strong interest in partnering with the County for this MHSA component especially since it will be focused on families with no other health coverage.

The goal of this program is to provide integrated care between the primary care provider and the mental health provider within the same clinic structure. Due to lack of coverage, many patients seen by the primary care providers appear to be in need of mental health care, but there have been no means to fund the assessment and treatment.

This work plan is specific to Adults, but is linked to Children/Youth (work plan CY 4.1), and Older Adults (work plan OA-3). The Council of Community Clinics will be utilized as the coordinating entity among all participating clinics. The Older Adult Work Plan has some additional outreach components but all three are designed to improve coordination and integration of primary care and mental health services.

The existing network of providers includes:

a. Family Health Centers of San Diego. Seven different sites serving zip codes 92103, 92113, 92109, 92115, 92101, 91977, and 92104.
b. Imperial Beach Health Center. One site serving 91932.
c. Indian Health Council (Indian Health Services-IHS). Two sites serving 92082 and 92070 zip codes. Both zip codes are in rural areas of the County.
d. La Maestra Community Health Centers. One site serving 92105 zip code.
e. Mountain Health and Community Services. Three sites serving rural east San Diego County including zip codes 91901, 91934 and 91906.
f. Neighborhood Health Care. One site serving the 92025 zip code.
g. North County Health Services. Two sites serving 92054 and 92069 zip codes.
h. San Diego American Indian Health Center (IHS). One urban site serving zip code 92103.
i. San Diego Family Care. Three sites serving 92111 and 92105. There are separate adult and pediatric sites to serve the 92105 zip code.
j. San Ysidro Health Center. One site serving 92173 zip code.
k. Southern Indian Health Council (IHS). One site serving the 91903 zip code.
l. Sycuan Medical/Dental Center (IHS). One site serving the 92019 zip code.
m. Vista Community Clinic. Three sites serving 92084, 92054 and 92083 zip codes.

As a general rule, regular clinic hours are Monday through Friday from 8 A.M. to 5 P.M. However, clinics will normally have one or two days a week where they are open until at least 7 P.M. or later and some of the larger clinic sites will be open on Saturdays, to provide increased access to working families.

Target Population: Adults who are seriously mentally ill, and their families who have been identified by the gap analysis, community input and the MHSA Adult Workgroups as being unserved. Prospective clients are currently receiving physical health care services at community clinics but are not currently receiving needed mental health assessment and treatment services because they are un-insured.

Program Goals: Integrated physical and mental health services by providing services via primary care community clinics.

Types of Services to be performed: Services to be performed include mental health assessment, information, referral and brief mental health services. Council of Community Clinics will manage the allocation of service funds for both assessment, treatment, medications and even outreach, if needed. They will authorize treatment after receipt of assessment.

What will the Services promote: The services will promote community based program to increase access to care in a normative setting for those who may be more responsive to services in health care settings. Individualized, culturally competent, and strength based assessment and treatment plans with families/youth actively involved in the development of the treatment plan.

Number of clients estimated to be served: An estimated 700 annually will be served annually. All patients referred will be entitled to an assessment. If the assessment indicates they need treatment, services will be authorized. During the initial 3 months of the program an estimated 175 will be served.

Where will the clients come from: From with the existing patient population at community clinics. Patients will be receiving physical health care but are uninsured and not receiving mental health treatment although such treatment may be needed.

3) Describe any housing or employment services to be provided.

The program will not be directly involved in the provision of either housing or employment services. Community Clinics will make referrals to appropriate community resources should specific issues be identified. For example, clinics will refer

to the nearest County Family Resource Center for access and screening regarding other services the County Health and Human Services Agency might provide in that region.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This is not a Full Service Partnership program, it is Outreach and Engagement.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This a unique program in that the clients are seeking medical care at a community clinic and as part of the clinic's effort to provide care they have identified possible issues related to mental health that should be addressed if the client is to be treated in a holistic manner. Since the target population is the uninsured, it is likely that the mental health issues have not been addressed. The issues may be identified as part of preventative health care visits or as part of the many health education activities that clinics participate in both within the clinic and the community. For example, community clinics regularly participate in community health fairs in the community and they may come in contact with families that need comprehensive care. Another example may be a teenager who may be treated for some injury in a recreational or sporting activity and the nurse and/or physician becomes aware of some other emotional or mental health issues that warrant a referral for assessment.

A key component of this project will be providing training to primary care providers on how to identify potential emotional or mental health issues that would warrant referral for assessment. Separate from the funds identified for this work plan activity, the County of San Diego will be allocating One Time Only training funds for specific training for Primary Care providers. The Council of Community Clinics is specifically interested in coordinating the training for all participating clinics. In order to maximize participation of all clinics in a County as large as San Diego County, trainings will be de-centralized to the various regions of San Diego County as much as possible.
The contracts will specify the expectations regarding training.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program in terms of providing services at community clinic sites and a new strategy of trying to integrate physical health care and mental health care within the same program.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Community clinics have long been involved in utilizing clients and family members within their service delivery model wherever possible. There are a great many people who, because of their own positive experience with community clinics as patients, later went to work for community clinics either as staff or in some volunteer capacity. As medical model programs, many of the medical staff do need appropriate professional credentials. However, many former clients have joined clinic staff in a support capacity or have become community outreach workers working for individual clinics.

In addition, all clinic organizations have Boards of Directors that include consumer representatives. Feedback from those consumer representatives on Clinic Boards regarding the implementation of this model will be incorporated into the evaluation of this program. In addition, the Council of Community Clinics, as the lead contractor for this program will conduct a series of client focus groups to elicit direct client input on the program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Health and Human Services Agency is organized into 6 geographic regions across the County. An Executive Level staff (Deputy Director – Regional General Manager) is responsible for one or more of the geographic regions. Each Regional General Manager has initiated a collaborative model within each region to bring stakeholders, including providers, into partnership with the County to discuss key issues of each region. Community Clinics have been participating in the Regional Collaboratives since the Health and Human Services Agency (HHSA) was established in the late 1990s. These Regional Collaboratives include the full spectrum of health and social services agencies as well community stakeholders. With the creation of a HHSA Behavioral Health Division merging Adult/Older Adult Mental Health, Children's Mental Health and Alcohol and Drug Services, there will be greater participation of mental health and alcohol and drug service providers into the Regional Collaboratives. This will facilitate greater coordination with the community clinics.

This project will enable the County to specifically address access for Native Americans within San Diego County. All of the existing Indian Health Services clinic organizations are members of the Council of Community Clinics. The four Indian Health Service providers include three rural organizations (Indian Health Council, Southern Indian Health Center, Sycuan Medical Center) and one Indian Health Services provider (San Diego American Indian Health Center) which targets Native Americans living in the urban areas.

It is also the expectation that the addition of the MHSA funded Mental Health/Primary Care Integration model will facilitate greater collaboration between the clinics and traditional mental health providers and the County.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Clinics serve an ethnically diverse population across San Diego. Globally the primary care clinics who are members of the Council of Community Clinics serve a largely minority population broken down as follows: 57% Hispanic, 3% Asian, 6% African-American, 25% White, and 9% Other. The large percentage of Other reflects the large number of multi-racial persons seen at community clinics. These numbers do not include the Native American population served at the four Indian Health Services provider agencies. These numbers do not also include the patients seen by Family Health Centers of San Diego (FHCSD) which operates in several neighborhoods with significant African American populations. Since the communities seen by FHCSD also have many Spanish speaking families, 95% of the FHCSD Mental Health Staff are bi-lingual. Individual clinics may have different ethnic mixes. For example, San Diego Family Care, with clinics in the Linda Vista and Mid-City neighborhoods the City of San Diego serves a high percentage of Indo-Chinese and other Asian groups. La Maestra Clinic which is also located in the Mid City neighborhood served primarily Hispanics in the area but also serves various Asian/Pacific Islander populations.

Community Clinics have individually adopted strategies to address serving culturally and linguistically diverse communities as they have developed in order to provide appropriate primary care services. Clinics have embraced the “promotora” model of training community health workers as a viable means to reach out to the community. Community workers have been used for purposes such as diabetes education, Healthy Families and Medi-Cal enrollment outreach, and in the North County, outreach to migrant agricultural workers. In addition to ethnic minorities, Mountain Health and Community Services has been a leader in developing effective strategies to reach out to rural populations in Eastern San Diego County.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Contracting with Community clinics will provide a unique opportunity to utilize provider organizations that have considerable experience with these specific target populations. Community Clinics are one of the leading providers of medical services for the County Office of AIDS coordination for primary care services under the Ryan White Act. This role has enabled the clinics to establish strong working relationships with social service agencies serving the Lesbian, Gay, Bisexual and Transgender (LGBT) communities of San Diego County. The clinics have been involved with Ryan White funding for over 15 years and this involvement has made them trusted partners with the LGBT community.

As an example, FHCSD policies include recruitment procedures and standards for representation of the community served; these policies address cultural sensitivity, diversity, and inclusiveness. On-going clinic supervision of mental health staff also addresses the cultural issues of each clinical case, with culture and diversity issues routinely discussed in weekly individual and group supervision meetings. Within the past year, FHCSD staff have attended external trainings; a sample of these topics: Latino Culture, Muslim Culture, African-American Culture, Asian Culture, Hearing Impaired Culture, Transgender Culture, Disabled Culture and Native American Culture.

In addition, the community clinics serve approximately 40% of all families enrolled in Medi-Cal managed care in San Diego County (Healthy San Diego Geographic Managed Care model). Community Clinics are also a significant provider of services to Healthy Families and CHDP services in San Diego County. Since 2/3 of enrollees in Medi-Cal Managed Care are children (both boys and girls) and Healthy Families and CHDP are exclusively boys and girls, community clinic providers have significant institutional knowledge of the specific needs of families and how to best address those needs.

11) Describe how services will bee used to meet the service needs for individuals residing out-of-county.

This program will provide services to in-county residents only.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Exhibit IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Approval by the Board of Supervisors of the MHSA CSS plan and approval of the sole-source contract with the Council of Community Clinics	12/13/05
Development of draft Statement of Work by County staff	January, 2006
Preliminary meeting – Council of Community Clinics and Clinic Directors	2/13/06
Contract Finalized	3/31/06
Implementation and start-up period	4/1/06 to 4/7/06
Services begin to clients	4/7/06

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN

County: San Diego	Fiscal Year: 2005-06; 06-07; 07-08	Program Work Plan Name: Enhanced Outpatient Mental Health Services
Program Work Plan: # A-8		Estimated Start Date: July 2006

1a) A brief description of the program:
Enhanced outpatient mental health services will be provided throughout the six Health and Human Services Agency (HHSA) regions of San Diego County. These services will provide culturally competent, services, including rehabilitation and recovery best practices to an additional 424 un-served adults ages 25-59 that have a serious mental illness, including those who may have co-occurring mental health and substance abuse disorders. This program will advance the MHSA goals of providing timely access to needed help, (including times of crisis); and reduce ethnic disparities by providing MHSA funding to approximately 11 Bio-psychosocial Rehabilitation and Recovery (BPSR) centers.

1b) Identification of the age and situational characteristics of the priority population to be served in this program:
Persons served who are un-served adults ages 25-59, who have a serious mental illness, including those who may have co-occurring mental health and substance abuse disorders, who have lacked access to mental health rehabilitation and recovery services due to barriers of language, wait times, lack of knowledge or awareness about the types and benefits of services available such as integrated treatment for co-occurring disorders. Persons served may also be those who have only accessed mental health services through the justice system or acute emergency care. In accordance with AB599, veterans are eligible for this program.

	1d) Fund Type				1d) Age Group				
1c) Identification of strategies for which you will be requesting MSHA funds for this program. 1d) Identification of the finding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a program.	FSP	Sys Dev	OE	OTO	CY	TAY	A	OA	ALL
1c) Enhanced outpatient mental health services funding will enable more clinic sites to recruit and retain bilingual and bicultural staff to offer services to the un-served Asian-American/Pacific Islander and Latino adult population who have a serious mental illness identified in the San Diego County gap analysis.	☐	☒	☐	☐	☐	☐	☒	☐	☐

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

MHSA system development funds will be used to expand existing service capacity at 11 bio-psychosocial rehabilitation and recovery (BPSR) out patient mental health programs located in the six Health and Human Services Agency (HHSA) regions in San Diego County. Funding will also be used to create new services in selected BPSR programs in all 6 regions. San Diego County Mental Health Services (SDMHS) will contract with community based organizations to provide these enhanced outpatient services.

These funds will expand services provision in San Diego County under a rehabilitation and recovery model of practice that was introduced in 1999 when the County Board of Supervisors authorized the HHSA and its Adult and Older Adult division to implement the System Redesign initiative. This quality improvement initiative had – and continues to have - the goal of transforming a service delivery system based on a medical model to one which is based on recovery goals and principles. Six BPSR principles have been key in this ongoing task of transforming this service delivery system. Services will be:

- Culture-centered and individualized for each client
- Comprehensive, integrated, and coordinated; both at the system and service delivery levels,
- Provided in the least restrictive and most appropriate setting,
- Built on the strengths and resilience of persons with a mental illness,
- Empowering – that is, they involve persons with a mental illness as full partners,
- Supportive and protective of client rights in their treatment and care.

Since 1999, this culture-centered (Pederson, 1994) and recovery based service delivery system has been advancing MHSA goals through the implementation of rehabilitation principles which have proven to be effective in reducing psychiatric hospitalization and assisting persons with a mental illness to become more productive community members. Since implementation, all contracted and County staff in this system have been trained on BPSR principles and best practices, part of a plan to steadily develop workforce capacity to deliver services based on recovery principles and which are also culturally appropriate. Under the leadership of the Psychosocial Rehabilitation Coordinator - both County and contract providers have participated in required trainings on these recovery principles, and they are standard offerings to all new employees, whether hired by contractors or in county-operated programs.

These MHSA system development monies will advance MHSA goals in several ways. The expansion of core BPSR services will enable existing programs to serve additional clients, as well as to expand the array of services. Services specifically stated in the RFP Statement of Work include those which are bolded:

- Behavioral health screening for both mental health and alcohol and drug issues. This initiative operationalizes BPSR principle 2 above by providing more integrated and coordinated services for clients with co-occurring disorders

- An integrated bio-psychosocial assessment which includes assessment of domestic violence

- Alcohol and drug assessment, co-occurring disorder (COD) treatment (including COD groups), and referrals as specified based on Continuous, Comprehensive, Integrated, Service of Care (CCISC) principles and criteria. This quality improvement initiative is an integrated and comprehensive treatment, training and administrative approach that supports the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis -specific and stage-specific treatment for each disorder.

This model is based on the following 8 clinical consensus best practice principles: 1) dual diagnosis is an expectation, not an exception and the interaction with the client shall be welcoming 2) the treatment relationship is empathic, hopeful, continuous 3) treatment services can be planned by using the four quadrant national consensus model for system level planning 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced 5) each disorder should be considered equally important and integrated dual primary treatment is required 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched

interventions 7) there is no one type of dual diagnosis program or intervention that is correct, treatment services are matched to client needs 8) outcomes are individualized.

- Crisis intervention and prevention,
- Medications support services, including disease management information. Under the MHSA System-wide Education and Training Plan, training will be provided on the San Diego Medication Algorithm Project (San/DMAP). This quality improvement initiative seeks to empower clients in their education and choice of medications for recovery. It is noted as a best practice in the President's Freedom Commission.

- Individual and group therapy. Ongoing group services are a primary modality and shall be based on evidence based and best practice approaches to rehabilitation. They include - but are not limited to - cognitive behavioral treatment, dialectical behavior therapy, motivational interviewing, disease management, and relapse prevention for both mental illness and substance use disorders. The system transformation will be further developed by expanding provider ability to provide more culturally appropriate treatment. Contractor will collaborate with the MHSA Community Education and Training Contractor and participate in cultural competence trainings to be developed under a System Wide Education and Training Plan (MHSA CCS Plan One Time Only Monies, OT-1).

- A service plan that is culturally competent, strength-based and contains measurable objectives for each client receiving services

- Pre-employment assessment for persons with a mental illness whose service plan includes employment-related objectives, and linkage to the Department of Rehabilitation Employment Services program

- Outreach to un-served and underserved populations, including – but not limited to - participation in two to four health fairs annually.

MHSA system development monies will advance MHSA goals and continue the transformation of San Diego's Adult and Older Adult System of Care (AOASOC) in a second significant way, by enabling the creation and expansion of new services in the North Inland region city of Fallbrook, an area that is experiencing rapid population growth in general, and of the Latino population in particular. The contractor will be expected to locate the proposed program within or near a primary care community clinic or other community agency such as a Family Resource Center (County social services agency) to enhance access for diverse populations who primarily access mental health through primary care.

The target population in this region is Latino adults, whilst in other regions, enhancements to BPSR centers will provide outreach for other underserved populations, especially Latinos, African Americans, Asian and Pacific Islanders, and immigrant and refugee populations who have a severe mental illness. In the Mira Mesa area of San Diego, underserved Filipino persons will be the focus of outreach, with clinic staff augmentations to add bi-lingual, bi-cultural staff with which to provide culturally appropriate services to this population. In the Central region, a program serving African Americans will be augmented in a similar fashion to provide more services of a culturally appropriate nature, and in East County, service expansions will improve access for Latinos and other immigrant populations, including Chaldeans and other Iraqi population groupings.

Contractors will be required to partner in the transformation of the system and advance MHS goals in a third significant way: through their involvement in planning and use of data. The RFP Statement of Work puts it thus:

> "*Contractor shall provide the services described herein to adults 25-69 years of age or older who are eligible for Medi-Cal funded services or are indigent, including those with co-occurring substance use. Contractor should demonstrate knowledge and application of the MHSA Gap Analysis when describing the target population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities."*

MHSA system development monies will advance MHSA goals and continue the transformation of San Diego's A&OA system of care in a fourth significant way by improving outcomes. For a system to be transformed it must be informed by data and able to measure outcomes. In 2005, BPSR outcome and process objectives requirements were added to all contracts and made a requirement of all County-operated BPSR centers (see Statement of Work, Addendum 1). From 2006 onwards, these measures will be applied to all clients who access the system because of MHSA system development funds.

System transformation is not possible without greater client and family participation. MHSA system development monies will advance MHSA goals and continue the transformation of San Diego's A&OA system of care in a fifth significant way: by incorporating client experience and talent into the operation of ALL BPSR OP centers. In a tangible step towards achieving this goal, all contracts will stipulate a minimum requirement of .5FTE in every BPSR OP center. Additional contractual requirements in place in all Bio-psychosocial rehabilitation out patient centers stipulate that:

3) Describe any housing or employment services to be provided.

While these system development funds for out patient expansion do not directly provide housing or employment, they will support people identifying and working toward housing and employment goals and will include linkages to a variety of supports related to housing (e.g., local Housing Authorities; listing of affordable housing) and employment (e.g., Employment Services program; Department of Rehabilitation; clubhouses). Pre-employment and employment services are offered as part of the array of rehabilitation services in every BPSR program. Employment services referrals may include CalWORKS or education and vocational training via linkage to the Department of Rehabilitation Employment Services program.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This program is not a FSP. MHSA funding ha been allocated for System Development.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The proposed program will advance the goals of recovery for adults in several key ways. First of all, the contractor will be required to expand services and provide new services that are built on BPSR principles as described in every expanded contract.

The AOAMHS System Redesign Implementation Plan approved by the Board of Supervisors in 1999 is based on BPSR principles that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members. BPSR guiding principles specify that services shall be:

- Client centered;
- Comprehensive and integrated with a broad array of services;
- Individualized, culture-centered, and built upon client's strengths;
- Provided in the least restrictive and most appropriate setting;
- Coordinated both at the system and service delivery levels;
- Delivered with clients as full partners in their treatment and care;
- Protective of client rights.

Following these guiding principles, the BPSR Center's program shall provide bio-psychosocial rehabilitation and recovery

services which are comprehensive, culturally competent, age and developmentally appropriate, and which exemplify best practices in psychiatric, vocational, nursing, social skill and illness management techniques, and which provide activities tailored to individual client's needs within their cultural context. The objective is to improve clients' competencies for a quality life in the community by offering services which not only eliminate or alleviate client symptomatology and pathology, but enable clients to manage their illness within a recovery-based context. BPSR Centers shall promote wellness and recovery by providing a user-friendly environment that is welcoming to clients of diverse cultural backgrounds and to others significant in these clients' lives. The Centers shall be an integral part of their regional communities, and places which encourage family members, local citizens and former clients to volunteer their talents to enrich their rehabilitation and recovery activities."

The values of recovery and resiliency will be promoted and continually reinforced in a third major way, through trainings based on BPSR principles provided through both one time only funds and ongoing training funds.

Training and technical assistance for BPSR programs will include training on both Deegan's 'Intentional Care' standards (staff performance standards developed by a leading consumer advocate) which are designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills.

These components will advance MHSA goals by providing client directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, reduce homelessness, contact with the justice system and reduce inappropriate use of acute inpatient care and medical care. Additionally our contract monitors ensure that providers are serving diverse populations by reviewing population served and meetings with these groups in the area to be served.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

The 11 BPSR centers currently provide culturally competent integrated mental health and substance abuse mental health assessment, domestic violence screening, medication supports and disease management, individual and group therapy, and employment screening and supports. The existing services will change under this proposal by providing additional client capacity, providing enhanced mental health, rehabilitation and recovery services to un-served clients, with specific emphasis in engaging Latinos, Asian/Pacific Islanders, African-Americans, Chaldeans and Native Americans in the HHSA

regions where the 11 BPSR programs are located. SDMHS recognizes that our GAP analysis demonstrates a need to provide additional services to narrow the gap in services for un-served and inappropriately served clients of distinct cultural and linguistic backgrounds.

The existing BPSR centers will change under this proposal in the following ways: **S**ervice delivery enhancements will ensure that additional services are both more culture-centered and recovery oriented. Three strategies will be used; the first is that rehabilitation services will be more integrated under the CCISC model, a component of the Behavioral Health Initiative that addresses co-occurring disorders. The second strategy addresses the provision and delivery of culturally competent services described in detail in Section 9. This strategy uses new contract requirements which specifies the hiring of new staff who are culturally and linguistically competent, and in training existing staff to provide rehabilitation and recovery services which are culturally appropriate services and evidence based. The third strategy involves the addition of new rehabilitation and recovery services and the coordination and linkage to primary health care providers in the six HHSA regions. The quality and relevance of these services will also be improved through training to provide more culturally competent services for un-served and culturally diverse populations who have a severe mental illness. .

