Department of Health and Human Services
Mental Health Administration

June 23, 2008

Dear Community Members:

We would like to inform you of our draft Implementation Progress Report that is being disseminated for a 30-day public review and comment period in accordance with a state mandate to report on Mental Health Services Act Community Services and Supports (CSS) activities. In compliance with state requirements, this report focuses only on activities that took place from January 1, 2007 through December 31, 2007.

You may review the Draft Progress Report by visiting our website at: http://www.ci.berkeley.ca.us/ContentDisplay.aspx?id=15648. A copy of the report will also be in the Berkeley Central Public Library located at: 2090 Kittredge St., in downtown Berkeley.

We welcome any comments you may have. If you would like to provide comments, please respond by July 23rd. You may direct your feedback via mail, phone or email to:

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The Berkeley Mental Health Commission will hold a public hearing regarding this report and any comments received on Thursday July 24th at 5:30pm at 2640 Martin Luther King Blvd.

Thank you for your time and attention!

Karen Klatt

Karen Klatt, MHSA Coordinator

City of Berkeley
Mental Health Division
Mental Health Services Act /Community Services and Supports
Implementation Progress Report
January—December 2007

Introduction

This report provides information about the City of Berkeley's Mental Health Services Act (MHSA) Community Services and Supports (CSS) programs. In accordance with state guidelines, the Implementation Progress Report "provides a briefing on the implementation of the CSS component of the MHSA Three Year Program and Expenditure Plan and highlights early successes and challenges in implementing the CSS Plan." More fundamentally, we want to focus on how these programs have begun to influence and change the overall mental health system.

Some of the key highlights during 2007 include:

- An active and productive Wellness Recovery Task Force
- Full Service Partnership program enrollments
- A Community Outreach and Engagement plan for unserved and underserved populations
- Strategic planning with community partners to improve consumer employment opportunities and outcomes.
- Contracts with community based providers for MHSA services to Children (ages 0-18) and Transition Age Youth (ages 18-25)
- Added new staff positions: Family Advocate; Employment Coordinator. Expanded: Consumer Liaison position**.**
- Conducted a range of cultural competence trainings
- Worked with the MHSA Steering Committee to redefine its role and developed a plan to broaden community participation on the Steering Committee
- Developed a plan for use of CSS One-Time funds. .
- Hired Peer Counselors to work with Transition Age Youth

Background

California voters approved the Mental Health Services Act (MHSA) in November 2004. The MHSA provides funding for state and local mental health programs in five categories:

- Community Services and Supports (CSS)
- Workforce Development and Education/Training
- Prevention and Early Intervention
- Capital Facilities and Technology and
- Innovative Programs.

The first category of funding to be released was Community Services and Supports (CSS). Berkeley Mental Health developed the CSS plan in collaboration with community stakeholders in 2005/2006. The State Department of Mental Health (DMH) approved Berkeley's Plan in

September 2006. The current amount of funding available for CSS programs is $1,281,754 plus a one-time augmentation of $925,300.

Planning is currently underway for the Workforce Development and Prevention and Early Intervention components. It is anticipated that these plans will be released for public comment in the next few months.

This report is being written in response to specific requirements provided by DMH. At the beginning of each section, the requirements are summarized and noted in italics.

A. Program Services Implementation

1) Work Plans: State Guideline*: Briefly report by Work Plan on how implementation of the approved program/services is proceeding:*

- *Report on whether the implementation activities are generally proceeding as described in the approved CSS Plan. If not, please identify the key differences.*
- *Describe the major implementation challenges that were encountered.*

There are three categories of CSS programs:

- Full Service Partnerships
- System Development
- Outreach and Engagement

Full Service Partnerships (FSP)

There are two full service partnership programs in the Berkeley CSS Plan:

1. Children's Intensive Support Services
2. Integrated Services Expansion for Transition Age Youth, Adults and Older Adults

What is a Full Service Partnership Program?