7) Describe which services and supports persons with a mental illness and/or family members will provide. Indicate whether persons with a mental illness and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

In these 11 BPSR out patient programs, persons with a mental illness will be hired to work at whichever level they qualify. As per contractual requirements, the contractor shall assure that program staff includes qualified individuals with experience as mental health persons with a mental illness or family members of mental health persons with a mental illness. To ensure that this occurs, the contract will stipulate that *"the program shall employ a minimum of .5 FTE staff to serve as a peer specialist who is an individual with experience as a mental health client. The program shall also demonstrate that this .5 FTE peer is a new position for the program."*

Persons with a mental illness will also be invited to be involved in governance of every BPSR program by participating in the Program Advisory Group (PAG). Specific contractual language read as follows:

> *"The PAG shall include at least 51 percent persons with a mental illness, and shall reflect the ages and cultures of the client population."*

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

These BPSR programs will maintain existing collaboration and Memorandum of Understanding (MOU) agreements, and expand them to include other community-based organizations, especially primary care centers through the Council of Community Clinics. Existing collaborative efforts are required by contract agreement, as in this sample language:

> *"Contractor shall establish formal, documented linkages with Mental Health Plan hospitals, crisis residential facilities, programs for the homeless, County of San Diego Sheriff's Department, and older adult programs, including the HHSA Aging & Independence Services' Senior Team, in the North Coastal Region."*

Additional contract language for all contracts in 2006 language has been added to include new community providers. A number of these providers will enhance culturally competent outreach and services.

> *"Linkage 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".*

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

There are five strategies which programs will use to become more culturally competent and meet the needs of culturally and linguistically diverse communities. The first strategy involves the use of specific contractual direction which requires contractors will to comply with all County of San Diego A&OAMHS cultural competence requirements to include Cultural Competency Clinical Practice Standards (CCCPS). The County of San Diego seeks to have a system that embodies and exemplifies the following principles:

The 14 principles are as follows;

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.

3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
9) Cultural factors are integrated into the clinical interview and assessment.
10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
14) Staff actively seeks out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

A second strategy to be utilized in helping chosen programs to be culturally competent concerns the issue of ethnic disparities identified in part II, Section II of the MHSA CCS Plan. It involves the use of RFP Statements of Work for every BPSR program to require contract providers to use the MHSA Gap Analysis. Contractors will use the data from this analysis to plan, develop, and implement services for un-served populations. They will be asked to specify how they will utilize best practices which are both evidence based and culturally appropriate to develop and provide rehabilitation and recovery services that meet the needs of the diverse populations in their respective regions.

A third strategy which programs will use to become more culturally competent and meet the needs of culturally and linguistically diverse communities requires the implementation of cultural competency requirements in all A&OAMHS

BPSR OP wellness which are described in the San Diego County Mental Health Services Cultural Competence Plan, Cultural Competent Clinical Practice Standards, and the and findings of the MHSA CCS Plan Gap Analysis. This will be accomplished through specific contractual language which requires providers to develop and provide culturally appropriate services:

> *"Culture-specific interventions shall be demonstrated in the area of group therapy modalities, especially in relation to adult and Transitional Age Youth (TAY) Latinos."*

The fourth strategy which programs will use to become more culturally competent and meet the needs of culturally and linguistically diverse communities involves devising and implementing plans to develop the cultural competencies of their workforce, and to develop linguistic proficiency. To implement Cultural Competent Clinical Practice Standards 4 and 5, all A&OAMHS RFP SOW's will state:

> *"Contractor shall provide a Human Resource Plan that includes how contractor shall recruit, hire and retain bilingual and culturally diverse staff,*
>
> *"Contractor shall identify a process to determine bilingual proficiency of staff at a minimum in the threshold languages for the County".*

While Contractors are determining linguistic proficiency and implementing their findings, some programs may need to augment their staffing language proficiency. To further implement Cultural Competency Clinical Practice Standard 6, all mental health service providers may access the services of two community based organizations who are contracted with SDCMHS to provide verbal and non-verbal (i.e. sign language) interpreting services. Interpreters Unlimited is contracted to provide translation services for spoken languages - including all Medi-Cal threshold languages for San Diego County, namely Spanish, Vietnamese, and Arabic - and Deaf Community Services for translations services for persons with a mental illness who are deaf or hard of hearing.

Monthly reports by Interpreter's Unlimited on the usage of verbal language interpreters by providers enable Program Monitors to monitor service utilization. In a bi-annual report on staffing and linguistic capacity, Quality Improvement unit and Regional Program Coordinators are responsible for monitoring county and contracted OP programs in their respective regions currently hold all programs accountable for use (MSR) bi-annual report on program staffing Monthly Status Reports sent to the and linguistic capacity.

The fifth strategy to be employed to meet the needs of culturally and linguistically diverse communities is pertains to training in cultural competence. To implement Cultural Competency Clinical Practice Standards 7 -14, there is a contractual requirement in the RFP Statement of Work that requires providers to participate in cultural competency training. All SDCMHS staff – including direct provider staff, administration, and clerical and support staff - is currently required to take 4 hours of cultural competency training annually. RFP language directs contractors thus:

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Gender differences and sexual orientation are currently addressed in training provided by Health and Human Services Training and Development (HHSA T&D) as part of agency wide training to improve the culturally competent delivery of services. Program providers will be asked to participate in trainings on cultural competent service delivery as an integral part of the System Wide Education and Training Plan (SWETP) which is described in the CSS Plan, OTO – 1. This training program will utilize the California Brief Multicultural Scale (CBMS), an 11 item scale contains specific questions on gender and sexuality. Providers can use their own responses to both ascertain their current level of cultural competence, and construct their own plan to strengthen existing competencies and remedy areas of deficit. Using the County Culturally Competent Clinical Practice Guidelines, a County approved curriculum will be developed which will include specific trainings in the areas of gender, sexuality, age, ethnicity and client culture for all service providers over a three year period beginning July 1st, 2006 or when the Education and Training Contractor is awarded the contract to design and implement trainings described in the SWETP.

11 Describe how services will be used to meet the service needs for individuals residing out-of-county.

These services are for in-county clients, however, clients returning from out-of county will be linked to this or any appropriate MHSA service.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Activity	Date
Board of Supervisors approval	December 2005
Request for Information issued	February 2006
Request for Proposals issued	April 2006
Contract awarded*	July 2006
Program manager hired	July 2006
75% of staff hired	August 2006
Staff trained	July - September 2006
Begin services to clients	August 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN

County: San Diego	Fiscal Year: 05-06/ 06-07/07-08	Program Work Plan Name: High Utilizer Comprehensive Integrated Services + Supported Housing for Older Adults with a Serious Mental Illness (SMI)
Program Work Plan #: OA-1		Estimated Start Date: July 2006

1a) **Program Description:**

This program will provide countywide age appropriate, culturally competent/linguistically appropriate comprehensive and integrated individualized mental health rehabilitation and recovery based services, case management with wraparound services and supports for older adults and their families and caregivers, following the Assertive Community Treatment (ACT) model. This program will provide timely access to crisis and supports to assists older adults and family /caregivers managing independent living, reducing isolation, improving mental health, assisting elders remaining safely in their homes, thereby advancing MHSA goals for older adults.

1b) **Priority Population**:

This program seeks to provide services to 83 unduplicated Severely Mentally Ill older adults aged 60 and older from the initial target population (Unserved, Latino, Asian including those with co-occurring substance use disorders) who have either/and /or a) history of repeated emergency mental health services during the year prior to admission to this program; b) several admissions to inpatient services or at risk for institutionalization (Nursing Home/ Board and Care Placement.); c) have been homeless or at risk for homelessness. Priority for admission to this program will be given to older adults with a SMI and with the most severe conditions and with highest incidence of emergency and inpatient services utilization, who may also be homelessness and/or risk of becoming homeless, and older adults having the most difficulties accessing care due to system barriers. In accordance with AB599, veterans are eligible for this program.

	1d) Fund Type				1d) Age Group				
1c) **Describe strategies to be funded, Funding Types requested (check all that apply), Age groups to be served (check all that apply)**	FSP	Sys Dev	O E	OT O	C Y	TA Y	A	O A	A L L

✓ Services will be provided 24hrs a day /7 days a week by a Personal Services Coordinator; interventions will be conducted at individual's home or in familiar setting to the older adult; ✓ Staff to consumer ratio will be 1 staff to 10 clients and ACT (Assertive Community Treatment) Team members will share responsibility for the provision of treatment, rehabilitation and support services; ✓ Outreach, engagement and crisis intervention to engage older adults in client directed treatment; ✓ Individualized comprehensive and integrated mental health and substance abuse assessment, geriatric mental health assessment, treatment planning and outcome monitoring; outpatient mental health services and medication management services; ✓ Peer/family counseling and In-Home Respite/ support to families and caregivers to reduce negative burden of care giving and postpone out-of home placement; peer Door-to-Door transportation services for client, family and caregivers; ✓ Training and technical assistance for the development, implementation and evaluation of: a) Evidence based Geriatric Assessment, Care Planning and Decision Support, Outcome Data Tracking, Analysis and Management, and Network Communication and Coordination; b) Evidence –based Assertive Community Treatment Model; Mary Ellen Copeland's Wellness and Recovery Action Plan ;and Pat Deegan's Intentional Care Guidelines. ✓ ACT Team will operate with dual diagnosis capable enhanced capacity	☒	☐	☐	☐	☐	☐	☐	☒	☐

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

This is a new program and San Diego County Mental Health Services (SDHS) will select via a competitive process a qualified and experienced agency/organization to deliver this Full Service Partnership for 83 Older Adults, servicing up to approximately 100 unduplicated clients each year. Utilizing the Assertive Community Treatment Team (ACT) Model, an Evidence-based model that has repeatedly proven effective with people who have serious mental illness who have not

been adequately served by the usual service system, Contractor will design and deliver a culturally/ competent /linguistically and age appropriate services, treatment, and support and rehabilitation services in all six (6) San Diego County, Health and Human Services Agency, (HHSA). The selected contractor for these services will be required to provide services that maintain a high fidelity to ACT Team practice as identified by the SAMHSA *ACT Implementation Resource Kit's and fo*r evaluating program fidelity and reporting its results quarterly.

Using a multi-disciplinary team with a ratio of 1 clinician to 10 clients, the ACT team will serve approximately 100 unduplicated individuals. Contractor will provide individualized services in individual's home and/or familiar setting to older adults, and will incorporate integrated mental health rehabilitation and recovery treatment, mental health education, and skill building activities in this program. Act Team members will share the responsibility for the treatment, rehabilitation and support services and each person's status will be reviewed daily by the team to ensure that nature and intensity of services can be adjusted quickly as client's needs change. At least 50% of the staff will be bi-lingual /bi-cultural, providing services to client's 24-hours a day /7 days per week, 365-days a year, having a team member on call during all hours to provide in-person response as needed.

The services to be provided by the ACT Team members will include but will not be limited to:

- ✓ Extensive outreach and engagement services to persons identified as having a high priority for this service.

- ✓ Contractor will outreach and educate community services providers about new MHSA funded older adult wrap around services and supports and about admission criteria for program. Referrals will come from local Emergency Services, Impatient Hospital, Long Term Care, Skill Nursing Facilities, County Case Management, Aging and Independent Services (AIS) Senior Teams, Case Management Programs and the to be implemented MHSA-Senior Mobil Outreach Teams (MHSA –Work plan OA-2).

- ✓ Services coordination and rehabilitation and recovery planning through a "single point of accountability" provided by the Act Team that will responsible for ensuring that services to be offered will be seamless and offer clients and family members an integrated service experience, to prevent clients from negotiating multiple provider and funding sources in order to get needs met.

- ✓ Intensive wraparound services and supports including; medication management, prescriptions and medication support services, supported housing services, supported employment and supported education services for those clients in need of such services.

- ✓ In person 24/7 crisis response to seniors experiencing mental health crisis, in their homes and/or in other locations in the community to assist in the stabilization of the client.

- ✓ Individualized comprehensive and integrated mental health and substance abuse screening; geriatric mental health assessment, treatment planning and outcome monitoring; outpatient mental health services and medication management services**.**

- ✓ Ongoing Individual and group supportive therapy provided by members of the individual treatment team. The role of individual and group therapy modalities is to address symptoms, stress and interpersonal issues that may occur in client's living situation or at work.

- ✓ Linkages to available community resources, including but not limited to mental health and primary care, Fee For Service (FFS) providers and Mental Health Plan hospitals, emergency rooms, crisis residential facilities, residential treatment facilities, Board and Care facilities, housing authorities, Psychiatric Emergency Response Team, law enforcement, and other adult and older adult programs throughout San Diego County.

- ✓ Senior Peer/Family Support – Provision of In-Home Respite services to enhance caregiver's ability to provide quality in-home or supplemental care to family or friends.

- ✓ Clients and families individual and group educational opportunities on a variety of topics that will strengthen ability to function independently and improve their quality of life.

- ✓ Door-to-Door transportation services for clients and family /caregiver with capacity to accommodate individuals confined to a wheelchair. Services will include transportation to doctor's appointments, grocery shopping and/or to socialization and leisure activities, thereby enhancing client, family and caregiver wellness and independence.

- ✓ The Act Team will participate in a pilot project for the implementation of a web-based Evidence-based Care Planning, Decision Support and Outcome Tracking Toolkit for Older Adults providing systematic approach for comprehensive screening, assessment, treatment plan development and outcome tracking. This toolkit will also provide a menu of treatment options and decision support module to assist clients and staff selecting treatment interventions. The Outcome tracking capacity provides for consumer and provider data collection, longitudinal care support and the management of care and coordination of client/clinician/service network communication. One Time Funding will fund the Technical Assistance for the development and implementation of the pilot project and for the training of program

staff on the Evidence–Based Toolkit. This project is part of a Regional Collaborative involving three Southern California Counties (Orange, Riverside and San Diego), the California Institute of mental Health and Dartmouth University Research Center.

- ✓ Following SAMHSA's ACT Implementation Resource Kit (2003), Contractor will implement a full fidelity ACT program. One time funding will provide to secure Technical Assistance and deliver training and other support for the implementation and evaluation of this Evidence-base practice.

- ✓ One time funding will be available to implement psychosocial rehabilitation interventions such as Mary Ellen Copeland's Wellness Recovery Action Plan, which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills, and Pat Deegan's Intentional Care Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways.

- ✓ Act Team staff will also participate in the system-wide MHSA Comprehensive Continuous Integrated System of Care (CCSIC) Cadre Training supporting the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders and ensuring that the program meets dual diagnosis capability criteria in accordance with the HHSA, Adult Older Adult mental Health, Children Mental Health and Alcohol and Drug Services Charter and Consensus Document for addressing Co-0ccurring Disorders. The CCISC model is a nationally recognized best practice that focuses on 8 key practices principles: 1) dual diagnosis is an expectation, not an exception and the interaction with the client shall be welcoming 2) the treatment relationship is empathic, hopeful, continuous 3) treatment services can be planned by using the four quadrant national consensus model for system level planning 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced 5) each disorder should be considered equally important and integrated dual primary treatment is required 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions 7) there is no one type of dual diagnosis program or intervention that is correct, treatment services are matched to client needs 8) outcomes are individualized.

3) Describe any housing or employment services to be provided.

The contractor's Housing Specialist in close collaboration with the to be identified MHSA housing technical expert, will develop a continuum of supportive housing opportunities for older adults may include: short-term emergency and

temporary housing; transitional group and independent living , and permanent supported housing to include independent permanent housing and permanent co-housing. $1,095,600 in One-Time funds in the first year will develop approximately 83 units. Although priority for this housing dollars will be dedicated to develop new housing opportunities for homeless clients, some of the OT housing dollars will be also utilized to provide housing subside clients at risk of becoming homeless.

Employment /educational services and long-term job supports, as well as personal growth opportunities will be provided in an integrated fashion with other services and supports and in the client's setting of choice. Employment services will be provided by the ACT Team Employment Specialist (ES) and will start as soon as client establishes work/education as a goal to include job search and securing competitive employment. Contractor will be also be required to provide linkages an referrals to existent employment programs such as the program offered by State Department of Vocational rehabilitation and Supported Employment services, Contracted Employment Services) and educational opportunities and personal growth opportunities provided through the regional San Diego Community Colleges, as well a to the to be implemented MHSA Supported Employment services (A-6). Services

4) **Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.**

The average cot for each FSP participant is $ 12,000 dollars, with additional $13,200 (approximate) one –time funds per client for housing.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

The San Diego County MHS System Redesign Implementation Plan approved by the Board of Supervisors in 1999 is based on Biopsychosocial Rehabilitation and Recovery (BPSR) principles that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members. The program will advance the goals of recovery by offering and providing services that are client-centered , comprehensive and integrated with a broad array of services; that are individualized to each client and build on the client's strengths; that are provided in the least restrictive and most appropriate setting; that are coordinated both at the system and service delivery levels; that involve clients as full partners in their treatment and care; and that ensure that client rights are

protected. This program will support client and family /caregiver development of skill and competencies, promote self-care and development of self-sufficiency.

The Contractor for this program will develop and implement policies and procedures involving the hiring and training qualified staff to include clients and families (licensed clinicians, registered nurses, and mental health rehabilitation specialists, peer specialists) to ensure that recovery and rehabilitation goals will be achieved. A Board Certified Geriatric Psychiatrist that, as the most senior member of the Act Team, will be responsible for providing clinical supervision and training on geriatric psychiatry to all staff. Supervision will be provided in the amount and type that is adequate to ensure client safety and to support and maximize client gains and functioning.

To ensure ongoing stakeholder participation in this program and in its implementation process, Contractor will l establish an advisory group, which meets on a regular basis, to advise on Contractor's implementation of recovery-oriented services. The Program Advisory Group (PAG) will include at least 51 percent clients, and shall reflect the ages and cultures of the client population. The Program Monitor will periodically attend PAG meetings.

To demonstrate that all FSP program goals and objectives are met, as stipulated by DMH, Contractor will implement the Data Tracking and Reporting System established by DMH and will submit a Program Status Report as required by DMH to the County Mental Health Contract Administration Unit and the Program Monitor.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

This is a new program. This program improves the existent continuum of case management services for older adults by adding the intensive case management level to the array of services... A Request for Proposal (RFP) for these services was being released in Mid-February and a contractor will be identified via competitive process.

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of the service program, team or other entity.**

Consistent with MHSA requirements, Contractor will assure that program staff includes qualified individuals possessing first hand knowledge of the mental health service system and the mental health needs of older adults and will utilize family and client community members in as many aspects of the programming as possible, including teaching special skills and providing one-on-one assistance to clients. Particular emphasis will be place on recruiting paid and unpaid volunteer staff from diverse communities.

The Peer/Family provided services will provide comprehensive support and counseling services to families and caregivers to postpone nursing home placement, and to reduce negative impact (burden of care) of care giving. This program component will provide interventions that: a) Delay placement in nursing home; b) Reduces nursing home cost; c) Improve Caregiver Mental Health; d) Decreases incidence of severity of depression; e) Improve health of family caregiver; f) Improve stress management; g) Helps family members overcoming stigma; g) Engaging family members in on-going treatment when overburdened; h) Provide respite to primary caregivers.

Contractor will hire a minimum of one (1.5 FTE) full time client and/ or a family member to serve as the ACT Team Senior Peer Program Coordinator (s) who will be responsible for providing support to Contractor for the development, implementation and coordination of all peer/family provided services offered by this program. With the support from clinical supervisor, the Senior Peer/Family Services Coordinator will recruit fifteen (15) senior peer/ family members as volunteers.

Program will provide via its volunteer program; a) individual and/or group support and educational opportunities designed for client and family/caregiver on a variety of topics that will strengthen their ability to function independently and improve their quality of life; b) Volunteer Senior Peers and Family members will assist clients and their family gaining knowledge and skill on how to utilize mental health system; c) Volunteers will provide Peer Counseling and Family/caregiver In - Home respite to support them through difficult times , and to help them developing a network of support and enhancing caregiver's ability to provide quality in-home and/or supplemental care to family or friends; d) Senior Peer Volunteers will also provide Door to Door transportation services to include transportation to doctor's appointments, grocery shopping or/and to socialization and leisure activities, thereby enhancing client, family and caregiver wellness and independence.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority populations, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

Contractor will be required to develop services as a part of the Older Adult System of Care Continuum and in coordination with the following agencies/organizations and to that effect will sign Memoranda of Understanding/Partnership Agreement to outline each agency's role in connection with the FSP program: HHSA/MHS, HHSA /Aging and Independence Services, senior volunteer organization such as the Retired Senior Volunteer Program, Mental Health Plan Hospitals, providers of primary care, substance use and social services, programs for the homeless, crisis residential facilities, law enforcement agencies, the County's Housing and Community Development (HCD) and the City of San Diego Housing Commission, State Department of Rehabilitation , faith based and other community organizations providing social services to Latino and Asian communities, consumer and advocacy organizations (National Alliance for the Mentally , Mental Health Association, PAI, Consumer Center for health Education and Advocacy, California Client network, Mental Health Clients Wellness and recovery, AARP, Older Adult Women League, etc.) and other key Aging Network providers.

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

Contractor for these services will deliver mental health services within the most relevant and meaningful cultural, gender sensitive and age appropriate context for the target population for this program (Latino and Asian older adults) to be served by this program. Contractor will be responsible for tailoring care to the different cultural needs by making program accessible, appropriate, appealing and effective to the older adults to be served. Because Evidence-based services represent the highest quality of care possible, all clients entering this program will have access to Evidence-based care regardless of culture. To achieve this, Contractor will be required to make adjustments, to tailor Evidence-based approaches and interventions in order to make them accessible and effective for cultural groups that differ in language and behavior from original population studied to the population served. Since there is no sufficient evidence that supports efficacy of existent EBP with older adults of diverse ethno/cultural background, San Diego Cultural Competence standards will be serve as guide for the tailoring of the interventions.

To support efforts for further research into services that best serve needs of older adults of a diverse ethno /cultural background, program will be required to collect quantitative and qualitative data that reflects accurately the population served by program and results will be interpreted in a cultural competent manner to continually assess, improve and inform Contractor and program staff about needed changes at the program and service levels. Contractor will also be required to collect data to include gender, age, ethnicity, socioeconomic status, linguistic proficiency, geographic area of

residency and sexual orientation.

All activities of the ACT Teams will follow cultural competence practices and all members of the Team will be knowledgeable about steps to follow to ensure services are culturally competent:

- ✓ Understand the racial, ethnic, and cultural demographics of the older adult population to be served;
- ✓ Become familiar and develop expertise a minimum of two of the most frequently served groups;
- ✓ Ask client about their cultural background and language preference and needs;
- ✓ Offer to match client with counselor of similar background;
- ✓ Translate program forms, brochures and other relevant treatment materials;
- ✓ Have access to trained mental health interpreters;
- ✓ Develop collaborative relationships with natural networks of support such as family and community organizations representing client's culture.
- ✓ Outreach to religious and faith based organizations;
- ✓ Offer training to staff in cultural responsive communication and interventions skills.

Contractor will be required to integrate through out all services and activities the County Cultural Competence Standards (CCS) and to develop and implement a Human Resource Plan for recruiting, hiring, retaining and engaging in on-going workforce development and to ensure that at least 50 % of all direct services staff (included peer/family specialist) is bilingual and bi-cultural.

Contractor will also develop a process determine bilingual proficiency of staff in at least the threshold languages for the County (English, Spanish and Vietnamese) and will be responsible for ensuring in-house language capacity to match clients' needs, and when language capacity not available, to ensure that staff has knowledge of how to access County Contracted interpreter services.

As part of the County CCS, all staff will complete Cultural Competency training and in the discharge of duties and responsibilities will demonstrate possessing the cultural sensitivity, awareness, knowledge and skills necessary to serve the clients in the all six San Diego County geographic regions.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Gap analysis conducted by San Diego County demonstrated that currently there are older adult women who access services at lower rate than older adult males. To ensure that this gender disparity on access to care is reduced, the program will be required to make strong efforts to outreach older adult women and will develop and implement age, gender, culturally appropriate interventions to engage and retain in treatment woman meeting program admission criteria.

Contractor will also be required to develop and provide training for staff on Gay Lesbian and Transgender issues, and to provide gender specific intervention to address the psychosocial needs of clients (woman and men) reporting gay, lesbian and /or transsexual sexual preferences. Referrals will be made to gay, lesbian and transgender providers when appropriate.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Services provided by this program will be targeted to all residents of San Diego County, however, clients that are currently in out-of County placement will be considered for admission as part of discharge plan.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

This section was completed; no further explanation needed.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Task / Activity	Time Period
2005	
Allocation request to BOS	November, 2005
Board of Supervisors Approval	December, 2005
Plan Submission	December, 2005
2006	

Procurement process begin	January, 2006
Providers Industry Day (Posting of Draft SOW for input	
RFP Release	February, 2006
SSC Identify service provider and initiate contract for services	March/May, 2006
Start Up Activities**:**	July 2006
Facilities & Equipment	
Staff hired	
Staff trained	
Services begin:	July - August 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego County	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Mobile Outreach at Home & Community
Program Work Plan #: OA-2		Estimated Start Date: July 2006
1a) Description of Program: Countywide culturally and linguistically apropriate, 24/7 mobile outreach services that identify older adults, 60 year or older, in the community who are in need of mental health intervention and access to services to the most appropriate level of care.		
1b) Priority Population: Seniors 60 years of age and older who are Latino, Asian, other clients who are high utilizers of emergency and in-patient services, the SMI homeless or at risk of homelessness, their families and care providers, including those with co-occurring substance use. Priority for these services will be given to: a) those older adults with the most severe conditions and with highest incidence of emergency use and hospital admissions, or those having the most difficulties accessing care due to system barriers, b) older adults in a mental health crisis (danger to self or others or grave disability) and who may potentially come in contact with local law enforcement agencies and/or who need immediate mental health crisis intervention and /or assessment, c) individuals with serious mental illness, which substantially interferes with activities of daily living and results in inability to maintain independent functioning without treatment and support**.**		

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ Mobile outreach by multi-disciplinary Teams - 24/7 Crisis Response ✓ Outreach and engagement to isolated (frail and homebound) seniors in home (and to homeless). ✓ Mental health and substance abuse screening, comprehensive/ integrated geriatric assessment, benefits eligibility, information, linkages & referrals ✓ Senior Peer Counseling Program provides support and education / knowledge to client and families on how to navigate mental health system ✓ Senior Peer/ Family– Run Volunteer In Home Respite Services for families and caregivers who are housing/supporting older adults with a SMI. ✓ Client/Family operated services – "Door To Door" - Senior Volunteer Services ✓ Client/Family led services and socialization of clients, family and care-givers; vans included in one-time funding, ✓ Geriatric Mental Health Certificate Training for mental health and other aging network services providers.	☐	☒	☐	☐	☐	☐	☒

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

San Diego County Gap Analysis has demonstrated that approximately 5500 older adults are unserved and/or underserved. This program will increase access to appropriate mental health services for older adults by providing mobile outreach and engagement strategies to increase utilization of mental health services by older adults.

SDMHS will select a qualified contractor via competitive procurement. Contractor will operate and maintain a countywide culturally and linguistically apropriate Senior Mobile Outreach Team (SMOT) that will provide mobile outreach and crisis response services to approximately 700 unduplicated clients each year. Services will be available 24 hrs/7 days a week, 365 days a year, with 8 minimum hours of operation including Monday through Friday and a team member on call all hours when team members are not on duty. Services will be provided in close collaboration and in coordination with the County HHSA/AIS Senior Teams,

The SMOT will be responsible for identifying and providing comprehensive and integrated mental health and substance abuse screening and assessment for seniors 60 year or older who are seriously mentally ill and are isolated (frail and homebound) in their home, who are homeless and/or at risk of homelessness who may have a co-occurring substance use disorder, and who are in need of mental health intervention and to assist them accessing most appropriate level of care and to improve their mental health and quality of life in the community. SMOT services will be available throughout all the six (6), Health and Human Services Agency (HHSA) regions in San Diego County.

Using a multi-disciplinary approach, Contractor will incorporate treatment, mental health education, and skill building activities into the program. The Mobile Outreach Senior Team will provide the following services:

- ✓ Licensed mental health clinicians and psychiatric nurses, who specialize in the geriatric population, will provide Mobile Outreach Services. They will serve seniors who are unable or unwilling to seek assistance in other mental health settings. The SMOT shall prevent isolation, hospitalization and institutionalization and will support clients to remain safely in their homes when possible. These services will be provided in seniors' home and in places in the community where seniors normally gather (senior/community centers, senior housing, homeless shelters, skill nursing, facilities, board and care facilities, community mental health clinics, emergency rooms and hospitals.
- ✓ Crisis Response Services will be available 24 hours a day, seven days a week, and in person to seniors experiencing mental healh crisis, in their homes and/or in other locations in the community. Final objective of crisis intervention shall be to rapidly assess situation and presenting problem, and assist client becoming stabilized.
- ✓ Referrals and initial screening will be coordinated via the HHSA, Aging and Independence Services 24 hours Call Center.

- ✓ Utilizing screening and assessment instruments specially designed and validated to assist in diagnosing geriatric persons, Contractor will provide comprehensive and integrated geriatric screening and bio-psychosocial geriatric assessment. The screening assessment will include but not be limited to mental health/substance abuse and domestic violence. Specific areas for screening will include: sensory perception (hearing and vision screening), fall/accident prevention, diet and exercise, immunizations and sexuality, dementia, medications, alcohol/drug use, cognitive decline, Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), social issues, caregiver burden, and depression and suicide risk on clients that appear depressed.
- ✓ Contractor will provide short-term case management (minimum of 30 days) and linkages to on-going outpatient mental health services, health care services, social services, housing, employment services, advocacy and other needed services and develop and maintain an up-to-date listing of community resources adequate to meet the needs of target population.
- ✓ Using Benefits Check-up's National Council on Aging (on line decision/support), Contractor will assist clients, family/caregivers to quickly and efficiently screen client's benefits eligibility and assist them with enrollment and determine client eligibility for different federal, state, and private benefit programs such as healthcare, prescription medication, affordable housing, education, energy assistance, etc.
- ✓ Contractor will operate a volunteer staffed senior peer support services including counseling, transportation and in-home respite services. This program component will provide client and family/caregiver with individual and group educational opportunities on a variety of topics designed to strengthen their ability to function independently and improve their quality of life. The In home -Respite services will provide family/ care givers with support through difficult times, thus enhancing caregiver's ability to provide quality in-home or supplemental care to family or friends. Contractor will develop and maintain reliable and up-to-date information for family/caregiver to be available through information and referral call centers, caregiver organizations, senior centers, local libraries and regional resource centers in the six county regions.
- ✓ To address the transportation needs of the population to be served, Contractor will develop volunteer – client/family operated door-to-door transportation. Transportation services shall be available during business hours, but especially after 5:00 p.m. on weekdays, and on weekends, when other social service transportation programs are typically not in operation and for those on a bus line when service is infrequent or not running and shall include transportation to doctor's appointments, grocery shopping or/and to socialization and leisure activities, thereby enhancing client, family and caregiver wellness and independence. One time funding for a vehicle with capacity to serve individuals confined to a wheelchair has been included in this Workplan. Contractor for these services will be required to participate in a formal interagency collaborative that will seek to develop countywide Consolidated Transportation Services.

- ✓ In partnership with local academic institutions Contractor will implement, within 6 months from program initiation, a 80 hours Geriatric Certificate Training for 60) mental health and other aging network services providers leading to a geriatric mental health Specialist Certificate. This training will also offer intensive specialized training in evidence-based practices in geriatric mental health. One-time funds for training curricula, materials and other related expenses are available for the provision of this training.
- ✓ To ensure quality Senior Peer Volunteer services, Contractor will provide Senior Peer Counseling Training to seniors and family/caregivers interested in providing help and emotional support to others seniors and their families and to the licensed professionals interested in providing clinical supervision and support to senior peer programs. Within 6 months of contract execution, Senior Peer Program Coordinator, staff providing clinical supervision and senior peer volunteers will complete Training for Trainers in the Santa Monica's Center for Healthy Aging Peer Counseling for seniors Model. One-time funds for training curricula, materials and other related expenses to the provision of this training are included with this procurement.
- ✓ Contractor(s) will participate in System-wide MHSA Comprehensive Continuous Integrated System of Care Cadre Training (MHSA-CSS OT-1System-wide training) and within one year from contract award, program will meet dual diagnosis capable criteria. The SMOT staff will also participate in activities supporting the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders and will ensure that Implementation shall be in accordance with an AOAMHS approved plan. The CCISC model is a nationally recognized best practice for the treatment of Co-Occurring Disorders (COD).

A Licensed Mental Health professional with geriatric mental health experience in treating older adults will be responsible for program implementation, day to day program operations, staff hiring and direct supervision, as well for delivering program outcomes which consistent with MHSA guidelines, The program goals are: a) reduce of ethnic disparities and increase access to mental health services; b) reduce unnecessary older adult emergency room and inpatient hospital involuntary visit; reduce isolation; c) reduce homelessness and risk of homelessness; d) increase client, family and care provider network participation in program; e) promote self care and development of self- sufficiency; e) and improve mental health and aging network provider knowledge. The County's Program Monitor, will assure that the program goals and objectives are met in accordance with contract terms and conditions.

Weekly Clinical supervision for staff and technical assistance for training development and implementation will be provided by a Board Certified Geriatric psychiatrist The duties and responsibilities of the consultant psychiatrist will include but will not be limited to: a) Weekly clinical consultation and supervision with SMOT, HHSA AIS' Senior Team staff and other treatment providers; b) Clinical psychiatric consultations for Senior Team clinicians on 5150 cases; c) Available 24/7 via beeper/phone to consult on psychiatric emergencies and/or to discuss specific cases, d) Direct patient consultation as needed and to perform capacity evaluations, e) Actively participate in all client utilization and outcome evaluation activities, f) Provide technical assistance for the design and implementation of Geriatric Mental Health Training Certificate for Mental Heath and Aging Network providers and other initial and on-going training.

3) Describe any housing or employment services to be provided.

This program will not provide direct housing or employment services. To meet older adult client needs for housing and employment, Contractor will assist clients, family members and community providers, identify Client's housing and employment interest and/or preferences.

Contractor will develop and maintain an up-to-date listing of array of low cost or affordable and safe housing to adequate meet the needs of target population, Staff of the SMOT will link clients to appropriate affordable and safe housing opportunities available through governmental and community based agencies through out all San Diego regions (County and City Housing departments/ Section 8 Program, Senior Housing Referral Services, Salvation Army, Fredericka Manor Supported and Independent Living, Senior Centers of San Diego Transitional Housing, Eye-Shared Housing). For clients who are homeless or at risk of homeless that have been identified in need of full services and support, referral will be made to the MHSA Older Adult Full Service Partnership program under (Workplan OA-1).

Contractor will also develop and maintain up today listing of employment services and employment and vocational opportunities and will assist client choosing from competitive, supported and transitional employment opportunities and linking them to available employment services (Department of Vocational Rehabilitation, MHS, Inc. Employment Services, Clubhouse and the to be developed MHSA Employment Services. Clients expressing interest to engage in educational and personal growth opportunities will be referred to programs sponsored by the Department of Vocational Rehabilitation, local Community Colleges and Regional Occupational Programs.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership.

This program is not a FSP. Providers will ensure that eligible clients are linked to the MHSA /FSP for Older Adults (OA-1).

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The San Diego County AOAMHS System Redesign Implementation Plan approved by the Board of Supervisors in 1999 and the Older Adult Mental Health Implementation Plan, approved by the Board of Supervisors in October 2000 are both initiatives that have begun the transformation of the system of care and are based on Bio-psychosocial Rehabilitation and Recovery (BPSR) principles and practices that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members. The program will advance the goals of recovery by offering and providing services that are client-centered and developmentally and culturally/linguistically appropriate, comprehensive and integrated with a broad array of services; that are individualized to each client and build on the client's strengths; that are provided in the least restrictive and most appropriate setting; that are coordinated both at the system and service delivery levels; that involve clients as full partners in their treatment and care; and that ensure that client rights are protected while ensuring that designed services/interventions are helping clients, family/caregivers and providers achieve their goals.

These services will help to minimize time clients spend in psychiatric hospital, assist clients managing crisis situations in community and helping client, family/caregiver and provider to develop skill to self-manage and prevent future reoccurrence or worsening of symptoms.

The Contractor for this program will be required to develop and implement policies and procedures involving the hiring and training qualified staff to include clients and families and to ensure that all staff receives the relevant training and supervision appropriate amount and type to ensure client safety and to support and maximize client gains and functioning.

Contractor will establish an advisory group, which meets on a regular basis, to advice on Contractor's implementation of recovery-oriented services. The Program Advisory Group (PAG) will include at least 51 percent clients, and shall reflect the ages and cultures of the client population and the Program Monitor will periodically attend PAG meetings.

To demonstrate that all SMOT program goals and objectives are met, as stipulated by DMH, Contractor will implement County established Data Reporting System and will submit a Program Status Report in monthly basis to the County Mental Health Contract Administration Unit and the Program Monitor.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This is a new program for San Diego County and its procurement will be linked to the procurement of the new FSP/ Intensive Case Management for Older Adults (MHSA- Workplan OA-1) and the County re-procurement of two existent older adult case management programs, an Older Adult Traditional Case Management program and the Older Adult Institutional Case Management. Together, these programs will provide support for the development of the Older Adult System of Care and will expand capacity to serve older adults.

7) Describe which services and supports persons with a mental illness and/or family members will provide. Indicate whether persons with a mental illness and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Client and family-run services include outreach, engagement, education, transportation, senior peer counseling, family and caregiver support and volunteer services.

Consistent with MHSA guidelines, Contractor for this program will be required to utilize family and community members possessing first hand knowledge of the mental health service system as paid and volunteer staff to assist in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to clients and will make special efforts to recruit paid and volunteers from diverse communities. Contractor will be required to have policies and procedures in place surrounding both the use of clients and family members as volunteers and the use of employees who are also clients.

A Client-Family/Caregiver Services Coordinator will be hired to assist with the development and coordination of volunteer services. The Services Coordinator with support from clinical supervisor will recruit a minimum of 15 senior peer volunteers. Senior Peer Counselors will be culturally/linguistically and ethnically representative of the population of the region to be served.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Contractor will be required to form partnerships with the following agencies and together work on solving access to care for older adults, while advancing MHSA goals.

In collaboration and coordination with HHSA / AIS (Aging and Independence Services) Senior Teams, other mental health and Aging Network and healthcare and community providers, Contractor will operate and maintain Mobile Outreach and Emergency Response services. Contractor will be required to coordinate all Senior Mobil Outreach intakes and referrals via the existent AIS' Call Center. The AIS' Call Center staff will serve as initial screener for program eligibility and will provide alternative resources to those individuals not meeting referral criteria. Contractor will develop and implement a Memorandum of Understanding/ Partnership Agreement with HHSA, AIS outlining each agency's role in connection with the mental health mobile outreach activities /services to be provided by each organization and outline the resources to be shared by the County Senior Teams and the contracted Senior Mobil Outreach Teams. MOU shall include standard procedures to guide activities such as: Participation in coordinating meetings between AIS-ST and Contractor's SMOT, Intake and referrals procedures, Screening procedure, Caseload assignment procedure to either County ST and Contracted SMOT, AIS-ST and SMOT access and limits to resources and services such as: access to AIS Call Center, to clinical consultant (s), to senior peer volunteer support and transportation services. MOU will l be developed and implemented in coordination with the MHS, Older Adult Coordinator.

Contractor for these services will also be required to work closely with HHSA/MHS Community mental Health Clinics, HHSA, Alcohol and Drug Services (ADS) , HHSA/ AIS - Adult protective services, providers of primary care, Fee For services providers, In- Home Support Services, transportation services , social services, housing and employment services, programs for the homeless, crisis residential facilities, protection and advocacy organizations, faith based and other community organizations providing social services to Latino and Asian communities.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

In an effort to assist County Mental Health Services in the planning and development of age and culturally appropriate interventions tailored to the needs of older clients, A/OAMHS in partnership with the UCSD Research Center conducted a system-wide needs assessment between October 2004 and September 2005. The specific aim of the study was to qualitatively assess the unmet need for mental health services among older adults in San Diego County. The study

specifically wished to determine: a) what needs were currently not being addressed by existing service, b) what services are necessary to address these needs, and c) the potential solutions related to mental health service delivery.

Specific to the Latino and Asian and Pacific Islander, participants felt that the need for service providers to speak and communicate in the client's language was one the most important unmet need, followed by the need for clinicians to understand the cultural issues affecting Latinos and Asian and Pacific Islander older adult consumers, and found the stigma related to a diagnosis of mental illness as an important barrier to using services. Among the recommendations/ solutions to improve access to services were: to provide more in-home services, to have access to advocates that speak client language, and to provide more culturally competent services, as well as educating older and younger generations alike to address the stigma of mental health.

With respect to the quality of services obtained by Latino and Asian and Pacific Islanders, participants reported that provider lack of cultural understanding of the needs of older adults and perceived age discrimination as a very important barriers to getting quality care. Participants complained that they are often stereotyped as somatizing their mental disorders when they feel otherwise and expressed dissatisfaction with the limited amount of time spent with physicians during their visits.

With regards to socialization and social support, participants indicated that older Latino and Asian and Pacific Islander older adults consumers are lonely, largely because their children are gone to work all day, and have a need for more social interaction, physical and emotional support. Participants also raised the issue of elder abuse and neglect at the hands of their children and the fear of police involvement. Recommended solutions to the social isolation and lack of social support included peer counseling and recreational activities like yoga and tai-chi.

To address the above identified needs and proposed solutions, Contractor for these services will be required to:

- ✓ Design and delivering services that will improve access to care reduce barriers and improve quality of care for Latino and Asian and Pacific Islanders older adults.
- ✓ Develop mechanisms to ensure ongoing community assessment of mental health needs and will document how and in what form community is receiving information and what is community experience with services provided.
- ✓ Provide educational and treatment opportunities will be welcoming to consumer and providers and will focus on supporting consumer and families becoming self-sufficient and responsible for the management of own health and on preventing relapse. Either in individual or group format, these service opportunities will be conducted in the client's primary language.

- ✓ Ensure that staff is appropriately trained and possess working knowledge about racial, ethnic, and cultural demographics about Latino and Asian older adults, to be familiar and have clinical expertise in working with these populations as well as training in cultural responsive communication and interventions skills.
- ✓ Collecting cultural background and language preference information from all clients and that client are offered opportunities to work with counselor of similar background.
- ✓ Develop and implement a Human Resource Plan for recruiting, hiring, retaining and engaging in on-going workforce development and for ensuring that at least 50 % of all direct services staff (included peer/family specialist) is bilingual and bi-cultural.
- ✓ Develop a process determine bilingual proficiency of staff in at least the threshold languages for the County (English, Spanish and Vietnamese) and will ensure that clients and have access to trained mental health interpreters.
- ✓ Establish collaborative relationships with natural networks of support such as family and community organizations representing client's culture, to conduct outreach to religious and faith based organizations.

Contractor will be required to demonstrate integration of Cultural Competence Standards described in the San Diego County Mental Health Services Cultural Competence Plan by providing County Contract Monitor (in July and January) with appropriate data to support these efforts.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Gap analysis conducted by San Diego County demonstrated that currently their older adult women are accessing services at lower rate than older adult males. To ensure that this gender disparity on access to care is reduced, the program will make strong efforts to outreach older adult women and will develop and implement age, gender, culturally appropriate interventions to engage and retain in treatment woman meeting program admission criteria.

Contractor will also be required to develop and provide training for staff on Gay Lesbian and Transgender issues, and to provide gender specific intervention to address the psychosocial needs of clients (woman and men) reporting gay, lesbian and /or transsexual sexual preferences.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

These services will be provided to in-county clients only.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

14)Please provide a timeline for this work plan, including all critical implementation dates.