These programs provide a range of services designed to meet various needs including housing, vocational and social needs. The programs are asked to "do whatever it takes" to engage participants and help them get their lives back on track. Funds are made available to help individuals with critical needs including subsidizing housing costs. These programs provide intensive supports to a limited number of individuals. Caseloads are usually 1:10—1:15.

Children's Intensive Support Services: CSS Funding: $136,705

- Brief Program Description: Fred Finch, Inc. operates this program providing intensive mental health services to children who do not have Medi-cal or other insurance. The program model provides brief, intensive interventions, usually up to 6 months. If additional services are needed Fred Finch works with Berkeley Mental Health to provide ongoing support. The program was designed to serve up to 10 youth at a time.
- Goals for 2007: Program fully operational
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- Progress/Challenges: It was originally envisioned that the program would be fully operational by January 2007. Due to delays in the contracting process the program began in June 2007. By the end of September they had enrolled four children and by the end of December, ten children were enrolled. This program has been very effective in meeting the needs of children and families. The referral process, managed by Berkeley Mental Health, has worked effectively in prioritizing children to receive these services. The collaborative process between BMH and Fred Finch has ensured that the needs of youth are met and that transfers between the agencies are well managed. The only implementation challenge with this program was that it took longer than anticipated to develop the initial contract.

Integrated Services Expansion for Transition Age Youth, Adults and Older Adults: CSS Funding $521,427

- Brief Program Description: Increase staffing at the adult mental health clinic to provide comprehensive mental health and support services. Most of the services will be for transition age youth and older adults, with an emphasis on Latino and Asian/Pacific Islanders — 18 clients to be served. Staffing includes 2 clinicians, .a 50 peer counselor, and a .50 Employment Coordinator. With expansion funds made available in FY 07/08 a .50 Housing Coordinator position was added along with additional funding to support housing.

- Goals for the period ending December 2007: 5-8 Consumers enrolled in the program, at least one individual referred for employment support.

- Progress/Challenges: Most of the staff were hired in 2007, the last clinician was hired in the beginning of 2008. Enrollments began in April 2007, by the end of 2007 there were 10 individuals enrolled. Five of these enrollees are transition age youth and two are older adults. Two of the enrollees are Asian/Pacific Islander and two are from the Latino community. One of the individuals enrolled was referred to vocational services. In contrast to the demographics in the ACT and AB2034 programs over the past nine years, the new FSP enrollments reflect a positive shift toward historically underserved populations. And we believe that unmet need continues to exist.

  Identifying individuals in need of FSP services from the un-served and underserved communities has been the biggest challenge to full enrollment. Outreach efforts continue and a decision was made to hold openings in this program allowing more time for outreach to be successful. Despite barriers including stigma and the lack of sufficient bilingual and culturally responsive services, there is significant demand in Berkeley and Albany for a broad range of low-intensity mental services. Full service partnership programs, however, are designed for a much smaller segment of people who need intensive mental health services. We were successful in recruiting excellent bi-lingual bi-cultural staff for this program.

One Time CSS Administrative Funds $925,300

During the later part of 2007 some funds were made available on a one-time basis to support CSS programs. These funds were used to expand the services made available in this FSP program. A number of clients had been receiving similar services under an AB 2034 program that was not approved for continued funding in 2007/08. The plan for these additional funds is to provide short-term intensive services for clients with the greatest needs to help them develop stable living situations. Like all CSS funds the city has three years to fully expend the funds.

System Development

Wellness/Recovery Services: CSS Funding $243,978

- Brief Program Description: Enhance services currently provided at Berkeley Mental Health to include activities promoting wellness and recovery. Reach out to family members and a focus on employment services. Staffing includes increasing the current Consumer Liaison to full time from part time, a .50 Family Advocate and a .50 Employment Coordinator (to be combined with the .50 in the FSP program). With expansion funds made available in 07-08, a 1.0 peer counselor position was added.

- Goals for period ending December 2007: 10—15 Consumers referred for employment services.