From the point of DMH approval, services are expected to be implemented within 3 to 12 months

Task / Activity	Time Period
2005	
Allocation request to BOS	Novemener,2005
Board of Supervisors Approval	December 2005
Plan Submission	December 2005
2006	
Procurement process begin	January 2006
Providers Industry Day (Posting of Draft SOW for input	
RFP release	February,2006
SSC Identify service provider and initiate contract for services	March/April 2006
Contract negotiation	May-June, 2006
Start Up activities: Contingent to plan approval:	July , 2006
Facilities & Equipment	
Staff hired	
Staff trained	
Services begin:	July- August, 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego County	Fiscal Year: 2005-06, 2006-07, 2007-08	Program Work Plan Name: Mental Health Services and Primary Care Services Integration (OE)
Program Work Plan #: OA-3 (linked to CY -4 & A-7)		Estimated Start Date: April 1, 2006 (contract execution date)

1a) Description of Program: This program will provide integrated mental health services in primary health care community clinics. Two service components will be provided 1) Depression and other mental disorders and 2) Co-morbid depression and diabetes services (Project Dulce and Impact Program)

1b) Priority Population: Unserved and Underserved older adult with serious mental illnesses (SMI) aged 60 years and older that are ethnically diverse and include Latinos and Asian Pacific Islander who are not accessing mental health services due to system barriers. This program will serve approximately 455 clients and seek to address the health care disparities among ethnically diverse individuals with mental health, physical health care needs and/or substance abuse disorders. In accordance with AB599, veterans are eligible for this program

	Fund Type			Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
1c)	☐	☐	☒	☐	☐	☐	☒
✓ Culturally and linguistically appropriate health care outreach and engagement, education, chronic disease management, social service referrals, advocacy and transportation provided by Volunteer Senior Peer (client/family)/ Community Health Workers;							
✓ Comprehensive and integrated collaborative screening, assessment for mental health and substance abuse, brief intervention (Problem Solving Therapy- In Primary Care) , linkages, information and referral;							
✓ Individual and group education and support groups for clients, family and caregivers, and coordinated volunteer respite for family and caregiver, provided by senior peer and family members.							
✓ Training via one-time funds for Primary Care providers on evidence-							

based and promising clinical practices for coordination and integration of mental health and primary care. Training will cover clinical practice guidelines, screening/assessment protocols (including for alcohol and drug problems, and domestic violence), chronic disease management and cultural competence. ✓ Training and technical assistance for the implementation and evaluation of the IMPACT + Dulce Pilot project (Evidence-based integrated management of Depression and Diabetes).							

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA:

This is a new program to be contracted out via Sole Source Contract.
San Diego County Mental Health Services gap analysis has demonstrated that approximately 5,500 older adults are unserved or underserved due to system and access barriers. This program increases access to care and decreases healthcare disparities by providing integrated mental health services in primary care services to Latino and Asian Pacific Islanders in a non –stigmatizing setting that is more consistent with how ethnically diverse populations seek health services.

The County of San Diego is proposing to utilize the many community clinics in San Diego County to provide mental health treatment services to older adults and their families. Services will be targeted toward uninsured clients. Service modality will be coordinated through a master agreement with the Council of Community Clinics to manage the authorization of care and provide general system management. The Council of Community Clinics will develop sub-contracts with individual clinic providers and reimburse for services provided by staff of the participating clinic organizations on a fee-for-service basis and authorize treatment and payment for necessary medications. The Council of Community Clinics represents the consortium of community clinics and Indian Health Services providers in San Diego County. The Council of Community Clinics was selected as the provider and coordinator of this program because they already serve in this role for the County for specialist care for Ryan White funds for the County of San Diego Office of AIDS Coordination and for dental services for San Diego County's First Five Commission.

San Diego County elected to pursue this program model because there are already 13 clinic organizations (9 community clinics and 4 Indian Health Services' provides) that offer mental health services at 27 different locations throughout San

Diego County. At this point, it has not been determined exactly how many of the clinics will participate in the program although all clinics have expressed a strong interest in partnering with the County for this MHSA component especially since it will be focused on families with no other health coverage.

The goal of this program is to provide integrated care between the primary care provider and the mental health provider within the same clinic structure. Due to lack of coverage, many patients seen by the primary care providers appear to be in need of mental health care, but there have been no means to fund the assessment and treatment.

The existing network of providers includes:

a) Family Health Centers of San Diego. Seven different sites serving zip codes 92103, 92113, 92109,92115,92101,91977, and 92104.
b) Imperial Beach Health Center. One site serving 91932
c) Indian Health Council (Indian Health Services-IHS). Two sites serving 92082 and 92070 zip codes. Both zip codes are in rural areas of the County.
d) La Maestra Community Health Centers. One site serving 92105 zip codes.
e) Mountain Health and Community Services. Three sites serving rural east San Diego County including zip codes 91901, 91934 and 91906.
f) Neighborhood Health Care. One site serving the 92025 zip code.
g) North County Health Services. Two sites serving 92054 and 92069 zip codes.
h) San Diego American Indian Health Center (IHS). One urban site serving zip code 92103.
i) San Diego Family Care. Three sites serving 92111 and 92105. There are separate adult and pediatric sites to serve the 92105 zip code.
j) San Ysidro Health Center. One site serving 92173 zip codes.
k) Southern Indian Health Council (IHS). One site serving the 91903 zip code.
l) Sycuan Medical/Dental Center (IHS). One site serving the 92019 zip code.
m) Vista Community Clinic. Three sites serving 92084, 92054 and 92083 zip codes.

The Contractor for this program will be responsible for the management of the MHSA Mental Health Specialty Pool. These pooled funds will be for specialty outpatient mental health services in Primary Care Clinics through the authorization of requests and payment of resulting invoices for mental health services. The MHSA Mental Health

Specialty Pool is intended to pay for medically necessary, diagnostic, therapeutic outpatient services and medication support service for Seriously Emotionally Disturbed older adults for whom there is not other funding source (Medi-Cal, Medi-care, CMS, private insurance etc) for these services.

As the fiscal agent, the Contractor for this program will be responsible for:

Subcontracting with Primary Care Clinic specialty providers and will ensure that a broad, geographically and culturally and linguistically competent panel of services providers is available at participant clinics,

Via the one-time funds included in the workplan, Coordinating initial and ongoing training for: a) Senior Peer Promotores/ Community Health Educators, b) Primary Care Providers, c) training for the IMPACT=Dulce pilot project.

Securing Board Certified Geriatric psychiatrist to provide consultation and technical assistance with the implementation different program component: a) mental health services, b) medication managements) IMPACT+ Dulce Pilot, d) training for staff and training for Primary Care providers, e) Clinical supervision to Community Clinics Staff, f) and as needed, to provide direct services to treatment resistant clients.

The Contractor for these services will provide administrative services Monday through Friday, from 8:00 a.m. to 5 p.m. daily, and ensure that sub-contracted Primary Care Community Clinics in addition to regular hours of operation maintain flexible evening and weekend hours available to clients. Any changes or modification of established and agreed upon days and hours will be done in coordination and with prior County's written approval.

Services to be provided included but will not be limited to:

- ✓ Culturally and linguistically competent health care outreach, education and engagement, and individual and group Peer Support and transportation services: These services will be provided by trained volunteers as Senior Peer Promotores/ Community Health Educators and services will be conducted in senior's home and in places in the community where older adults and their families normally gather (ethnic communities, churches, social services agencies, community clinics): a) Senior Peer Promotores/Educators will provide information, education and advocacy on how to navigate the mental health system to clients and family members, b) They will provide peer support to family/caregivers to help them through difficult times, c) and will also provide door to door transportation to doctor's appointments and other needed services for clients and families residing in areas where public

transportation is infrequent or not available, to ensure client and family/caregiver timely access to services. One time funding has been included in this procurement for the purchase of one vehicle with wheelchair capacity.

- ✓ Comprehensive and integrated collaborative screening, assessment: Subcontractor will be required to provide age appropriate and culturally and linguistically competent comprehensive and integrated screening and bio-psychosocial assessment for mental health, substance abuses, domestic violence and medical needs. Specific areas for screening will include: a) sensory perception (hearing and vision), b) Fall/accident prevention, c) diabetes, d) diet and exercise, e) immunizations, f) sexuality, g) dementia, h) medication, I) alcohol /drug use, j) cognitive decline, k) Activities of Daily Living (ADLs), l) Instrumental Activities of Daily Living (IDL's), m) Social Issues, n) Caregiver Burden, o) Depression and Suicide Risk.

- ✓ Information and Referral: When clients identified needing full range of services and support, staff at community clinics will provide clients and family/caregivers with appropriate referrals to services such as: community mental health, social services, self-help, housing and employment services. All Community Clinics will maintain an up to date and readily available listing of community resources adequate to meet the needs of older adults.

- ✓ Treatment**:** Primary Care Clinics evidence-based depression treatment for two population groups will be also provided: 1) 255 older adults with depression and other mental illness will receive medication management, problem solving skills training, individual and group supportive therapy and 2) 200 additional older adults with co-morbid depression and diabetes will be assigned a Dedicated Care Manager (DCM) that will be responsible for educating client about depression and diabetes, monitoring symptoms and provide counseling for depression, this as part of the IMPACT + Dulce Pilot project.

- ✓ Training for Senior Peer Promotores/Health Educators: In coordination with the MHS Older Adult Mental Health Coordinator, Contractor will coordinate an eighty (80) hours training for sixty (60) seniors and/or to family/caregivers interested in providing outreach, education and emotional support to others seniors and their families, and to licensed professionals interested in providing training, clinical supervision and support to cultural /ethnic and linguistic specific senior Peer Promotores/health educator programs. This training curricula will include but not be limited to the following topics: 1) Senior Peer Promotora /Community Health Educators: Definition, characteristic, role, work environment and cultural issues, 2) Cultural competent Outreach, engagement, education, community resources, linkages, information and referral with older adults, 3) Senior Peer Counseling Skills and Confidentiality; 4) The aging process ,5) Older Adult Mental Health, 6) Medications Use and Misuse, 7) Substance Abuse, 8) Wellness, habilitation, recovery and self-sufficiency, 9) Care Management and Record Keeping, 10)

Family/care-giver support. One-time funds for training curricula, materials and other related expenses to the provision of this training is included with this procurement.

- ✓ Training for Primary Care Providers: In partnership with local academic institutions, Contractor will develop and implement a Primary Care /Mental Health Provider Training Curricula. Primary Care Providers will receive training and education that supports increased coordination and integration of mental health in primary care and other health services. Training for health care and mental health providers in primary care settings will include but will not be limited to: 1) Older Adult Mental Health and Aging process, 2) Clinical Practice Guidelines; 3) Screening /Assessment Protocols (to include protocols for alcohol, substance abuse and domestic violence); 4) Title 9 medical necessity criteria for mental health and referral and liaison with San Diego County Mental Health Services (SDCMHS), 5). Chronic disease management; 6) Cultural Competence. Training for Primary Care provider will also include specialized training in Geriatric Mental Health, Evidence-based practices and Integration and Coordination of Mental Health services in Primary Care settings. One time funding for the provision of this training curricula, materials and other related expenses has been included with this procurement.

This program advances MHSA goals by increasing access to integrated services experience for Unserved and Underserved older adults mental health and reducing ethnic disparities in healthcare and particular efforts will be made to outreach to unserved and underserved Latino and Asian and Pacific Islander eligible clients residing in all six (6) Health and Human Services Agency (HHSA) in regions. To demonstrate that Mental Health and Primary Care Integration program goals and objectives are met, as stipulated in the contract, Contractor will implement County established Data Reporting System and will submit a Program Status Report in monthly basis to the County Mental Health Contract Administration Unit and to designated Program Monitor.

3) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program:

For clients needing either employment or housing services only, staff will provide with appropriate referrals to either existent or new MHSA funded Employment Services to be implemented, or to existent County and City Housing services.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program:

This program is not a FSP. Providers will ensure that eligible clients are linked to the MHSA /FSP for Older Adults (OA-1)

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced:

The San Diego County AOAMHS System Redesign Implementation Plan approved by the Board of Supervisors in 1999 and the Older Adult Mental Health Implementation Plan, approved by the Board of Supervisors in October 2000 are both initiatives that have began the transformation of the system of care based on bio-psychosocial rehabilitation and recovery (BPSR) principles and practices that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members. This program will advance the goals of recovery by offering and providing services that are client-centered and developmentally and culturally/linguistically appropriate, comprehensive and integrated with a broad array of services; that are individualized to each client and build on the client's strengths; that are provided in the least restrictive and most appropriate setting; that are coordinated both at the system and service delivery levels; that involve clients as full partners in their treatment e and care; and that ensure that client rights are protected while ensuring that designed services/interventions are helping clients, family/caregivers and providers achieve their goals.

Recovery and Rehabilitation are incorporated through out the different components of this workplan. The services provided by Senior Peer Promotores/ Family Community Health Workers (outreach, engagement, transportation and educational activities) promote recovery and self-sufficiency and IMPACT's Problem Solving Therapy in Primary care (PST-PC) empowers individuals and their families and promotes involvement and responsibility in the self-management of heath conditions by targeting specific problems, helping client define treatment goals and identify time limited interventions and taking a high degree of ownership and responsibility for solving their own problems.

Contractor has already in place a Program Advisory Group (PAG) that includes client, family, providers and community stakeholder representatives of all communities they serve. The PAG will include at least 51 percent clients, and shall reflect the ages and cultures of the client population served by this program. The County Program Monitor will periodically attend PAG meetings.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal:

This is a new program.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity:

The Contractor for this program will be required to develop and implement policies and procedures involving the hiring and training qualified staff to include clients and families and will ensure that all staff receives the relevant training and supervision appropriate amount and type to ensure client safety and support to maximize client gains and functioning.

Contractor will coordinate recruitment, hiring and training of at least 1.2 FTE paid and 10 volunteer Senior Peer/Family Promotores/ Community Health Educators per region. The 1 paid client/family member will be responsible for the coordination of Volunteer Senior Peer Promotora/Educator Services. The services provided by volunteers will be outreach, education and advocacy on how to navigate the mental health system to clients and family members, peer support to family/caregivers to help them through difficult times, and will also provide door to door transportation to doctor's appointments and other needed services.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals:

In addition to addressing the needs of Latino and Asian older adults, this program will enable the County to address access for Native Americans within San Diego County. All of the existing Indian Health Services clinic organizations are members of the Council of Community Clinics. The four Indian Health Service providers include three rural organizations (Indian Health Council, Southern Indian Health Center, Sycuan Medical Center) and one Indian Health Services provider (San Diego American Indian Health Center) which targets Native Americans living in the urban areas.

It is also the expectation that the addition of the MHSA funded Mental Health/Primary Care Integration model will facilitate greater collaboration between the clinics and traditional mental health providers and the County.

Another example of collaboration will be the IMPACT + Dulce Pilot that will be implemented and operated through collaboration with San Diego County Health and Human Services, SDMHS, Project Dulce, University of California, San

Diego, the Council of Community Clinics, the Hospital Association of San Diego and Imperial Counties, The center for health Strategies (CHCS), and The California Endowment the IMPACT+ Dulce Pilot Project will be implemented. The California Endowment is providing $455,000 in funding for pilot implementation and evaluation of the Project Dulce+ IMPACT as a model of collaborative treatment of depression and diabetes. CHCS has awarded $50,000 for program development and evaluation under their Medicaid Value program. This is one of ten projects nationwide chosen for this prestigious award, which involves consultation with nationally recognized experts in population –based management of chronic disease. The goal is to demonstrate the effectiveness, feasibility, and cost of establishing this co-integrated model within the organizational and financial structures of primary care clinics. A successful evaluation will provide evidence supporting wider implementation in additional clinics.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies will be used to meet their needs:

Contractor for this program will implement services to meet the needs of the target population, Unserved and Underserved older adult with serious mental illnesses (SMI) aged 60 years and older that are ethnically diverse and include Latinos and Asian Pacific Islander who are not accessing mental health services due to system barriers.

The Contractor for these services will be responsible to ensure that all services interventions meet San Diego County Clinical Standards and will ensure that services are responsive to the population to be served: Latino and Asian older adults and other ethnically diverse older adults.

- ✓ Subcontractors providing these will ensure that services are culturally competent and specially tailor to serve the diverse backgrounds of the clients in the geographic regions.

- ✓ Culturally and linguistically competent community outreach and education activities will be conducted by trained Senior Peer Promotores/ Community Health Workers in client's primary language. Senior Peer Promotores' role will be to serve as Cultural Brokers and to educate older adults, their families, and community and primary care providers about client's mental health needs.

- ✓ Staff conducting clinical activities (Screening, Assessment and Treatment) will understand the racial, ethnic, and cultural demographics of the older adult population to be served; will develop expertise a minimum of two of the

most frequently served groups; and will match client with counselor of similar background;

- ✓ Subcontractors plan for recruiting, hiring, retaining and training of workforce will target at least 50% of all direct services subcontracted staff (included peer/family specialist) be bilingual and bi-cultural in at least the San Diego county threshold languages (Spanish, Vietnamese, English).

- ✓ Subcontractor will have in place a plan to evaluate staff's level of language competence and language utilization of County Contracted Interpreting /translation services when program staff has no capability to speak a client's language.

- ✓ It will be responsibility of the Council of Community Clinics to demonstrate that Subcontractors have integrated cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan by providing County Contract Monitor (in July and January) with appropriate data to support these efforts.

To support efforts for further develop Culturally Competent Evidence –base Treatments for older adults of a diverse ethno /cultural background, providers will collect accurate data to inform Contractor and program staff about needed changes at the program and service levels. Contractor will also be required to collect data to include gender, age, ethnicity, socioeconomic status, linguistic proficiency, geographic area of residency and sexual orientation.

As part of the County CCS, all staff will complete Cultural Competency training and in the discharge of duties and responsibilities will demonstrate possessing the cultural sensitivity, awareness, knowledge and skills necessary to serve the clients in the all six San Diego County geographic regions.

The following are San Diego County Cultural Competence Clinical Standards that Contractor will be required to follow:

1) Providers engage in a culturally competent community needs assessment
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities,
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served
5) There is linguistic capacity & proficiency to communicate effectively with the population served
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation,

and acculturation

8) Staff shall demonstrate knowledge about
   a) specific cultural features that may be present in various disorders,
   b) culture-bound syndromes,
   c) cultural explanations of illness,
   d) help seeking behaviors, include faith-based, in diverse populations, and
   e) appreciation for traditional ethnic and cultural healing practices
9) Cultural factors are integrated into the clinical interview and assessment
10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services
13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
14) Staff actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The needs assessment study on LGBT conducted by Alliance healthcare Foundation (2004) found that one- thirds of all 306 seniors surveyed reported concerns about feeling “sad” or “depressed” and 8.5 % reported feeling “suicidal”. More than one in five (21.8%) of the 306 individuals interviewed reported attending individual therapy or counseling sessions. Another 5% reported needing but having no access to mental health services. As the leading provider of Primary care services under Ryan White Act for over 15 years, Community health clinics are well positioned to establish working relationships with social service agencies serving the Lesbian, Gay, Bisexual and Transgender (LGBT) communities of San Diego County and to help address the unique needs of this population.

San Diego gap analysis has demonstrated older adult women from these two ethnic groups are underrepresented in the mental health system. Given also the successful tack record of primary care clinics providing services to underrepresented communities makes them the natural partner to assist and support County efforts to increase access to care for older adult women of Latino and Asian backgrounds.

On-going individual and group clinic supervision and external training of mental health staff and LGBT and gender issues will be required. Contractor will also be responsible for the coordination of all required training for staff on Gay Lesbian and Transgender issues, and to ensure that sub-contracted services provided are gender sensitive and that intervention utilized to address the psychosocial needs of clients (women and men) reporting gay, lesbian and /or transsexual sexual preferences and culturally appropriate.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county:

This program will be focused on in-county residents from urban and rural areas. Clients returning from out-of-county placements will be linked to this program as part of their discharge plan.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA:

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates:

Task / Activity	Time Period
2005	
Allocation request to BOS	November, 2005
Board of Supervisors Approval	December 2005
Plan Submission	December 2005
2006	
Procurement process begin	January 2006
Sole Source process begin	February, 2006
Contract executed	April, 2006
Start Up activities	April, 2006

- Facilities & Equipment	
- Staff hired	
- Staff trained	
Services begin: Outreach and engagement services fully deployed	April 15, 2006

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN		
County: San Diego	**Fiscal Year**: 2005-06, 2006-07, 2007-08	**Program Work Plan Name**: Services for Deaf and Hard of Hearing
Program Work Plan: ALL- 1		**Estimated Start Date**: July 1, 2006

Program Description:
The Program will provide countywide, specialized mental health services for children/youth with a serious emotional disturbance (SED), as well as transition-aged youth (TAY), adults/older adults with a serious mental illness (SMI), who are deaf or hard of hearing. The program will operate a culturally, linguistically and developmentally appropriate outpatient counseling service for unfunded clients of all ages. Services shall be provided in a Communication Accessible Language, including, but not necessarily limited to, American Sign Language. The program shall provide necessary linkages to appropriate agencies for clients identified as needing psychotropic medication management.

Priority Population:
The priority population are the uninsured, unserved Seriously Emotional Disturbed (SED defined in the W&I Code 5600.3) children (0-17) and Seriously Mentally Ill Transition Age Youth (16-24), adults (18-59), and older adults (60 years and older) who are deaf or hard of hearing. Individuals served may also have a co-occurring mental illness and substance use disorder. In accordance with AB 599, veterans are eligible for this program. A minimum of 65 SED/SMI children, youth, adults, and older adults who are deaf and hard of hearing are estimated to be served annually by this program.

Based on the gap analysis, undertaken during the preparation of CSS Plan, an estimated 15,821 children, 8,900 TAY, 16,007 adults, and 4,613 older adults may be considered to have “unserved” mental health needs within the County of San Diego. Through the community input process associated with development of the MHSA CSS Plan, the Deaf and Hard of Hearing community was identified as having a significant unmet need for mental health services to unfunded clients. This population resides throughout the San Diego County, and no regionalization of services will be provided. Instead, the contractor will provide services countywide.