- Progress/Challenges: The staff positions originally allocated to this program were all filled in 2007. The Peer Counselor position that was added this fiscal year has not yet been filled. A Wellness Recovery Task Force was created to involve consumers, family and staff in activities to promote wellness and recovery. The Family Advocate created informational materials for family members and began to work with clinic staff on ways to reach out to family members. A consultant was hired to work with mental health staff, the Department of Rehabilitation, Rubicon, and Alameda County Vocational Services to develop an employment support system for Berkeley Mental Health. The Employment Coordinator came on board in July 2007, but only a few individuals were referred for employment services.

  The development of employment services was the most significant implementation challenge faced in this program. The collaborative process was quite helpful but it took longer than anticipated to develop the plan. Staff needed to be trained on using the new referral system. This system did become operational in 2008.

Outreach and Engagement

Multicultural Outreach: CSS Funds $88,431

- Brief Program Description: Develop methods to engage ethnic communities and increase service utilization in these communities. Plan to begin with outreach to Asian

communities. This program builds on the success of the Latino Families in Action outreach model that has been operating for six years. Funds pay for a .50 Multicultural Outreach Coordinator and for small contracts with ethnic service provider organizations.

- Goals for period ending December 2007: Asian/Pacific Islander outreach plan developed. Outreach efforts result in reaching 80 Latinos and 80 Asian Pacific Islanders. Identify shared resources opportunities with Alameda and Contra Costa County.

- Progress/Challenges: The Multicultural Outreach Coordinator did complete an outreach plan for the Asian/Pacific Islander community that included meting with community leaders, engaging students and parents to discuss issues of concern, and providing trainings to staff and community members. These efforts reached approximately 65 Asian Pacific Islander individuals. Despite these efforts we are still struggling to develop a core group of individuals to work with the mental health system to improve accessibility for this population. This has been the biggest implementation challenge in this area.

  Efforts with the Latino community have been more successful due to a history of strong working relationships. Well over 80 individuals were reached. A model entitled "Latino Family Consultation Services" was developed to provide consultation and support to families facing various emotional, social and economic challenges.

  A day long all staff training on clinical issues in working with lesbian, gay, bisexual and transgender people was held in April as well as outreach to LGBT leaders in Berkeley to address access and cultural competence issues. While some contacts were made with Alameda and Contra Costa Counties, strategies have not yet been developed for a regional approach to serving various ethnic groups.

<u>Transition Age Youth Outreach & Service Program: CSS Funds $98,900</u>

- Brief Program Description: These services are targeted to homeless transition age youth (ages 18-25) with serious mental illness. The contract funds a full time clinician and a part time peer counselor to provide support and therapeutic services to this population. These staff are part of a larger support program that provides a winter shelter and a year round Saturday support program for homeless transition age youth.

- Goals for period ending December 2007: 50 Transition age youth reached through outreach efforts, 5 transition age youth referred to full services partnership programs.

- Progress/Challenges: The contract for this program was awarded in June 2007 to the Youth Emergency Assistance Hostel (YEAH) Lutheran Church of the Cross program for homeless youth. The primary implementation challenge was the length of time it took to develop the contract. The original plan was to have the program begin in January of 2007. The program did provide outreach to at least 50 youth and at least 5 individuals were referred to full service partnership programs. Once the program started, we decided

it would be more useful to track the number of individuals receiving primary services from this program rather than track outreach contacts. Seventeen youth received case management and therapeutic support in 2007. The role of the peer counselor has worked exceptionally well in helping youth to access resources in the community. By providing this level of additional support the program has been able to increase the amount of service offered year round.