A current contract providing service to deaf and hard of hearing, mentally or emotionally impaired adults had 25 admissions and 23 discharges over a six month period ending December 2005. In the month of January 2006, there were 18 unduplicated clients.

	1d) Fund Type				1d) Age Group				
	FSP	Sys Dev	OE	OTO	CY	TAY	A	OA	ALL
1c) Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	☐	☐	☒	☐	☒	☒	☒	☒	☒
✓ The program will offer linguistic, culture specific integrated mental health services including screening, mental health assessment and individual/group therapy. ✓ There will be care coordination and linkage with child/youth, adult, and older adult community supports services. ✓ The approach will be individualized, client directed, culturally competent and strength based assessment. The families/youth and adult/older adult will be actively involved in the development of the treatment plan. ✓ The program will collaborate with existing deaf and hard of hearing community based organizations. ✓ The current assessment standard forms and processes for the entire Mental Health System has been modified to ensure consideration of domestic violence, screening and referral when appropriate. ✓ Clinical staff will be given orientation and training on wraparound principles/approach, domestic violence and co-occurring disorders (Comprehensive Continuous Integrated System of Care model, CCISC). ✓ The services will be dual diagnosis capable and will include screening, assessment, treatment, and referral, a wellness, strength-based and resilience focus, when appropriate and will adhere to San Diego County's Cultural Competence standards. ✓ Program services are estimated to cost $194,600.									

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA:

San Diego Mental Health Services (SDMHS) will contract with a community-based organization through the Request for Proposals (RFP) process. The proposed services advances the MHSA goals by providing improved access to care to unserved deaf and hard of hearing SED/SMI child/youth/adults and older adult community within the County of San Diego.

The provider shall operate a specialized, linguistically and developmentally appropriate outpatient counseling service for unfunded seriously emotionally disturbed (SED) children/youth, and seriously mentally ill (SMI) transition age youth, adult and older adults in San Diego County who are deaf or hard of hearing, including those who may have a co-occurring substance abuse disorder. The program will provide care coordination, linkage and individualized/family-driven services and supports. One-time funds in the first year are included for six weeks of program start-up costs.

Services shall be provided in Communication Accessible languages, including, but not limited to American Sign Language. The provider shall provide necessary linkages to appropriate agencies for clients needing psychotropic medication management.

The program is intended to provide interventions to assist clients and families to achieve a more adaptive level of functioning. Interventions for these activities may include individual and group counseling, or telephonic contacts. To facilitate client empowerment in the spirit of psychosocial rehabilitation practices, the formation of client self-help groups will be encouraged. Another goal is to provide maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements of learning, development, independent living and enhanced self-sufficiency. The program will provide services directed toward persons who can improve or stabilize through treatment in this setting.

The program will be expected to develop and conduct twice a year, a four hour basic training workshop or presentation on the deaf culture, including essentials of working with deaf or hearing impaired clients who are mentally or emotionally impaired. This educational program will be presented to organizational and fee for service providers throughout the County of San Diego. Yearly, the program will provide a four-hour Cultural Competence training open to organizational fee-for-service providers, addressing awareness, knowledge and skills for working with the deaf or hearing-impaired culture and other diverse cultural backgrounds.

The objectives of the program are:

100% of clients shall be assessed for substance use during mental health assessment and referred for services when appropriate.
100% of clients shall be assessed and screened for domestic violence and referred for services when appropriate.
Provider will administer the Youth Services Survey (YSS) to child and adolescent clients, and their parent/caregiver, and the Adult client satisfaction survey for adults and older/adults, at time intervals designated by County Mental Health.

The program will operate from 8:00 AM to 5:00 PM, weekdays. Provider may "outstation" staff, who can provide in-home services to home-bound seniors with approval from the County of San Diego. The facility shall comply with the requirements of the Americans with Disabilities Act (ADA) and California Title 24.

3) Describe any housing or employment services to be provided:

The program will not provide direct housing and employment services to the clients. There are Family Resource Centers in all the regions of the County of San Diego with eligibility and case management staff that can provide employment services through the State CALWORKS program and housing referrals to clients on public assistance and social workers who can refer clients to emergency short-stay housing and other appropriate housing facilities in the area. The clients can also be referred to the housing specialists of the San Diego County Department of Housing and Community Development as well as the County's other Housing Authorities, for eligibility to the Section 8 Housing Program, or rental assistance. The program will also collaborate with existing mental health outpatient clinics/providers and other community agencies that can meet other social service needs of the client.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program:

This program is not funded through a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced:

The goals of recovery for the populations will be advanced by ensuring that services provided will be integrated, linguistically and culturally competent, driven by client choice and anchored in rehabilitation and recovery practices that include; ability to manage their symptoms/illness, be self sufficient and productive, have meaningful personal relationships, and be able to learn, and be productive members of their community.

The program shall provide comprehensive and integrated assessments of mental health/substance use, crisis intervention services, individual therapy, collateral contact, and group therapy services as needed for clients who are deaf or hard of hearing.

The program will plan and provide services in a manner consistent with the Children's System of Care philosophy and principles, as well as the Adult and Older Adult Mental Health System of Care philosophy and principles. Qualified clinicians capable in alternative communication modalities, such as American Sign Language, will enable the program to achieve the goals of recovery or resiliency.

To ensure that program goals or values will be promoted by the program, staff will be required to attend four hours per year of Cultural Competence training, and an 8-hour Wraparound basics course (for staff who has not taken the course in the last four years). Clinical staff shall be required to meet the licensing Continuing Education Units (CEUs) and other paraprofessional staff shall have a minimum of eight hours of clinical training per year.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal:

This is a new service. Currently, the County of San Diego has one contracted program through a community organization, San Diego Mental Health Center for Deaf and Hard of Hearing, which provides outpatient mental health services to the deaf and hard of hearing adult/older adult population of the County of San Diego. This enhancement will create a new program that provides services across all ages, including children/youth and transition age youth in the County.

The Statement of Work was issued on the website of the Purchasing and Contracting Department of the County of San Diego. An Industry Day was held on 02-17-06 to generate comments and possible improvements to the statement of Work before a Request for Proposal is completed. A Source Selection Committee will be convened to review and analyze the technical and cost proposals of the interested providers of the proposed service. The provider/agency that meets the requirements contained in the Statement of Work, in the most economical and efficient manner will be selected.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity:

Clients will not be participating in the provision of direct mental health services. The contractor will be required to establish a Client/Family Advisory Group to ensure client/family input at all levels of the operation and provision of services within the program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals:

It is anticipated that this program will collaborate with existing deaf and hard of hearing established providers and entities. System services and outcomes for deaf and hard of hearing individuals will be improved by increasing access to care for unserved linguistically deaf and hard of hearing community SED and SMI clients.

The contractor for this program will be expected to make collaborative connections with Tribal entities in the County, including, but not limited to, Memorandums of Understanding for sharing information, joint attendance at program/agency meetings, cross-educational efforts, and encouragement of Native American members to serve on the Client/Family Advisory Group.

San Diego Mental Health Services has implemented the Continuous Comprehensive Integrated System of Care model (CCISC) and is in the process of training all programs to provide minimal screening, assessment and referral for dually diagnosed children and youth. Regular meetings are conducted by the System of Care Council to discuss program implementation and future plans. Mental Health Services is in the process of merging with the Alcohol and Drugs Services to form a Behavioral Services Group. This will integrate and improve service delivery to clients who have co-occurring disorders. Several programs of the Mental Health Services Act (discussed in detail in Exhibit 4, Work Plans) will address the needs of the clients for employment and housing; CY-5.3 Homeless/Runaway, TAY-1 Integrated Services and Supported Housing, A-1 Homeless Integrated Services and Supported Housing, and A-6 Supported Employment Services

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies will be used to meet their needs:

To ensure that the program will be competent to meet the needs of the culturally and linguistically diverse Communities in San Diego County, the staff will be required to attend four hours per year of Cultural Competence training. In addition, the County of San Diego Training and Development Department conducts Cultural Diversity Classes regularly.

The deaf community is a culture on its own, with a distinct language and set of values. The contractor is required to provide two trainings a year on the cultural norms and values of the deaf community to the community at large and their own staff. Clinical staff hired by this program will have to possess specific knowledge and skills, not only in the culture of the Deaf, but also be capable in communicate in American Sign Language (ASL). Training of clinical interns who can sign in ASL will be a component of the program, to expand the cadre of professionals that can provide counseling services.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Reports from the National Mental Health Association (NMHA) indicate that adolescent girls, as well as gay and lesbian youth and adults are at risk and may not be receiving needed mental health services. Contractor will be made aware of the overall disparity by gender that exists among children/youth, TAY, adults, and older adults seeking MH services, such that males are seen at a disproportionately higher rate than females. Requirements will be included in the RFPs for this program to provide a plan to address this gender disparity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county:

The program will provide services to in-county residents.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA:

All strategies were listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates:

2006	
February	**Industry Day, Request for Proposal, Pre Proposal Conference**
March	**Review of Proposals, meeting of Source Selection Committee**
April	**Select Winning Bid, Negotiation of Contract**
May	**Processing of Contract by Purchasing and Contracting Department**
June	**Orientation of Contractor**
July 1, 2006	**Contract Execution**
July	**Hiring of Staff, Program Mobilization**
August - On going	**Program fully operational**

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN

County: San Diego	**Fiscal Year**: 2005-2009	**Program Work Plan Name**: Services for Victims of Trauma and Torture REVIEWED AND REVISED 3/8/06
Program Work Plan: ALL- 2		**Estimated Start Date**: July 1, 2006

Program Description:
This program will provide countywide, specialized mental health services for adults/older adults and transition aged youth (TAY) who have a serious mental illness, and children/youth with a serious emotional disturbance (SED), who are victims of trauma and torture. The program will operate a culturally, linguistically and developmentally appropriate outpatient counseling service for indigent clients of all ages. The program shall provide individual, group and family counseling, information, referral and necessary linkages to social service agencies, linkages to physical health care and programs that can assist clients identified as needing psychotropic medication management.

Priority Population:
The priority population are the uninsured, unserved adults (18-59), and older adults (60 years and older), seriously emotional disturbed (SED defined in the W&I Code 5600.3) children (0-17) and seriously mentally ill Transition Age Youth (18-24), who are victims of trauma and torture. Individuals served may also have a co-occurring substance use disorder. In accordance with AB 599, veterans are eligible for this program. A minimum of 65 adults, and older adults, SED/SMI children and youth who are victims of trauma and torture are estimated to be served annually by this program.

Through the community input process associated with development of the MHSA CSS Plan, the victims of trauma and torture community was identified as having a significant unmet need for mental health services to unfunded clients. Data provided to the County estimates the number of victims of torture to be approximately
11, 0000 persons. This population resides throughout the San Diego County, and no regionalization of services will be directed.

This is a new program for San Diego County Mental Health Services (SDCMHS)

	1d) Fund Type				1d) Age Group				
	FSP	Sys Dev	OE	OTO	CY	TAY	A	OA	ALL

1c) Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	☐	☐	☒	☐	☒	☒	☒	☒	☒
✓ The program will offer linguistic, culture specific integrated mental health services including screening, mental health assessment and individual/group therapy, and case management linkage and brokerage. ✓ There will be care coordination and linkage with child/youth, adult, and older adult community supports services. ✓ The approach will be individualized, client directed, culturally competent and strength based assessment. The families/youth and adult/older adult will be actively involved in the development of the treatment plan. ✓ The program will collaborate with existing victims of trauma and torture community based organizations. ✓ Screening for domestic violence, and referral and linkages to other social service programs when appropriate. ✓ Staff will be given orientation and training on wraparound principles/approach, domestic violence and co-occurring disorders (CCISC model). ✓ The services will provide dual diagnosis services to include screening, assessment, treatment and referral to other support services.									

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

San Diego Mental Health Services (SDMHS) will contract with a community-based organization through the Request for Proposals process. The provider shall operate a specialized, linguistically and developmentally appropriate outpatient counseling service for unfunded adult and older adults with, SED children/youth, and transition age youth with a serious mental illness who are victims of trauma and torture, including those who may have a co-occurring substance abuse disorder. The program will provide care coordination, linkage and individualized/family-driven services and supports. One-time funds in the first year are included for six weeks of program start-up costs.

The proposed services advance MHSA goals in several key ways. Firstly, this new program will provide newly-created access to care to unserved persons with a severe mental illness who are also victims of trauma and torture. These individuals often suffer from post-traumatic stress disorder and other anxiety disorders, as well as depressive disorders that severely impact their ability to function and be productive members in the community.

Secondly, this program will advance MHSA goals by providing a range of rehabilitation interventions which will assist persons with a serious mental illness recover from both the debilitating effects of the mental illness, and the effects of torture and trauma, and achieve a desired quality of life consistent with a bio-psychosocial approach to recovery from a serious mental illness.

The third way in which MHSA goals will be realized through this program will be through the development of a flexible service delivery system for this unique system wide program. This system wide program will deliver services to eligible persons in a County with a huge geographical catchment area of almost 3,000,000 people, comprised of many heterogeneous and diverse population mixes. One of the key features of a system which is culture-centered and recovery based is the recognition that rehabilitation and recovery interventions can occur in a variety of settings besides the program site itself. In the northern regions of San Diego County, the program will be expected to outreach and serve American Indian populations in the Escondido and the Pauma Valley areas, as well as the expanding and underserved Latino population who form almost 50% of the North Inland region's population in and beyond the city of Escondido. Un-served and underserved groups in the downtown or Central region of San Diego who include refugee and immigrant populations who need outreach and culturally appropriate services include persons of African descent, including a Sudanese population that is the second largest in the nation and a group which was heavily impacted by civil war and its attendant trauma and torture. In the East region of San Diego County in the city of El Cajon and its environs, one finds one of the nation's largest grouping of Chaldean persons, another target population for the effects of trauma and torture. When deemed clinically appropriate or because of cultural considerations, the service delivery settings may include a variety of community settings (including faith based institutions), and private homes.

A fourth way in which MHSA goals will be achieved is through program participation in CCISC training which aims at an integrated approach to persons with a dually diagnosis of mental illness and substance abuse. This approach recognizes that many persons with a severe mental illness who are victims of trauma and torture are also at risk for co-occurring disorders with alcohol or substances, both self administered or prescribed by a medical professional. San Diego Mental Health Services has implemented the Continuous Comprehensive Integrated System of Care model (CCISC). This quality improvement initiative is an integrated and comprehensive treatment, training and administrative approach that supports the

coordination and integration of mental health and substance abuse services for persons with co-occurring disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis -specific and stage-specific treatment for each disorder. It is based on the following 8 clinical consensus best practice principles : 1) dual diagnosis is an expectation, not an exception and the interaction with the client shall be welcoming 2) the treatment relationship is empathic, hopeful, continuous 3) treatment services can be planned by using the four quadrant national consensus model for system level planning 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced 5) each disorder should be considered equally important and integrated dual primary treatment is required 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions 7) there is no one type of dual diagnosis program or intervention that is correct, treatment services are matched to client needs 8) outcomes are individualized.

This program advances the goals of the MHSA in a fifth way, by outreach to other mental health providers to increase provider competency and system capacity. This program will outreach other providers by providing training on how to work more competently and effectively with victims of trauma and torture. The program will be expected to develop and conduct a four hour basic training workshop – offered bi-annually - in the essentials of working with persons who are victims of trauma and torture, including culturally appropriate assessment, diagnosis, and treatment interventions. This workshop should conceptualize victims of trauma and torture as a heterogeneous cultural grouping and provide information on a variety of models which are best practice interventions currently available in the field. This workshop will include empirically supported treatments (EST's), and be available to organizational and fee for service providers throughout the County of San Diego. Yearly, the program will provide a four-hour Cultural Competence training open to organizational fee-for-service providers, addressing awareness, knowledge and skills for working with this special population who are also from diverse cultural backgrounds.

To advance MHSA goals, the program will achieve the following objectives:

- 100% of clients shall be assessed for substance use during mental health assessment and referred for services when appropriate.
- 100% of clients shall be assessed and screened for domestic violence and referred for services when appropriate.
- Provider will administer the Youth Services Survey (YSS) to child and adolescent clients, and their parent/caregiver, at time intervals designated by County Mental Health.

The program will operate from 8:00 AM to 5:00 PM, weekdays. The facility shall comply with the requirements of the Americans with Disabilities Act (ADA) and California Title 24.

3. Describe any housing or employment services to be provided.

This program will not provide direct housing and employment services to the clients. It will support clients who identify and working toward housing and employment goals, and utilize linkages to a variety of supports related to housing (e.g., local Housing Authorities; affordable housing listings) and employment (e.g., Employment Services program; Department of Rehabilitation; clubhouses). Employment services referrals may include CalWORKS, or education and vocational training via linkage to the Department of Rehabilitation Employment Services program. Pre-employment and employment services are offered as part of the array of rehabilitation services in every BPSR out patient wellness program, and Family Resource Centers in all the Health and Human Service Regions of the County of San Diego have eligibility and case management staff that can provide employment services through the State CALWORKS program.

Clients at risk of homelessness can be referred to the County Emergency Shelter Beds (ESB's), and to the existing homeless shelter providers in the County such as St. Vincent de Paul. Housing referrals can also be made to housing specialists of the San Diego County Department of Housing and Community Development for eligibility to the Section 8 Housing Program, or rental assistance. The program will also collaborate with existing mental health outpatient clinics/providers and other community agencies that can meet other social service needs that clients may have.

4. Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This program is not funded through a Full Service Partnership.

5. Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The goals of recovery for the populations will be advanced by ensuring that services provided will be integrated, linguistically and culturally competent, driven by client choice and anchored in rehabilitation and recovery practices that include;

- the ability to manage their symptoms/illness,
- being self sufficient and productive,
- having meaningful personal relationships, and be able to learn, and
- being productive members of their community.

The program shall move towards those recovery goals by providing comprehensive and integrated assessments of mental health/substance use, crisis intervention services, individual therapy, collateral contact, and group therapy services as needed for clients who are victims of trauma and torture.

The program will plan and provide services in a manner consistent with the Adult and Older Adult Mental Health System of Care philosophy and principles, and the Children's System of Care philosophy and principles. Qualified clinicians will enable the program to achieve the goals of recovery or resiliency.

To ensure that program values and goals will be promoted by the program, staff will be required to participate in System Wide Education and Training Plan (OTO #2), a plan which includes training on Cultural Competency, the CCISC approach to co-occurring disorders, and training on domestic violence and victims of trauma and torture.
.
The program will be monitored by the COTAR (Contract Monitor or designee) to ensure that the contractor complies with the service delivery requirements of the Statement of Work as contained in the Request for Proposals. The program will be required to submit a Monthly Status Report which details staff productivity. The bi-annual report includes staff cultural and linguistic capabilities.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal**.

This is a new program. The County of San Diego has no contract with any program which provides outpatient mental health services to the victims of trauma and torture in the County of San Diego.

7) **Describe which services and supports persons with a mental illness and/or family members will provide. Indicate whether persons with a mental illness and/or families will actually run the service or if they are participating as a part of a service program, team or other entity**.

Persons with a mental illness will also be invited to be involved in the governance of this new program by participating in a Program Advisory Group (PAG), or equivalent body which is already part of the program's structure of governance having client membership. If the program has an advisory group, the contractor will be expected to include a minimum of 2 clients. In accordance with the goals of a recovery based system, qualified clients will be considered for employment at all levels of the organization. Clients shall be hired to work at whichever level they qualify. To achieve the MHSA goals of a recovery based system, clients shall be encouraged to lead and participate in self-help groups consistent with bets practice recovery methods for persons in recovery from both mental illness and trauma and torture.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

If they do not currently exist, this program will create new collaboration and Memorandum of Understanding (MOU) agreements with other community-based organizations, especially programs which may currently services to victims of trauma and torture. Priority organizations include – but are not limited to - primary care centers through the Council of Community Clinics, Mental Health Plan hospitals, crisis residential facilities, programs for the homeless, County of San Diego Sheriff's Department, and older adult programs, including the HHSA Aging & Independence Services' Senior Team, and the 17 bio-psychosocial rehabilitation service (BPSR) wellness and recovery centers which will provide psychiatric evaluations and medication management.

This program will be expected to participate in a least one Regional Provider Monthly meeting, and one quarterly Behavioral Health Regional Meeting as a function of ongoing outreach for linkage and collaboration.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Since many victims of trauma and torture may also be members of culturally diverse groups, training will play a key role in equipping service providers in their ability to provide services which are both effective in treating the effects of torture. The Statement of Work for this program describes it thus:

> *"Contractor shall provide outpatient mental health services to victims of trauma and torture utilizing a comprehensive approach that is community based, client and family driven and culturally competent.*

Because so many survivors of torture are in exile from their culture of origin, "culturally competent" assumes a special meaning and valence. In this context, "culture" is understood to refer to the client's culture of origin, as well where the general "culture of fear" that develops in societies where torture is widespread."

To achieve this goal, the Contractor shall be required to develop the cultural competencies of their workforce, and to develop linguistic proficiencies. This will operationalize the Cultural Competent Clinical Practice Standards listed in the Organizational Provider's Handbook and is stated thus in the program SOW:

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

"Contractor shall identify a process to determine bilingual proficiency of staff at a minimum in the threshold languages for the County."

While Contractors are determining linguistic proficiency and implementing their findings, some programs may need to augment their staffing language proficiency. To further implement Cultural Competency Clinical Practice Standard 6 on linguistic proficiency, this provider may access the services of two community based organizations who are contracted with SDCMHS to provide verbal and non-verbal (i.e. sign language) interpreting services. Interpreters Unlimited is contracted to provide translation services for spoken languages - including all Medi-Cal threshold languages for San Diego County, namely Spanish, Vietnamese, and Arabic - and Deaf Community Services for translations services for persons with a mental illness who are deaf or hard of hearing.

Monthly reports by Interpreter's Unlimited on the usage of verbal language interpreters by providers enable Program Monitors to monitor service utilization. In a bi-annual report on staffing and linguistic capacity, Quality Improvement unit and Regional Program Coordinators are responsible for monitoring county and contracted OP programs in their respective regions currently hold all programs accountable for use (MSR) bi-annual report on program staffing Monthly Status Reports sent to the and linguistic capacity.