2) MHSA Principles, State Guideline: *For each of the six areas below, very briefly describe one example of a successful activity, strategy or program implemented through CSS funding and why you think it is an example of success e.g. what was the result of your activity. Please be specific.*

a. Community collaboration

As noted above a contract was developed with YEAH to provide services to homeless youth. One of the goals of this program was to increase the collaboration between YEAH and Berkeley Mental Health so that transition aged youth in need of full service partnership and other mental health services could be effectively screened, treated or referred. Using MHSA and City General Funds, YEAH enhanced its clinical capacity, expanded beyond basic shelter and support services, and developed closer working relationships with Berkeley Mental Health. As a consequence, consumers began to receive services that matched their level of care needs. Coordination improved and a number of youth were successfully engaged in intensive services. The YEAH clinician who had made the initial connection with the young adult continued her support while BMH FSP staff engaged the individual. This allowed for a successful transition and successful enrollment. In many previous experiences with the TAY population where this level of support was not available, young adults often simply dropped out of services.

b. ***Cultural competence***

Significant work was done with the Cultural Competence Committee during 2007 to redefine its mission and develop goals and objectives. As part of this process the committee reviewed its practice of offering an annual daylong training on cultural competence issues. It was decided that it would be more effective to offer shorter more frequent trainings. A training series on working with the Asian/Pacific Islander community was developed and implemented. This training model allowed staff time to present specific case issues and receive consultation which improved overall service delivery.

c. Client driven mental health system

The involvement of consumers in the MHSA planning process led to more involvement in other aspects of system planning, including the Continuous Quality Improvement Committee, the Mental Health Commission and the Wellness Recovery Task Force. While consumers and family members had been involved previously in these areas, the CSS planning process stimulated broader and more substantive participation. Consumers successfully advocated for several issues that became priorities on the agendas of these committees including, use of police in 5150s, measuring recovery, improving access, and use sub-payee services. Some of these areas will be discussed later in this report. This is an example of how consumer input has driven the staff time and resources of the mental health division.

d. Family driven mental health system

MHSA funds were used to create a Family Advocate position. This individual was hired in June of 2007. As part of her initial work she developed a brochure and met with clinical staff to discuss how to reach out to family members. She began attending the BMH Family Support Groups offered since 1978, She also attended NAMI meetings and developed relationships with advocates at the Mental Health Association. Through this outreach a family member found the brochure about family services at BMH and contacted the Family Advocate. The Family Advocate encouraged her to attend the family support group. As a result, she became interested in doing more advocacy for family members. She was invited to join the re-vamped MHSA Steering Committee and was seated on this group in 2008. This is a very encouraging outcome for Berkeley Mental Health as family member involvement in MHSA and system planning has not been strong.

e. Wellness/recovery/resiliency focus

The Consumer Liaison position was increased to full-time through CSS funds. One of the projects completed by the Consumer Liaison was a brochure entitled "Making the Most of Your Medication Appointments." Based on the work of Patricia Deegan, PhD, the brochure outlines "Strategies for reclaiming your power," including becoming more educated about mental health issues and how to prepare for a psychiatric appointment. One of the most significant aspects of this work was having consumers engage with the Medical staff about how to make medication support services more recovery and resiliency focused. This dialogue continues through a consumer/psychiatrist meeting held bi-monthly.

f. Integrated Service Experience

A part of the Wellness/Recovery program BMH engaged in a planning effort with employment providers to develop an employment referral system. This included working with line staff from BMH and from vocational programs including Rubicon, Alameda County Vocational Services and the Department of Rehabilitation. The goal was to initiate more individualized vocational planning for each consumer so that services are tailored to individual client needs and incorporated into care plans rather than general referral by case managers and clinicians to a few vocational programs. The results of this work were implemented in 2008 and have led to integrated vocational planning for consumers.

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

The City of Berkeley was not specifically required to meet the SB 163 wraparound requirements of the MHSA guidelines. Wraparound services for Medi-Cal children in Berkeley and Albany are provided by Alameda County Behavioral Health Care Services (ACBHCS). Berkeley works cooperatively with ACBHCS and Alameda County Social Services on this issue.