An additional strategy to be employed to meet the needs of victims of trauma and torture who are members of culturally and linguistically diverse communities pertains to cultural competency training. To implement Cultural Competency Clinical Practice Standards 7 -14, there is a contractual requirement in the RFP Statement of Work that requires providers to participate in cultural competency training. All SDCMHS staff – including direct provider staff, administration, and clerical and support staff - is currently required to take 4 hours of cultural competency training annually.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Reports from the National Mental Health Association (NMHA) indicate that adolescent girls, as well as gay and lesbian youth and adults are at risk and may not be receiving needed mental health services. Contractor will be made aware of the overall disparity by gender that exists among children/youth, TAY, adults, and older adults seeking MH services, such that males are seen at a disproportionately higher rate than females. Requirements will be included in the RFPs for this program to provide a plan to address this gender disparity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county:

The program will provide services to in-county residents.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA:

All strategies were listed in Section IV.

13) Timeline

2006	
February	Industry Day, Request for Proposal, Pre Proposal Conference
March	Review of Proposals, meeting of Source Selection Committee
April	Select Winning Bid, Negotiation of Contract
May	Processing of Contract by Purchasing and Contracting Department
June	Orientation of Contractor
July 1, 2006	Contract Execution
July	Hiring of Staff, Program Mobilization
August - On going	Program fully operational

2007	
June	Submit year-end reports
July - August	Evaluate program output, compliance with outcomes Review of expenditures against approved budget
September	Provide feedback to MHS Administrators, Board of Supervisors
December	Submit report to the State

2008	ProgramMonitoring
January	Feedback on program performance
February	Evaluate over all performance and compliance with the requirements of the Statement of Work
March - April	Recommend corrective action if necessary to improve performance or recommend penalty for non compliance.
May – June	Recommend non renewal of contract or secure new budgets for contract extension for additional years.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN

County: San Diego	**Fiscal Year:** 2005-06, 06-07, 07-08	**Program Work Plan Name:** Walk-In Assessment Center, North County
Program Work Plan: ALL 3		**Estimated Start Date:** July 1, 2006

1a) Program Description:
The Program is a voluntary walk-in (no prior appointment) assessment center that will provide an age and culturally appropriate crisis mental health services to children, youth, adults and older adults of the North San Diego County Region. Currently, the County of San Diego has a Children/Youth Emergency Screening Unit located in the South Region and an Emergency Psychiatric Unit providing in the Central Region providing services to Adults/Older Adults. It was expressed by participants in the Community Forums that there is a need for improved access to crisis mental health services within the geographic region identified as North County. This walk in service will provide screening and triage for appropriateness of hospitalization to reduce escalation of crisis mental health situations and minimize unnecessary inpatient treatment; make referrals/appointments/linkages to community mental health clinics or other appropriate support services to facilitate access to services; and provide brief, interim therapeutic services when there is a wait for initiation of services.

1b) Priority Population:
This program will provide crisis services for all ages defined above, and will meet a community identified need for services in the North San Diego County Region by being geographically placed in this region. Geomapping of population densities by ethnicity and crisis utilization, across all age ranges, will be made available to potential contract bidders. The County of San Diego is the sixth most populous County in the United States and the third in California. There is significant population density in the North Region of our County where contractor will be directed to locate the clinic. The North Coastal Region was home to 7% of the County of San Diego clients that utilized crisis services in FY03-04, while the North Inland Region had 6% of the clients reflecting this need. The North Inland Region encompasses about 60% of the land area of the County and is geographically the largest of the six regions.
The contractor will be expected to make targeted outreach efforts to unserved and underserved children/youth with SED and their families, TAY, Adults and Older Adults with serious mental illness as identified in the MHSA CSS Plan Gap Analysis. While this clinic will not target a specific ethnic/racial or gender population, the contractor will be made aware of disparities in service access across numerous populations, including Hispanic, Asian/Pacific Islanders, and female clients. In accordance with AB 599 veterans are eligible for this program.

	1d) Fund Type				1d) Age Group				
	FSP	Sys Dev	O E	OTO	C	TA	A	O A	A L

					Y	Y			L
1c) Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	☐	☒	☐	☐	☒	☒	☒	☒	☒
✓ The program will be contracted to a provider who will meet the technical and fiscal requirements specified in the Request for Proposal. ✓ The program will envision the operation of a voluntary walk-in assessment center that will provide age and culturally appropriate crisis mental health evaluations. The program will provide linkages to other mental health services existing in the North Region when hospitalization is not required and additional services are needed. ✓ By establishing a walk-in assessment center, access to emergent mental health services will increase in the North San Diego County Region. ✓ The approach will be to provide individualized, culturally competent and strength based assessments. The families/youth and adult/older adult will be actively involved in the development of the treatment plan. ✓ The current assessment standard forms and processes for the entire Mental Health System will be modified to ensure consideration of domestic violence, screening and referral when appropriate. ✓ Clinical staff will be given orientation and training on wraparound principles/approach, domestic violence and co-occurring disorders (CCISC model). ✓ The services will include screening, assessment and referral, a wellness, strength-based and resilience focus, when appropriate and will adhere to San Diego County's Cultural Competence standards. ✓ Program services will be aligned with original CSS draft Children/Youth (CY) funding allocation of $351,000 for children and youth, and an additional $372,000 dedicated for those over 18 years of age, with a total of $723,000. ✓ This program will physically coexist with CY4.2, the Children's Mobile Psychiatric Emergency Response Program									

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA:

San Diego Mental Health Services (SDMHS) will contract with a community-based organization through the Request for Proposals process. The program will be located in the North Regions of San Diego County, which includes the North Coastal Region and the North Inland Region.

The program will serve individuals of all ages, who are experiencing a mental health crisis or urgent need for mental health services. Contracted provider will be requested to develop and submit a plan on how efforts will be made to outreach Asian and Latino children, youth, adults and older adults. Priority shall also be given to individuals with Medi-Cal and those who are indigent. Individuals with other health care coverage may be referred to other resources.

The program will provide walk-in assessment services in the North Region of the County to increase access to crisis mental health services and reduce unnecessary utilization of emergency inpatient services for children, youth, adults and older adults

The walk-in assessment center will provide age and culturally appropriate crisis mental health evaluation to children, youth, adults and older adults located in the North Region. Clients shall be assessed and screened for domestic violence and referred to services when appropriate. Clients shall also be screened to determine the need for referral in a primary care physician and referred for services when appropriate.

The program is targeted to promote the return of 70% of client served to their current residence, diverting them, when appropriate, from unnecessary emergency room or inpatient services.

This program shall provide comprehensive and integrated assessment of mental health/substance abuse, crisis intervention, and follow-up appointments and psychotropic medication management when needed for children, youth, adults and older adults. Request for services shall be voluntary. Clients requiring involuntary services shall be referred to the Police-teamed, Psychiatric Emergency Response Team (PERT) or a facility designated to provide involuntary detainment and evaluation under the Lanterman-Petris-Short (LPS) Act. This program will not be authorized to initiate involuntary detainment of individuals meeting criteria under WIC 5150.

A telephone triage, referral and consultation with the community shall be provided.

The program will be encouraged to partner with existing outpatient mental health providers in the North County Region, the County operated emergency screening services located in the Central and South Regions, the fee for service hospitals in the region, local Tribal entities, Hispanic and Asian/Pacific Islander communities, community primary health care clinics and other appropriate community and social service agencies as appropriate. An effort to collaborate with Juvenile Justice and Justice Departments will be encourage, to address the needs of clients recently released from incarceration or at risk of future incarceration, as this population has been seen to significantly overlap with those needing crisis mental health services.

It is estimated that a minimum of 241 clients will be served annually – it is expectation, but not restriction, that these clients will primarily be residents of the North County Region who are experiencing a mental health crisis and are at risk of psychiatric hospitalization.

An off-set schedule will be encouraged, such as 12:00 PM through 8:00 PM – this program will not provide 7 day/24 hour services. The services will be provided in a clinic setting with a separate waiting area for children and adults, to ensure the security and safety of the clients. The program will be staffed by one full-time licensed mental health clinician, a part-time registered nurse, a part time clerical staff, and a consulting psychiatrist

3) Describe any housing or employment services to be provided:

The program will not provide direct housing and employment services to the clients. Two North Region Family Resource Centers are situated in the area with eligibility and case management staff that can provide employment services through the State CALWORKS program and housing referrals to clients on public assistance and social workers who can refer clients to shelters and housing facilities in the area. The clients can also be referred to the housing specialists of the San Diego County Department of Housing and Community Development for eligibility to the Section 8 Housing Program, or rental assistance. Clients in need of other social services shall be referred to the existing homeless shelter providers in the North Region. Clients not on public assistance will be connected to private agencies that have employment services. The program will also collaborate with existing mental health outpatient clinics/providers and other community agencies that can meet the other social service needs of the client.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program:

This program is not funded through a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced:

The program will plan and provide services in a manner consistent with the Children's System of Care philosophy and principles, as well as the Adult and Older Adult Mental Health System of Care Psychosocial Rehabilitation and Recovery philosophy and principles. It shall provide crisis mental health interventions to meet the needs of the youth and family, TAY, adults and older adults, and increase the safety of SED/SMI persons in the North County Region.

To ensure that program goals or values will be promoted by the program, staff will be given four hours per year Cultural Competence training, and an 8 hour course on Wraparound basics (for staff who has not take the course in the last four years). Clinical staff shall be required to meet the licensing Continuing Education Units (CEUs) and other paraprofessional staff shall have a minimum of eight hours of clinical training per year.

This service advances and supports recovery and resilience by preventing unnecessary hospitalization, increasing access to outpatient services, providing education for clients and families as to available resources, and by actively reducing crisis in clients/families thereby augmenting stabilization.

The program will be monitored on a regular basis to ensure that the contractor will comply with the service delivery requirements of the Statement of Work as contained in the Request for Proposals which are:

i. Provide, operate and maintain community client and mental health promotion services in accordance with the State Department of Mental Health (DMH) Information Notice 96-02 regarding staff qualifications.
ii. Use forms for recording client information and activities in case files as directed by the Program Monitors.
iii. Have a defined mechanism for emergency telephone consultation and/or referral of clients after hours

iv. Demonstrate a family partnership in the development and provision of service delivery which shall be reflected in the client chart.
v. Demonstrate organizational advancement of family partnership and community collaborations in the areas of program design, development and policies and procedures.
vi. Submit a Monthly Status Report which shall contain noteworthy activities/unusual events, community contact/interaction with other agencies, client complaints/grievance and request for a transfer of provider, programmatic issues and actions initiated to solve or mitigate them, emerging issues or potential problems, quality improvement activities, position listing, staff changes, staff development/training, monthly wait list, family participation, caseload per staff, number of admissions and discharges, number of active cases and number of incident reports.
vii. Compliance with all applicable provisions of the Children's, Adult, Older Adult Organizational Provider Handbooks, Organizational Provider Financial Eligibility and billing Procedures Manual and Documentation and Uniform Clinical Records Manual.
viii. Establish a Client/Family Advisory Group

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal:

The program is a new service that will be provided in the North San Diego County Region and will complement the existing mental health outpatient clinics and school-based services in the region. There are currently two mental health hospitals, 3 outpatient clinics, and 1 clubhouse in the North Inland Region; 1 hospital, 1 crisis residential provider, 4 outpatient clinics and 1 clubhouse in the North Coastal Region.

The Statement of Work was issued on the website of the Purchasing and Contracting Department of the County of San Diego on 2-17-06. Prior to that date, an Industry Day was held on 01-17-06 to generate comments and possible improvements to the Statement of Work before a Request for Proposal is completed. A Source Selection Committee will be convened to review and analyze the technical and cost proposals of the interested providers of the proposed service. The provider/agency that meets the requirements contained in the Statement of Work, in the most economical and efficient manner will be selected.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity:

Although clients will not be participating in the provision of direct mental health services, the contractor will be required to establish a Client/Family Advisory Group to ensure client/family input in the operation and provision of mandated services of the program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals:

The contractor for this program will be expected to make collaborative connection with Tribal entities in the County to decrease the stigma of mental health within the Native American community, increase physical access to mental health care, and increase staff awareness of the particular needs within that community.

The contractor will be directed to collaborate with the existing contractors in the region operating on-going mental health programs for children/youth, TAY, adult, and older adults in San Diego County. In addition, the program will be encouraged to utilize services from the MHSA programs that are intended to promote collaboration within the clubhouses in the community; TAY-2 Clubhouse/Peer Support Services for transition age youth, and A-5 Clubhouse Enhance and Expand with Employment Services.

San Diego Mental Health Services has implemented the Continuous Comprehensive Integrated System of Care model (CCISC) and is in the process of training all programs to provide minimal screening, assessment and referral for dually diagnosed children and youth. Regular meetings are conducted by the System of Care Council to discuss program implementation and future plans. Mental Health Services is in the process of merging with the Alcohol and Drugs Services to form a Behavioral Services Group. This will integrate and improve service delivery to clients who have co-occurring disorders. Several programs of the Mental Health Services Act (discussed in detail in Exhibit 4, Work Plans) will address the needs of the clients for employment and housing; CY-5.3 Homeless/Runaway, TAY-1 Integrated Services and Supported Housing, A-1 Homeless Integrated Services and Supported Housing, and A-6 Supported Employment Services

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies will be used to meet their needs:

To ensure that the program will be competent to meet the needs of the culturally and linguistically diverse communities in the North County Region, the staff will be required to attend four hours per year of Cultural Competence training. The County of San Diego Training and Development Department conducts Cultural Diversity Classes regularly. The contractor will be provided the San Diego Mental Health Services Cultural Competence Plan Annual Update FY 2003-2004 document that contains strategies to effectively provide cultural competent services to the gender-sensitive, culturally and linguistically diverse population of the County. Private providers and County clinics are required to submit a Cultural Competence Report twice a year listing the ethnic/racial background and language proficiencies of staff, as well as the courses on Cultural Competency that staff have taken.

A current contract, Interpreters Unlimited, provides interpreter services for mental health providers and County clinics.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

There exists an overall disparity by gender among children/youth seeking MH services (60% male and 40% female). Among adults and older adults who are hospitalized, 51% of MH services are provided to females, but based on the prevalence data the number should be closer to 65%. The contractor will be made aware of the overall disparity by gender that exists among children/youth, TAY, adults, and older adults seeking MH services. Requirements will be included in the RFP's for this program to provide a plan to address this gender disparity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county:

The program will provide services to in-county residents. Eligible clients coming from other counties with the intent to stay in San Diego County would be eligible for crisis emergency mental health services through this program.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA:

All strategies were listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates:

2006	
February	**Industry Day, Request for Proposal, Pre Proposal Conference**
March	**Review of Proposals, meeting of Source Selection Committee**
April	**Select Winning Bid, Negotiation of Contract**
May	**Processing of Contract by Purchasing and Contracting Department**
June	**Orientation of Contractor**
July 1, 2006	**Contract Execution**
July	**Hiring of Staff, Program Mobilization**
August - On going	**Program fully operational**

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year**: 2005-06	**Program Work Plan Name:** System-wide Community Education, Training & Technical Enhancements
Program Work Plan: OT- 1		**Estimated Start Date:** April, 2006

1a) Program Description:
This system development work plan is composed of two parts:

i) A comprehensive System-Wide Education and Training Program (SWETP) encompassing Cultural Competence, the San Diego Medication Algorithm Roadmap to Recovery (R2R) program, and the Behavioral Health initiative. These quality improvement initiatives will enhance service delivery in the SDMHS system for all populations; and

ii) **Technical Enhancements:** Computers, telemedicine equipment and a training room to enhance clinical services.

1b) Priority Population: Target populations of all ages, service providers, County staff and consumer advocates.

	1d) Fund Type			**1d)** Age Group				
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	O E	C Y	TA Y	A	O A	ALL
1c) **(A) <u>System Wide Education and Training Program</u>: 3 components** Component 1: **CULTURAL COMPETENCE** Training will focus on enhancing provider's Awareness, Knowledge, and Skills in fostering client recovery. Trainings will cover the three (3) competency domains of Awareness, Knowledge, and Skill development. ✓ A comprehensive Cultural Competency Training curriculum will be constructed in accordance with the findings of MHSA Gap Analysis, and with the San Diego County MHS Cultural Competency Plan and competencies identified from the Cultural Competency Clinical Practice Standards. It will consist of existing trainings offered by a variety of providers including HHSA Training and Development, as well as new training modules to be created with assistance from the training Contractor and other provider entities. ✓ It will address core cultural variables and groups, including ethnic and racial groups identified in the Gap Analysis: Native Americans, Asian and Pacific	☐	☒	☐	☐	☐	☐	☐	☒

Islanders, Latinos, and African Americans. It will also include non-ethnic groups based on sex (men and women), gender (trans-gendered persons), sexual orientation (gay, lesbian, bi-sexual, heterosexual) , socio-economic status, age (older adults and transitional age youth), disability (i.e. disability culture, with a focus on client culture in mental health), recovery cultures (specifically alcohol and drug and mental health), refugees and immigrants. ✓ To achieve this goal of a comprehensive curriculum, the training Contractor shall co-ordinate the design, planning, development, implementation, and evaluation of comprehensive, system-wide trainings related to the Cultural Competency Training Curriculum (CCTC) for San Diego County Mental Health Services (SDCMHS). The goal of these trainings is to increase competencies of workforce providers and administrative staff, and to empower clients, youth and families in the identification, prevention, treatment and de-stigmatization of mental illness and severe emotional disturbances (SED). All trainings will include evaluation components to measure their effectiveness. ✓ All programs and providers in Adult/Older Adult and Children's systems will be recipients of these trainings. This will include staff involved at every level of service delivery: administrative and support staff, clerical and support staff and direct service staff. ✓ Contractor will provide training to enhance the cultural competence of primary care and mental health professionals in primary care settings in the integration of physical and mental health care. Trainings will involve up to 20 service sites and approximately 100 direct staff, and will be chosen from this County approved curriculum. ✓ This training plan will be collaborative in nature, utilizing both County and contractor resources, as well as regional entities in other Counties. The Statement of Work for this contract specifies" "Services shall include multiple collaborative partners in education, domestic violence and other behavioral health disciplines." ✓ The California Brief Multicultural Competency Scale (CBMS) will be used prior to the training series as a base for individualized training plans for each participant.								

✓ Contractor shall co-ordinate training on the CBMS and the findings to assist providers in developing individualized cultural competency training plans.								
Component 2*:* **San Diego Medication Algorithm (San/DMAP)** The Texas Medication Algorithm Project is cited as a model program in the Presidents New Freedom Commission report. San/DMAP is based on this model, and promotes best choices of medication for schizophrenia and assesses medication effectiveness in collaboration with consumers. San D/MAP, based on TMAP, offers a systematic means to increase the use of evidence-based medication practices, to standardize and improve documentation, including practical outcome measures, to increase care coordination, and to shift the clinician-client relationship from one aimed at "compliance" to one aimed at "alliance." In October 2002, San Diego Mental Health Services (MHS) embarked on a pilot project to test the viability of the Texas Medication Algorithm Program (TMAP) in county-operated clinics, as well as to establish the implementation and operational models to efficiently implement the algorithm and its various program elements as the clinics' new standard of practice. The project was carried out with considerable collaboration with clients and family members. Collaborative project oversight and conduct continues with these important stakeholders participating in the San D/MAP Implementation and Peer-Education Committees, and with actual leadership of the peer-education program, Roadmap to Recovery. The collaborative implementation model developed has since become that used to implement this evidence-based practice (EBP) in several other counties in California, and will be the model for its implementation under the auspices of Medi-Cal's CalMEND project. A critical component of San D/MAP is Roadmap to Recovery (R2R), a peer-facilitated education program that promotes both individual client recovery and this shirt in the clinician-client relationship. To date, only the schizophrenia algorithm has been adopted in the pilot clinics in its entirety, but to achieve MHSA recovery goals and continue with system transformation, R2R will be expanded by introducing it in all BPSR wellness and recovery centers. Training to be provided on San/DMAP and								

R2R will include: ✓ Each program will also identify peers who will become R2R trainers. ✓ Client trainers will facilitate a series of 10 weekly groups which educate clients on disease management and other issues ✓ These groups are currently offered in English and Spanish, and – as needs are identified and resources permit – will be offered in the threshold languages of Vietnamese and Arabic.								
Training Component 1: Introduction to San/DMAP Training Component 2: San/DMAP: Roadmap to Recovery (R2R) √ Each program will also identify peers who will become (R2R) trainers. √ Client trainers will facilitate a series of 10 weekly groups which educate clients on disease management and other issues. √ These groups are currently offered in English and Spanish, and – as needs are identified and resources permit – will be offered in the threshold languages of Vietnamese and Arabic. Component 3*:* **Behavioral Health Initiative** In order to achieve MHSA goals to provide services which are integrated and coordinated, all staff delivering behavioral health services will be trained to screen, assess, treat, and link clients to appropriate services. In accordance with the Behavioral Health Workforce Development Plan, training will be offered in the following areas: 3.1 DUAL DIAGNOSIS/CO-OCCURRING DISORDERS • CCISC model to train MHS and ADS staff in the principles and practices of integrated treatment for co-occurring disorders. This quality improvement initiative is an integrated and comprehensive treatment, training and administrative approach that supports the coordination and integration of mental health and substance abuse services for persons with co-occurring								

disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis -specific and stage-specific treatment for each disorder. This model is based on the following 8 clinical consensus best practice principles : 1) dual diagnosis is an expectation, not an exception and the interaction with the client shall be welcoming 2) the treatment relationship is empathic, hopeful, continuous 3) treatment services can be planned by using the four quadrant national consensus model for system level planning 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced 5) each disorder should be considered equally important and integrated dual primary treatment is required 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions 7) there is no one type of dual diagnosis program or intervention that is correct, treatment services are matched to client needs 8) outcomes are individualized. ✓ Screening, Assessment, and Referral 1: Providers in ADS, AMHS and CMHS will be trained in how to identify persons with severe mental illness who are suffering from behavioral health issues, including substance abuse, domestic violence and trauma. ✓ Screening, Assessment, and Referral 2: Non-mental health community providers – including those working in primary care settings - will be trained to identify symptoms and dysfunctions associated with mental health problems and co-occurring health issues, including substance abuse and trauma. The goal here is to give these providers sufficient information about common mental health and substance abuse problems to facilitate more efficient and effective linkages for person who may be suffering from co-occurring disorders to A&OAMHS and CMHS. ✓ Treatment, and Referral: of co-occurring disorders for mental health and alcohol and drug providers. Treatment interventions will include – but not be limited to - motivational interviewing and relapse prevention								
3.2 TRAUMA - Victims of domestic violence, trauma and torture								

✓ A one day conference on the identification, dynamics and treatment of domestic violence in relation to persons experiencing severe mental illness ✓ Two half-day conferences on the identification and treatment of trauma as experienced by veterans and victims of torture ✓ The Training Contractor will provide technical assistance to the contractor providing mental health services to victims of trauma and torture								
(B) Technical Enhancements: *B.1. Computers, Software and Telemedicine Equipment* A recent survey of Mental Health contract providers found that most do not have sufficient computer equipment and software to access the new Mental Health MIS, which is currently being procured by SDMHS. One new system component is an electronic health record. In order to access the new MIS, providers must have sufficient PCs and/or portable devices for all staff that will be using the system, including direct services staff. Typically, direct services staff use the current system only in a limited fashion. The expanded use of the system by direct services staff is expected to significantly enhance clinical services and coordination of care. Non- profit providers may be able to acquire technologically-appropriate computers for their staff via the San Diego Futures Foundation, which provides free computers to community based organizations. However, these computers will not come loaded with software needed to interface with the new MIS. One time funding is requested to assist contract providers to acquire necessary software. *Telemedicine Equipment* Telemedicine services can include therapeutic interventions, medication evaluation and monitoring, emergency evaluations and case management. It can be valuable tool to increase access to mental health services by providing remote access for clients who would have difficulty traveling to the service hub. One time funding is requested to purchase telemedicine equipment for up to three sites in order to pilot								

telemedicine's usefulness in expanding mental health services in remote areas. SDMHS is currently evaluating the following two primary applications for initial use of the telemedicine equipment (plus one more site if costs are less than $25,000 per site:								
✓ Establish telemedicine hub site(s) at the Emergency Screening Unit (ESU) and/or the Emergency Psychiatric Unit (EPU) that will be connected to existing satellite sites in community-based health clinics to provide services such as screening, assessment, and psychiatric consultation for clients being served in a primary care setting; ✓ If sufficient funds are left over after ESU and EPU sites are set up. Establish a satellite site in the North County to be connected to the ESU and/or EPU hub site(s) described above, to provide as screening, assessment, and psychiatric consultation, on a walk-in basis for clients needing urgent services. *B.2. Training Room* The current training room used by SDMHS and Alcohol and Drug Services has no built in audiovisual equipment of any kind. Purchase of audiovisual and training room equipment to enhance training experiences for contract service providers, collaborative partners, consumers/family members and other clinical staff. ✓ Upgrades to the room will include large screen, built in projectors and audio equipment. ▪ Training outcomes will be enhanced through establishing a training environment conducive to learning.								

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The System Wide Education and Training Plan (SWETP) advances MHSA goals in several crucial ways. First of all, it vastly increases the number of trainings which can be provided in the crucial area of cultural competence to train

providers in how to deliver services to clients identified in the Gap Analysis who are both un-served and underserved. Secondly, it utilizes data to obtain outcomes by including evaluation components with which to assess the effectiveness of trainings provided under SWETP. Thirdly it requires that trainings provided by County and Contract providers be coordinated for more effective and efficient service delivery. In addition, the new training room will vastly improve the capacity of San Diego County Mental Health Services to deliver training to providers in this diverse and geographically huge area in a more efficient and effective fashion. Technical enhancements such as the purchase of equipment to facilitate an electronic client record increases the ability of the system to collect client data more effectively and efficiently. Enhanced abilities to collect outcome data will provide the information needed to improve the type and quality of services delivered to clients.

3) Describe any housing or employment services to be provided:

N/A.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program:

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The SWETP will empower service providers, clients, and families to advance rehabilitation & recovery goals by enhancing their awareness, knowledge, and skills in key areas of cultural competence and behavioral health. The technical enhancements will enable services to be delivered in a more efficient and effective way to persons with a mental illness in our system.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) **Describe which services and supports persons with a mental illness and/or family members will provide. Indicate whether persons with a mental illness and/or families will actually run the service or if they are participating as a part of a service program, team or other entity**.

Clients and family members are integral partners in the System Wide Education and Training Plan, and play the leading role in the Roadmap to Recovery (R2R) component of the San Diego Medication Algorithm Project (San/DMap). The Roadmap to Recovery is a client run training program wherein clients are trained and paid as Peer Facilitators for a 10 week course in disease management. In addition, clients and family members are members of the System of Care Training Academy, an advisory body which will currently plays a critical role in San Diego County Mental Health Service's training offerings. Clients and family members are currently trainers in the Children's System of Care, a component of the Training Academy.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations**. **Explain how they will help improve system services and outcomes for individuals.**

To implement the System Wide Education and Training Plan (SWETP), the Training Contractor shall collaborate with multiple partners in San Diego County Mental Health Services (both County and Contract providers), San Diego County Alcohol and Drug Services (SDCADS), and County of San Diego Training and Development (T&D) to create, coordinate and deliver the trainings outlined previously. Specific details are to be found in the Statement of Work in the Request for Proposals for these MHSA services.

"Contractor shall collaborate with SDCMHS, ADS and the System of Care Training Academy in the design, planning and implementation of this comprehensive training program, and in an ongoing analysis of system training needs."

A crucial part of the SWETP is the collaborative effort with community care clinics to provide training on mental health and cultural competency to primary care providers. These clinics include providers who serve diverse populations throughout San Diego County, including Native Americans and other un-served and underserved populations. Specific requirement are to be found in the Statement of Work for this contract.

<u>Behavioral Health Initiative and Primary Care</u>

"Contractor will provide training for community clinic primary care and mental health providers on Care Coordination/Consultation, and referral and liaison with San Diego County Mental Health Services (SDCMHS). The goal of this training is to facilitate smooth client transfers between primary care mental health providers and the mental health system of care providers. Training shall include information on Title IX medical necessity criteria for mental health, as well as on jointly developed procedures for shared clients. Trainings will involve participating service sites."

"Contractor will provide training to enhance the cultural competence of primary care and mental health professionals in primary care settings in the integration of physical and mental health care. Trainings will involve up to 20 service sites and approximately 100 direct staff, and will be chosen from a County approved curriculum that will include - but not be limited to - the following three topics:

Increasing awareness of care giver attitudes that could be barriers to service, including biases and prejudices

Increasing knowledge of culture-specific ways of understanding mental illness, and

Skill building to engage and treat persons from diverse cultural backgrounds with a mental illness".

In this collaboration, services will be provided where clients come for primary care. Because of the stigma associated with mental illness in many cultural groups, mental health services will be more readily accessible to these persons. The SWETP will enable staff in these facilities to be trained to deliver services which are more culturally appropriate.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The first section of the System Wide Education and Training Plan focuses on training to deliver more culturally competent services. For the first time, all providers will be given an instrument (the California Brief Multicultural Competency Scale) which will enable them to assess their level of competency and plan a program to enhance their cultural competencies in the areas of awareness, knowledge, and skills. A comprehensive curriculum will be developed to augment existing trainings so that providers will be able to meet the needs of diverse populations. Once again, this is specified in the Statement of Work for this SWETP contract.

Cultural Competency

"Contractors shall co-ordinate and provide the planning, development, and implementation of a County approved curriculum in cultural competency to increase awareness, knowledge, and skill competencies in the workforce. *This curriculum will address requirements stated in the current SDCMHS Cultural Competency Plan."*

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

As stated in Section 8, program providers will be asked to participate in trainings on cultural competent service delivery as an integral part of the System Wide Education and Training Plan (SWETP). This training program will utilize the California Brief Multicultural Scale (CBMS); an 11 item scale contains specific questions on gender and sexuality – on women, men, lesbians and gay persons. Contingent on their responses to this self-assessment instrument, all care providers will be expected to construct their own plan to strengthen existing competencies and remedy areas of deficit. Using the County Culturally Competent Clinical Practice Guidelines, a County approved curriculum will be developed which will include specific trainings to be offered in the areas of gender, sexuality, age, ethnicity and client culture for all service providers over a three year period. It should be pointed out that County Training and Development currently offers trainings on both gender and sexuality.

11) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls:

N/A.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA:

This program uses one-time-only funds for system-wide enhancements that are not part of CSS ongoing programs.

13) Timeline:

(i) Activity	Date
Identify trainers for each component, including conference	April 2006
Establish training schedule for each component, including conference	April 2006
Create system for logistical support for training	April – May 2006

Develop database to notify participants for training	April – June 2006
Create system to develop and collect materials relevant to all components	By 6/30/06
Conduct training according to schedule	From 6/01/06 through 6/30/08
Collect training evaluations from participants and managers	Ongoing
Conduct annual assessment of training plan and modify as needed	Annually at 6/30/07 and 6/30/08

(ii) Activity	Date
Prioritize software and computer equipment to be provided	By 4/15/06
Assess specific needs for training room equipment	By 4/15/06
Develop a room enhancement plan	By 5/1/06
Purchase and install room enhancement upgrades	By 6/1/5/06
Amend contracts with one time funding for designated equipment	By 7/1/06
Select sites for piloting Telemedicine	By 4/30/06
Establish protocols for use of Telemedicine Equipment	By 7/1/06
Purchase Telemedicine equipment for County programs	By 7/1/06
Amend contracts for equipment to be purchased by contract providers	By 7/1/06
Provide training	By 9/30/06

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	**Fiscal Year**: 2005-06	**Program Work Plan Name:** System-wide Outreach One Time Funding
Program Work Plan: OT- 2		**Estimated Start Date:** April 2006

1a) Program Description:
A) Ten psycho-educational radio segments pertaining to current trends in community mental health and
B) Breaking Barriers initiative to evaluate strategies to overcome stigma and perceived barriers for unserved populations in ethnically diverse communities

1b) Priority Population:
General audiences listening to radio and CSS target populations of all ages, with emphasis on unserved/underserved from specific cultural groups.

	1d) Fund Type			**1d)** Age Group				
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA	ALL
1c) A. <u>Community Mental Health Psycho-Educational Radio Presentations</u> ✓ Psycho-educational radio segments featuring mental health services experts, medical/clinical staff; community based agency providers and private practitioners, family members and consumers pertaining to mental health issues, education and access to care. ✓ Radio programs will include a range of topics, including understanding mental illness and serious emotional disturbances that affect children, adults, older adults and families; medication's role in the treatment of mental illness, environmental and cultural issues (e.g. Stigma), current trends in best practices and evidence based practices in the treatment of mental disorders, working with other families, communities, schools and other people in ensuring Systems of Care that are responsive to the needs of our community, co-occurring disorders, strategies in prevention and early intervention. ✓ The psycho-educational component is part of a Health and Human Services weekly one-hour program (Radio station AM 1700) spanning one year that would	☐	☐	☒	☐	☐	☐	☐	☒

also include topics such as Aging and Independence, Child Welfare and Public Health. B. Breaking Barriers The Breaking Down Barriers initiative is a partnership with the state's Mental Health Association to initiate an evaluation of effective strategies to reduce mental health stigma and increase access to mental health services from underserved communities. ✓ The initiative will create effective collaborations with other agencies, community groups, client and family member organizations and other stakeholders in one or two selected pilot communities, per our analysis of the unserved and underserved in this community. ✓ This effort will also help inform our planning and implementation efforts of our Prevention and Early Intervention efforts as part of the MHSA.								

2) Please describe in detail the proposed program for which you are requesting MHSA finding and how that program advances the goals of the MHSA.

A. Community Mental Health Psycho-Educational Radio Presentations advance the goals of the MHSA in several ways. These weekly radio program sponsored by a variety of Health & Human Services Agency Department would include ten segments on mental health issues, covering a full range as described above in 1c, the overall goal of which would be to increase awareness and knowledge about mental illness. Through these educational efforts to "normalize" mental illness, stigma will be deceased and barriers to service removed. As stigma is reduced and fear of engaging with the system lessens, access to services becomes a real option for many un-served populations, and leads to greater service utilization.

A second MHSA goal involves building community partnerships with underserved person. Only with meaningful involvement and feedback will Latinos and other underserved populations trust the process and encourage friends and families to make greater use of mental health services. This will come about by eliciting family and community involvement in the creation, testing and marketing of these segments. In 2001 the Cultural Competency Resource Team (CCRT) completed a very successful video projects on awareness and treatment of depression in Spanish speaking adolescents and families, and Filipino families. Using this model, families and community members will be involvement in these presentations by helping develop culturally appropriate tools and strategies with which to engage and involve the wider Latino and other communities of color in accessing mental health services. A third goal which

comes out of this greater engagement by persons from underserved groups is to have more involvement by Latinos and other un-served groups in future Mental Health Services Act planning for prevention and outreach.

B. Breaking Barriers: This initiative will promote MHSA goals in the following ways. Firstly, stigma associated with severe mental illness will be challenged through education and outreach as to the nature, causes, and treatment of mental illness from a recovery based perspective. This entails using all educational means available - including the radio presentations described in Section A above - to educate and inform underserved groups as to the nature of mental illness. Secondly, Breaking Barriers will link community based organizations to better understand perceived barriers to mental health services experienced by diverse populations, and identify strategies to reach diverse populations which are both un-served and underserved. This includes – but is not limited to - San Diego's Latino community, San Diego's East African Mental Heath Refugee Community, and Native American populations in San Diego.

3) Describe any housing or employment services to be provided.

This project provides only indirect services as support to the overall mental health system. Radio segments can include information on housing and employment for clients with SMI.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This program is not funded through a Full Service Partnership.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

A. The radio programs will highlight stories of recovery and management of mental illness by using culturally relevant radio presentations and video materials.
B. Information from "Breaking Barriers" will be used to improve access to care and reduce stigma. Both of these outcomes are expected to advance recovery goals.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

These are new programs proposed only for first year funding through one time only funding.

7) Describe which services and supports persons with a mental illness and/or family members will provide. Indicate whether persons with a mental illness and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

A key MHSA goal involves the building of community partnerships with underserved person, including clients and family members. MHSA goals will be met by each program in the following way:

a. Persons with a mental illness and family members of person with a mental illness will participate in the planning, creation, and marketing of these Community Mental Health Psycho-Educational Radio Presentations.
b. Persons with a mental illness and family members of person with a mental illness will participate in the planning, and delivery of the "Breaking Down Barriers" program. A minimum of a .5 FTE in this program will be occupied by a client (or clients) in recovery from a severe mental illness.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

A. The radio program is sponsored by the Health and Human Services Agencies, offering direct collaboration with Aging and Independent Services, Alcohol and Drug Services and other Agency departments. In addition, segment guests will be drawn from provider and other stakeholder groups, including persons with a severe mental illness.
B. Breaking Barriers will operate as part of collaboration between the Mental Health Association of San Diego (MHASD), the County of San Diego, and the California Endowment. MHASD will create effective collaborations with local client advocacy groups and entities such as Family Health Centers of San Diego, National University, San Diego Indian Health Center, Senior Community Centers of San Diego, and South Bay Community Services. MHASD will act as a central linking agency, working with culturally specific organizations such as Project ESSEA

(East African Refugee organization) which have already created effective ways in which to reach out to under represented communities in one or two selected pilot communities, per our analysis of the un-served and underserved in this community.

9/10) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs. / Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Cultural competence and sexual orientation and gender sensitivity are required expectations of our current providers and will be a requirement in all MHSA programs as well. To ensure that MHSA goals will be promoted by the program, staff will be required to abide by the requirements of the County of San Diego's Cultural Competency Plan (CCP) and participate in System Wide Education and Training Plan (SWETP), a plan which includes training on Cultural Competency, and training on domestic violence and victims of trauma and torture. A specific strategy which requires all providers to meet the needs of diverse communities is the annual, mandatory 4 hours of Cultural Competency Training required under the CCP.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county:

These programs will not provide services to individuals residing outside of the County of San Diego.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA:

These programs use one-time-only funds for system-wide enhancements that are not specifically part of CSS ongoing programs.

13) Please provide a timeline for this work plan, including all critical implementation dates:

A. Radio Segments Activity Date

Develop calendar of topics and dates	April 2006
Arrange for guests and publicize to increase call-ins	May – June 2006
Implement schedule and conduct radio program	From 5/1/06 to 6/30/07
Publicize availability of program at clinics and clubhouses	From 5/1/06 to 6/30/07

B. Breaking Barriers Activity	Date
Identify potential communities and collaborating partners for pilot implementation	May 2006
Conduct focus groups to collect consumer and family member input	April- July 2006
Design proposed strategies to reduce stigma and increase access	April- July 2006
Collect consumer and family member input on proposed strategies	By 9/15/06
Revise strategies as needed	By 10/1/06
Implement chosen strategies	By 10/15/06
Evaluate effectiveness of strategies	By 1/15/07
Submit report, including recommendations on replicability in other communities	By 1/31/07

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: County of San Diego
Program Work Plan #: Includes All Workplans
Fiscal Year: FY05-06 *(please complete one per fiscal year)*

	Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	Child/Youth	Un/Underserved Children with SED							0		0	
	Transition Age Youth	Un/Underserved TAY with SMI							0		0	
	Adults	Un/Underserved Adults with SMI							0		0	
	Older Adults	Un/Underserved Older Adults with SMI							0		0	
	All Populations	Un/Underserved Individuals with SMI							0		0	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Un/Underserved TAY with SMI							0		0	
Transition Age Youth	Un/Underserved TAY with SMI							0		0	
Adults	Un/Underserved Adults with SMI							125		125	
Older Adults	Un/Underserved Older Adults with SMI							0		0	
All Populations	Un/Underserved Individuals with SMI							0		0	

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Un/Underserved Children with SED							325		325	
Transition Age Youth	Un/Underserved TAY with SMI							0		0	
Adult	Un/Underserved Adults with SMI							175		175	
Older Adults	Un/Underserved Older Adults with SMI							114		114	
All Populations	Un/Underserved Individuals with SMI							0		0	

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: County of San Diego
Program Work Plan #: Includes All Workplans
Fiscal Year: FY06-07 *(please complete one per fiscal year)*

	Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	Child/Youth	Un/Underserved Children with SED	66		66		67		68		267	
	Transition Age Youth	Un/Underserved TAY with SMI	48		48		48		48		192	
	Adults	Un/Underserved Adults with SMI	108		108		109		110		435	
	Older Adults	Un/Underserved Older Adults with SMI	20		20		21		22		83	
	All Populations	Un/Underserved Individuals with SMI	0		0		0		0		0	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Un/Underserved TAY with SMI	255		255		255		256		1021	
Transition Age Youth	Un/Underserved TAY with SMI	221		223		223		223		890	
Adults	Un/Underserved Adults with SMI	656		656		656		656		2624	
Older Adults	Un/Underserved Older Adults with SMI	175		175		175		175		700	
All Populations	Un/Underserved Individuals with SMI	60		60		60		61		241	

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Un/Underserved Children with SED	325		325		325		325		1300	
Transition Age Youth	Un/Underserved TAY with SMI	0		0		0		0		0	
Adult	Un/Underserved Adults with SMI	175		175		175		175		700	
Older Adults	Un/Underserved Older Adults with SMI	113		114		114		114		455	
All Populations	Un/Underserved Individuals with SMI	32		32		33		33		130	

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: County of San Diego
Program Work Plan #: Includes All Workplans
Fiscal Year: FY07-08 *(please complete one per fiscal year)*

	Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	Child/Youth	Un/Underserved Children with SED	66		66		67		68		267	
	Transition Age Youth	Un/Underserved TAY with SMI	48		48		48		48		192	
	Adults	Un/Underserved Adults with SMI	108		108		109		110		435	
	Older Adults	Un/Underserved Older Adults with SMI	20		20		21		22		83	
	All Populations	Un/Underserved Individuals with SMI	0		0		0		0		0	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Un/Underserved TAY with SMI	255		255		255		256		1021	
Transition Age Youth	Un/Underserved TAY with SMI	221		223		223		223		890	
Adults	Un/Underserved Adults with SMI	656		656		656		656		2624	
Older Adults	Un/Underserved Older Adults with SMI	175		175		175		175		700	
All Populations	Un/Underserved Individuals with SMI	60		60		60		61		241	

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Un/Underserved Children with SED	325		325		325		325		1300	
Transition Age Youth	Un/Underserved TAY with SMI	0		0		0		0		0	
Adult	Un/Underserved Adults with SMI	175		175		175		175		700	
Older Adults	Un/Underserved Older Adults with SMI	113		114		114		114		455	
All Populations	Un/Underserved Individuals with SMI	32		32		33		33		130	

List of Attachments

1. GAP Analysis
2. Mapping

County of San Diego
Attachment 1- Gap Analysis Given to San Diego MHSA Workgroups

UNSERVED ADULTS				
Populations	**State Prevalence Data Estimated Need**	**Compared To Who We Are Currently Serving**	**Estimated Service Needs** ***(Based On 03-04 Data)***	Examples of State Recommended Service Interventions
Latino Adults (25-59)	Prevalence Data indicates that there may be a need for services for up to: **15,415**	Currently Serving: **5,993**	Prevalence Data: 15,415 Currently Serving: - 5,993 **9,422**	On-site services in primary care clinics On-site services in faith based communities Education for client and family or other caregivers on mental illness
Asian/Pacific Islander Adults (25-59)	Prevalence Data indicates that there may be a need for services for up to **3,596**	Currently Serving: **1,626**	Prevalence Data: 3,596 Currently Serving: - 1,626 **1,970**	On-site services in primary care clinics On-site services in faith based communities Education for client and family or other caregivers on mental illness
Adults (25-59)	No prevalence data available	4,615 Adults received only Emergency or Inpatient Services • 3,836 of those received 1-2 Crisis/Emergency Services only • 300 of those received 1-2 IP and 0-2 Crisis/Emergency Services only • 479 of those received 3+ IP or Crisis/Emergency Services only	Estimated Service Needs: 4,615	Assertive community treatment teams Integrated substance abuse and mental health services where the client receives substance abuse and mental health services from one tem with one plan.
Estimated # of Adults (25-59) unserved potentially needing MH Services = 16,007				

Other Notes: It is estimated that of the total unserved adults:

- 11,000 may not have Medi-Cal or any other type of insurance.
- 1,190 may have been homeless sometime during the year

UNDERSERVED & INAPPROPRIATELY SERVED ADULTS			
Populations	**Number Potentially Underserved By Age And Services Received**	Estimated Service Needs	**Examples of State Recommended Service Interventions**
Adults (25-59)	613 Adults receive only 1-3 Outpatient and/or Case Management Services a year • 343 of those received 1-2 Crisis/Emergency Services. • 178 of those received 1-2 Inpatient and 0-2 Crisis/Emergency Services. • 92 of those received 3+ Inpatient or Crisis/Emergency Services.	Estimated Service Needs: 613	24 hour, 7 day a week response by Personal Services Coordinators Peer supportive services and client and family run services
Adults (25-59)	3,093 Adults receive 7+ Outpatient and Case Management Services a year • 1,119 of those received 1-2 Crisis/Emergency Services • 1,176 of those received 1-2 Inpatient and 0-2 Crisis/Emergency Services • 798 of those received 3+ Inpatient or Crisis/Emergency Services	Estimated Service Needs: 3,093	Development of temporary housing options Mobil crisis services
Adults (25-59)	4,824* Adults receive only Medication Management Services a year *Includes adults with a diagnosis of Schizophrenia, Bipolar, Major Depression and Other Psychosis • Note 27.3% of African Americans were diagnosed with Schizophrenia compared to 18.7% of the total client population	Estimated Service Needs: 4,824	Values driven evidence based clinical services that are integrated with overall services planning and support housing, employment, and/or education goals.