4) System Development information, State Guideline: *For the General System Development category only, briefly describe how the implementation of the General System Development programs have strengthened or changed the County's overall public mental health system. If applicable, provide an update on any progress made towards addressing any conditions that may have been specified in your DMH approval letter.*

The only General System Development program in the CSS plan is the Wellness/Recovery Services program. The program was developed in response to areas of concern expressed during the CSS planning process. It combined various suggestions and proposals including a proposal for a consumer run drop-in center, supports for employment and ways to increase family involvement. There were not sufficient funds to support all of these efforts and so aspects of each of these areas were incorporated into the Wellness Recovery Services program.

Some of the ways in which this program has changed the overall mental health system have been addressed previously including:

- Improved coordination regarding employment services
- Development of resource materials and enhanced services for families
- The creation of the Wellness/Recovery Task Force and increased consumer advocacy

Changing the mental health system is an ongoing challenge for MHSA programs. Money management is one of the areas that the Wellness Recovery Task Force has been working on for a number of months. Berkeley Mental Health provides case management support to clients who have a county or other representative payee. Staff help consumers develop a budget and then broker requests for rent, other payments and cash for consumers. At times this creates conflicts for both staff and clients.

The Wellness Recovery Task Force reviewed materials from the Village Program in Long Beach and consulted with local organizations that provide payee support services. They heard from clients and staff about their frustrations. As a result of these efforts it was decided to develop resources within BMH to help clients take explicit, systematic steps toward becoming their own payee. The Task Force also developed a "frequently asked questions" resource for clients about payee services. A money management binder was developed as a resource tool so that clients could keep track of their expenses.

These resources provide some practical support for staff and clients. Beyond that, exploring the issues pertaining to money management encourages us to look at issues of power and control within the mental health system. Instead of focusing on how to manage client's money the emphasis will be on how to assist them towards managing their own money. It is a step towards developing a more strength based, recovery-focused mental health system.

There were no conditions noted in our DMH approval letter for our CSS plan.

B.) Efforts to Address Disparities

1) Disparities in Access. State guidelines: *Briefly describe one or two successful current efforts/strategies to address disparities in access and quality of services to unserved or underserved populations targeted in the CSS component of your Plan. If possible, include results of the effort/strategy.*

In the Asian Pacific Islander community, we contacted leaders and held four focus groups: two with middle and high school students, and two more with parents of students. The results were to better understand stigma about mental illness from an API perspective, at what point API consumers will seek mental health services, and which kind of services are needed. They recommend reducing parents' stress by distributing informational booklets in their languages, parenting classes, and holding community activities, i.e. festivals.

In the Latino community, we contacted community leaders in particular churches, other groups, etc. and developed a series of workshops to outreach to Latinos and reduce stigma surrounding mental health. This series focused on using cultural values to illustrate certain concepts in mental health. We were very successful with 80-150 people participating. A major result was to create therapeutic support groups for men, women, couples, and youth anger management. This also resulted in creating Latino Consultation Services, which focuses on small workshops led by community leaders themselves. This allows the Multi-Cultural Outreach Coordinator to offer brief, one to three appointment consultations with participants, as well as clinical referrals.

Long standing efforts to recruit a more diverse work force have been successful with more bi-lingual/ bi-cultural staff being hired with MHSA funds. The Cultural Competence Committee sponsored a series of half-day training sessions beginning in 2007 focused on services to the Asian-Pacific Islander community.

2) Challenges. State guidelines: *Briefly describe one challenge you faced in implementing efforts/strategies to overcome disparities, including where appropriate what you have done to overcome the challenge.*

Bilingual and bicultural direct service staff at Berkeley Mental Health are not sufficiently connected to outreach and engagement efforts. They carry full caseloads that make it difficult to respond fully to increased service demands that result from successful outreach. This phenomenon is a reflection of overall system resource problems, but it also perpetuates access disparities and breeds discouragement and mistrust in underserved communities. There have been particular challenges in reaching the Asian /Pacific Islander community.

BMH is working with consultants funded by CSS One-time Funds to revise its Cultural Competence Plan and to implement a set of recommendations that address disparities. Specifically, the plan speaks to involving the Multi-Cultural Services Coordinator in management and policy decisions that will lead to re-allocating clinical staff time to address disparities. It will also outline ways in which

Berkeley Mental Health can begin to motivate, inspire and engage community members and partner agencies in the design, implementation and evaluation of mental health services.