Estimated # of Adults (25-59) underserved potentially needing MH Services = 8,530

Other Notes:

- 7,239 Adults received Jail MH services
  - 34.3% were African American compared to 23.9% for the total client population
- 8,774 Adults were dually diagnosed
- 2,765 Mentally Ill Adults may have been homeless (estimated)

POPULATIONS	STATE ESTIMATE OF NEED - PREVALENCE	CMH PROVIDED SERVICE	POTENTIAL SERVICE GAP
TOTAL UNSERVED = 15,821*			
Children Ages 0-5	**9,593** children need services	CMH served **1,726** children in FY03-04, a difference of **7,867**. However, only 47% of these children meet criteria for additional MH services.	**3,697**
Children Ages 6-11	10,099 children need services.	CMH served **6,945** children FY03-04.	**3,154**
Children Ages 12-17	7,697 children need services.	CMH served **9,307** children in FY03-04.	No Unserved Gap – **This population may have Underserved needs**
Asian/Pacific Islander Children	**1,911** Asian/Pacific Islander children need services	CMH served **464** Asian/Pacific Islander children in FY03-04, a difference of **1,447.**	**888**, adjusted for Age
Hispanic Children	**15,931** Hispanic children need services	CMH served **7,126** Hispanic children in FY03-04, a difference of **8,805.**	**4,975**, adjusted for Age
African American Children	**2,021** African American children need services	CMH served **2,653** children in FY03-04.	No Unserved Gap – **this population may have Underserved needs**
Native American Children	**169** Native American children need services	CMH served **157** children in FY03-04, a difference of 12.	No Unserved Gap, adjusted for Age – **this population may have Underserved needs**
Dependent Children, Child Welfare Sys	CASRC estimated 41.8% of CWS clients need MH services. 14,177 clients open to CWS FY02-03, an estimated need of **5,926**.	CMH served **4,335** clients open to CWS FY02-03, a difference of **1,591**.	**246**, adjusted for Age and Ethnicity/Race
Wards of the Court, Juvenile Justice System	CASRC estimated 52.1% of JJ clients needed MH services. 8,801 clients in JJ in FY02-03, an estimate of need of **4,585**.	CMH provided services to **3,545** clients open to JJ in FY02-03, a difference of **1,040**.	**965**, adjusted for Age and Ethnicity/Race
Unfunded Children	Children without MediCal receive fewer services and have more difficulty accessing services. **15,667** unfunded children,<200% poverty that are not MediCal enrollees.	**956** Children seen without MediCal or AB2726 funding, resulting in a difference of **14,711**.	**1,896,** adjusted for Age and Ethnicity/Race

*The State's estimate of need for all children 0-17 in San Diego County is 27,391. In FY03-04, CMH provided services to **17,716** (unduplicated) children.

Populations	Identified Underserved Populations	CMH Served	Potential Service Gap
UNDERSERVED CHILDREN			
Children Utilizing Inpatient or Crisis Services	Children/adolescents who repeatedly utilize hospital or crisis services are seen at increased risk for needing higher level of residential placement or greater involvement within JJ.	In FY03-04, **531** CMH clients were placed in psychiatric hospitalization; **2,128** clients were seen for Crisis services	- **175** CMH clients were hospitalized more than once in FY03-04, 95 within 30 days of last discharge - **31** received inpatient services only - **115** received Crisis Services (ESU) only
Co-Occurrence of Substance Use Disorder (SUD), Dual Diagnosis	CASRC study indicates 40.8% of CMH clients meet criteria for a SUD, resulting in prevalence estimate for the co-occurrence of a SUD in **7,228** children.	**1,122** CMH clients were concurrently open to ADS in FY02-03 (data available), representing 6% of all CMH clients. Only **266** CMH had a Substance Use Disorder indicated as a secondary diagnosis.	Potentially **6,106** CMH clients may be underserved related to a co-occurring substance use disorder**.**
Children Receiving Services ONLY through Juvenile Forensic Services	The Juvenile Justice System has recognized that children leaving their custody who had been receiving mental health services only through JFS fail to continue to obtain subsequent treatment/supervision in the community, and are at a higher risk for reoffending/rearrest as a result.	In FY03-04, **2,698** children in the Juvenile Justice System received services through JFS only –did not have additional treatment provided within the CMH system. According to a study supervised by Judge James Milliken, 25% of children leaving the JJ system had private insurance.	**Potentially 2,024**children, or 75% of those leaving the Juvenile Justice System having received no further CMH services, may be underserved.
African American Children	The State estimate of SED among African American children ≤200% poverty is 2,021	CMH provided service to 2,653 African American Children in FY03-04	African American children represented 16% of those served by CMH, 22% of those concurrently open to CWS, 13% open to ADS, and 18% of those open to JFS in FY03-04.
Native American Children	The State estimate of SED among Native American children ≤200% poverty is 169	CMH provided service to 157 Native American children in FY03-04	Native American children represented 1% of those served by CMH, 1.6% of those concurrently open to CWS, 3.1% open to ADS, and 0.2% of those open to JFS in FY03-04.
Transition Age Youth	25% of 18 year-old clients seen by AMH had been seen by CMH the prior year. Analysis of the percentage of 17 year-old CMH clients served by	CMH provided services to 368 clients 18 years or older in FY03-04.	**Approximately 75% of 18 year-old AMH clients had no prior CMH service. Differences in the diagnostic eligibility requirements exist between**

Populations	Identified Underserved Populations	CMH Served	Potential Service Gap
UNDERSERVED CHILDREN			
	AMH the next year by AMH is pending.		**AMH and CMH.**

POPULATIONS	STATE ESTIMATE OF NEED - PREVALENCE	CMH PROVIDED SERVICE	POTENTIAL SERVICE GAP
TOTAL UNSERVED = 15,821*			
Children Ages 0-5	**9,593** children need services	CMH served **1,726** children in FY03-04, a difference of **7,867**. However, only 47% of these children meet criteria for additional MH services.	**3,697**
Children Ages 6-11	10,099 children need services.	CMH served **6,945** children FY03-04.	**3,154**
Children Ages 12-17	7,697 children need services.	CMH served **9,307** children in FY03-04.	No Unserved Gap – **This population may have Underserved needs**
Asian/Pacific Islander Children	**1,911** Asian/Pacific Islander children need services	CMH served **464** Asian/Pacific Islander children in FY03-04, a difference of **1,447.**	**888**, adjusted for Age
Hispanic Children	**15,931** Hispanic children need services	CMH served **7,126** Hispanic children in FY03-04, a difference of **8,805.**	**4,975**, adjusted for Age
African American Children	**2,021** African American children need services	CMH served **2,653** children in FY03-04.	No Unserved Gap – **this population may have Underserved needs**
Native American Children	**169** Native American children need services	CMH served **157** children in FY03-04, a difference of 12.	No Unserved Gap, adjusted for Age – **this population may have Underserved needs**
Dependent Children, Child Welfare	CASRC estimated 41.8% of CWS clients need MH services. 14,177 clients open to CWS FY02-03, an estimated need of **5,926**.	CMH served **4,335** clients open to CWS FY02-03, a difference of **1,591**.	**246**, adjusted for Age and Ethnicity/Race

POPULATIONS	STATE ESTIMATE OF NEED - PREVALENCE	CMH PROVIDED SERVICE	POTENTIAL SERVICE GAP
System			
Wards of the Court, Juvenile Justice System	CASRC estimated 52.1% of JJ clients needed MH services. 8,801 clients in JJ in FY02-03, an estimate of need of **4,585**.	CMH provided services to **3,545** clients open to JJ in FY02-03, a difference of **1,040**.	**965**, adjusted for Age and Ethnicity/Race
Unfunded Children	Children without MediCal receive fewer services and have more difficulty accessing services. **15,667** unfunded children,<200% poverty that are not MediCal enrollees.	**956** Children seen without MediCal or AB2726 funding, resulting in a difference of **14,711**.	**1,896,** adjusted for Age and Ethnicity/Race

*The State's estimate of need for all children 0-17 in San Diego County is 27,391. In FY03-04, CMH provided services to **17,716** (unduplicated) children.

UNSERVED OLDER ADULTS				
Populations	**State Prevalence Data Estimated Need**	**Compared To Who We Are Currently Serving**	**Estimated Service Needs** ***(Based On 03-04 Data)***	**Examples of State Recommended Service Interventions**
Older Adults 65+	Prevalence Data indicates that there may be a need for Older adults 65 + for services for up to **4,492**	Currently Serving: **1,357**	Prevalence Data: 4,492 Currently Serving: - 1,357 **3,135**	Integrated assessment teams Mobile services Linkage to a full range of services Peer supportive services Home care assistance
Latino Older Adults 60+	Prevalence Data indicates that there may be a need for services for up to **1,070** By age group: • 60-64 = 495 • 65+ = 575	Currently Serving: **420** By age group: • 60-64 = 195 • 65+ = 225	Prevalence Data: 1,070 Currently Serving: - 420 **650** By age group: • 60-64 = 495 - 195 = 300 • 65+ = 575 - 225 = 350	On-site services in primary care clinics On-site services in faith based communities Education for client and family or other caregivers on mental illness
Asian/Pacific Islander Older Adults 60+	Prevalence Data indicates that there may be a need for services for up to **437** By age group: • 60-64 = 281 • 65+ = 156	Currently Serving: **187** By age group: • 60-64 = 127 • 65+ = 60	Prevalence Data: 437 Currently Serving: -187 **250** By age group: • 60-64 = 281 – 127 = 154 • 65+ = 156 - 60 = 96	On-site services in primary care clinics On-site services in faith based communities Education for client and family or other caregivers on mental illness
Older Adults 60+	Prevalence data is not available	578 Older Adults received only Crisis/Emergency or	Potential Service Gap = 578	Education for the client and family or other caregivers as appropriate regarding the nature of medications,

UNSERVED OLDER ADULTS				
Populations	**State Prevalence Data Estimated Need**	**Compared To Who We Are Currently Serving**	**Estimated Service Needs** ***(Based On 03-04 Data)***	**Examples of State Recommended Service Interventions**
		Inpatient Services • 525 of those received 1-2 Crisis/Emergency Services only • 26 of those received 1-2 Inpatient and 0-2 Crisis/Emergency Services only • 27 of those received 3+ Inpatient or Crisis/Emergency Services only		the expected benefits and the potential side effects
Estimated # of Older Adults (60+) unserved potentially needing MH Services = 4,613 Other notes: Based on the State Prevalence Report there is no general service gap for Older Adults aged 60-64 Many Older Adults have coverage through Medicare and receive services from providers not in our system of care				

UNDERSERVED/ INAPPROPRIATELY SERVED OLDER ADULTS			
Populations	**Number Potentially Underserved By Age And Services Received**	Estimated Service Needs	**Examples of State Recommended Service Interventions**
Older Adults 60+	476 Older Adults received a low number services (1-3) • 17 of those received 1-2 Crisis/Emergency Services only • 11 of those received 1-2 Inpatient and 0-2 Crisis/Emergency Services only • 2 of those received 3+ Inpatient or Crisis/Emergency Services only	Potential Service Gap = 476 30 utilized Emergency and Inpatient Services	Peer supportive services and client run services Integrated service teams and planning with social service agencies
Older Adults 60+	1,144 receive 7+ Outpatient and Case Management Services a year • 41 of those received 1-2 Crisis/Emergency Services • 58 of those received 1-2 Inpatient and 0-2 Crisis/Emergency Services • 29 of those received 3+ Inpatient or Crisis/Emergency Services	Estimated Service Needs: 128	**Supportive housing** **Integrated substance abuse and mental health services** **Outreach to older adults in their homes**
Older Adults 60+	357 Older Adults received only Medication Management * Only includes older adults with a diagnosis of Schizophrenia, bipolar, Major Depression, or Other Psychosis	Potential Service Gap = 357	Values driven evidence based clinical services that are integrated with overall services planning and which support housing and other client selected goals
Estimated # of Older Adults (60+) underserved potentially needing MH Services = 961 Other notes: Many Older Adults have coverage through Medicare and receive services from providers not in our system of care 213 Older Adults were dually diagnosed 140 Older Adults are noted in InSyst as being in jail at some time during the year			

UNSERVED TRANSITION AGE YOUTH (TAY)				
Populations	**State Prevalence Data Estimated Need**	**Compared To Who We Are Currently Serving**	**Estimated Service Needs**	**Examples of State Recommended Service Interventions**
Transition Age Youth (Ages 18-24)	Prevalence Data indicates that there may be a need for services for **13,182**	Currently Serving: **5,409**	Prevalence Data: 13,182 Currently Serving: - 5,409 **7,773**	Integrated assessment teams Mobile services Linkage to a full range of services Peer supportive services
TAY 18-24	Prevalence data is not available	TAY receive only Crisis/Emergency or Inpatient Services a year 1,127 • 943 of those received 1-2 Crisis/Emergency Services only • 83 of those received 1-2 Inpatient and 0-2 Crisis/ Emergency Services only • 101 of those received 3+ Inpatient or Crisis/ Emergency Services only	Estimated Service Need = 1,127	Staff working with transition age youth who are trained in developmental and cultural needs of TAY Education for the client and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects

Estimated # of TAY (18-24) unserved potentially needing MH Services = 8,900

Other Notes: MHSA identifies TAY as 16-24. This age was unserved based on the DMH Prevalence data. In addition their services are provided in the CMH system

It is estimated that of the total unserved TAY, 2,500 may not have Medi-Cal or any other type of insurance (28%)

Both the Latino and Asian/PI TAY numbers noted below are included in the estimate of 8,900

UNSERVED TRANSITION AGE YOUTH (TAY)				
Populations	**State Prevalence Data Estimated Need**	**Compared To Who We Are Currently Serving**	**Estimated Service Needs**	**Examples of State Recommended Service Interventions**
Latino TAY	Prevalence Data indicates that there may be a need for services for up to 4,085 By age group: • 18-20 = 1,575 • 21-24 = 2,510	Currently Serving: **1,579** By age group: • 18-20 = 608 • 21-24 = 971	Prevalence Data: 4,085 Currently Serving: 1,579 **2,506** By age group: • 18-20 = 1,575 - 608 = 967 • 21-24 = 2,510 - 971 =1,539	Seamless linkages with both children/youth and adult mental health system On-site services in primary care clinics Education for client and family or other caregivers on mental illness Housing options
Asian/Pacific Islander TAY*	Prevalence Data indicates that there may be a need for services for up to **571** By age group: • 18-20 = 230 • 21-24 = 341	Currently Serving: 259 By age group: • 18-20 = 105 • 21-24 = 154	Prevalence Data: 571 Currently Serving: - 259 **312** By age group: • 18-20 = 230 – 105 = 125 • 21-24 = 341 – 154 = 187	Seamless linkages with both children/youth and adult mental health system On-site services in primary care clinics Education for client and family or other caregivers on mental illness Housing options

UNDERSERVED/INAPPROPRIATELY SERVED TRANSITION AGE YOUTH (TAY)			
Populations	**Number Potentially Underserved By Age And Services Received**	Estimated Service Needs	**Examples of State Recommended Service Interventions**
TAY 18-24	154 TAY receive only 1-3 Outpatient and/or Case Management Services a year • 79 of those received 1-2 Crisis/Emergency Services. • 52 of those received 1-2 Inpatient and 0-2 Crisis/Emergency Services. • 23 of those received 3+ Inpatient or Crisis/Emergency Services.	Estimated Service Needs: 154	Integrated service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization and independent living skills
TAY 18-24	516 TAY receive 7+ Outpatient and Case Management Services a year • 168 of those received 1-2 Crisis/Emergency Services • 183 of those received 1-2 Inpatient and 0-2 Crisis/Emergency Services • 165 of those received 3+ Inpatient or Crisis/Emergency Services	Estimated Service Needs: 516	Mobile Crisis Services Integrated service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization and independent living skills
TAY 18-24	774* TAY receive only Medication Management Services a year *Includes TAY with a diagnosis of Schizophrenia, Bipolar, Major Depression and Other Psychosis	Estimated Service Needs: 774	Values base evidence based practice that is integrated with overall service planning and support housing, employment, and/or education goals
TAY Receiving MH services in Jail 18-24	Currently serving: • 1,949 TAY received Jail MH services	Estimated Service Need = 1,949	Linkage with integrated mental health services
TAY who were in the Foster Care System and/or Juvenile forensics	Overall results show that 25% of children in AMH in 03-04 received services from CMH in 02-03- still waiting for info re Foster Care and JF	Additional analysis is still being conducted on all these categories.	Seamless linkages with both CMH and AMH services Supportive Housing Peer supportive services and client run services

UNDERSERVED/INAPPROPRIATELY SERVED TRANSITION AGE YOUTH (TAY)			
Populations	**Number Potentially Underserved By Age And Services Received**	Estimated Service Needs	**Examples of State Recommended Service Interventions**
Estimated # of TAY (18-24) underserved potentially needing MH Services = 3,393 Other Notes: MHSA identifies TAY as 16-24. Services for TAY between the ages of 16 and 18 receive services in the CMH system. 1,815 TAY were dually diagnosed 490 TAY may have been homeless (estimated)			

Overview:
As one of the requirements of the Mental Health Services Act each County must conduct a service needs assessment or "gap analysis". The intent of the gap analysis is to assist County Mental Health in service planning by predicting service needs.

Components of the Gap Analysis:
The Gap Analysis compares information about the prevalence of serious mental illness with the numbers of individuals currently being served to develop an estimate of unmet need. The Gap Analysis addresses several components:

- ***# of Unserved*** - Individuals who meet the criteria for specialty mental health services but are not currently receiving any services.
- ***# of Underserved and/or Inappropriately Served***- Individuals who are receiving less services than needed in order for them to function better or who may be receiving the wrong type of services. Examples include: Individuals receiving specialty mental health services but who are potentially "at risk" of out-of-home placement, homelessness, criminal justice involvement, institutionalization, hospitalization and/or emergency room services.
- ***Racial/ethnic disparities*** – Individuals from various racial/ethnic populations who are disproportionately underserved.

DMH Prevalence Data
The State Department of Mental Health (DMH) has issued prevalence data, which estimates the number of youth who have serious emotional disturbance (SED) and the number of adults who have serious mental illness (SMI). The prevalence rates were developed by an epidemiologist, who based his analysis on national studies of the prevalence of serious mental illness by age, gender and ethnicity. The prevalence rates, by age gender and ethnicity for SED and SMI were applied to the demographic characteristics for each California county. Since the public mental health system is intended to serve those persons who have low resources, the prevalence rates were applied to the population below 200 percent of federal poverty level.

Using the Gap Analysis to Assist With Service Planning:

It is recommended that the County of San Diego MHSA Planning Workgroups utilize information from the Gap Analysis when planning for services. When using the Gap Analysis the following should be kept in mind:

- The Gap Analysis is a summary document
- It is intended to be a pointer or indicator of priorities.
- Resulting numbers should not be interpreted as absolute values.

San Diego Gap Analysis

The methodology used to determine the number of persons who are "unserved" was to subtract the number of persons currently served by the County of San Diego public mental health system from those identified in the DMH Prevalence data as needing services. San Diego also conducted an in-depth analysis of population subgroups to identify service needs based on diversity and special needs.

The methodology used to determine the number of persons "underserved" was to analyze the use of inpatient, emergency, and jail services, as well as analyzing the utilization of those services based on demographics of the client population. This comprehensive analysis was conducted by Children and Adolescent Services Research Center (CASRC) for data regarding children and adolescents and by Dr. Todd Gilmer of UCSD Department of Family and Preventive Medicine for data regarding transitional age youth (TAY), adults, and older adults.

Summaries of the results of the San Diego Gap Analysis are shown in Tables 1 and 2. Table 1 reflects a rough estimate of overall service needs based on a simple comparison of total prevalence and total numbers served**.**

Table 1:

Estimated total persons in need of MH services in DMH Prevalence report:	77,436
Total number of persons currently served in San Diego County:	- 58,000
Total number estimated to be in need of MH services:	19,436

Table 2 reflects a more complete estimate of service needs based on an in depth analysis of demographic sub-populations and current service utilization patterns*.

Table 2:

	Estimated Unserved	Estimated Underserved	Total
Youth	15,821	8,451	24,272
TAY	8,900	3,393	12,293
Adults	16,007	8,530	24,537
Older Adults	4,613	961	5,474
Total of up to:	45.341	21.335	66.676

* These numbers have been revised since the handout dated 5-17-05 due to changes in the State's definition of "unserved