3) Native American services. ***State guidelines:*** *Indicate the number of Native American organizations or tribal communities that have been funded to provide services under the MHSA and what results you are seeing to date if any.*

The City of Berkeley CSS plan does not directly fund Native American organizations or tribal communities. In our plan we indicated that we would work with Alameda County on outreach to Native American organizations and communities. Our Cultural Competence Coordinator works closely with the Alameda County Ethnic Services Manager to support this collaboration. We look forward to expanding this area of collaboration in the coming year.

4) Policy issues. ***State guidelines:*** *List any policy or system improvements specific to reducing disparities, such as the inclusion of linguistic/cultural competence criteria to procurement documents and/or contracts.*

The City of Berkeley has language in all of its contracts regarding cultural competence. During 2007 the Multi-Cultural Outreach Coordinator worked on developing specific policies for the use of language support services. Translation of MHSA and other agency documents has improved significantly in the past year; technology has been purchased and is being used for translation at public meetings. The Cultural Competence Committee worked for a number of months on outlining specific goals and objectives for their work. Those objectives include: training for staff in using interpreters; ways to reach out to community organizations; more explicit integration of cultural issues in staff meetings, supervision and case conferences; and strategies to influence ongoing planning processes.

C.) Stakeholder Involvement

State guidelines: *Provide a summary description of any changes you have made during the time period covered by this report in your Community Program Planning Process. This would include things like addition/deletion/alteration of steering committees or workgroups, changes in roles and responsibilities of stakeholder groups, new or altered mechanisms for keeping stakeholders informed about implementation, new or altered stakeholder training efforts.*

During 2007 the MHSA Steering Committee changed its focus and recommended changes to its membership. After the CSS Plan was approved in September 2006 the Steering Committee began to discuss how their role would change from overseeing CSS planning efforts to looking at implementation issues and later, the planning and implementation of very different MHSA components. They also wanted to look at how the CSS programs were helping the system transform to a more culturally competent, consumer and family driven system that promotes wellness/recovery and resilience principles.

Towards the end of 2007 the State Department of Mental Health made available one-time CSS funds. Since the previous CSS work groups had been disbanded, the Steering Committee was involved in the planning for the use of those funds.

The Steering Committee also identified the need for expanding the diversity of its membership. A number of meetings were held in conjunction with the Multi-Cultural Outreach Coordinator to discuss ways of reaching out to various ethnic communities. The Steering Committee had, through its initial membership and then later attrition, become a smaller core group that needed to grow and diversify in order to meet the evolving demands of MHSA oversight. The membership needed to be expanded and revitalized. These issues led to a recommendation to reformulate the Steering Committee. This process was actually carried out in 2008 but the preparatory work occurred in 2007.

The Multi-Cultural Outreach Coordinator framed his work as helping to implement the values of the Mental Health Services Act. This allowed him to provide some education about the Act to the community and also helped make the MHSA more accessible to the community. These efforts paid off in 2008 when the Prevention and Early Intervention planning committee and the new Steering Committee were formed as more community members volunteered to participate.

New educational materials were developed to summarize the CSS planning process in anticipation of recruiting new members to the Steering Committee. The stakeholder lists from the CSS planning process were reviewed and updated. The process for disseminating information for the 30-day public comment period was formalized. This included contacting the local media, disseminating hard copies and making information available via the website.

D. Public Review and Hearing

State Guidelines: *Provide a brief description of how the County circulated this implementation Progress Report for a 30-day public comment and review period including the public hearing. Include the following information:*

1) The dates of the 30-day stakeholder review and comment period, including the date of the public hearing conducted by the local mental health board or commission.

- Public comment period: June 24—July 24.
- Public Hearing held by the Mental Health Commission on July 24th.

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

- Notification sent to MHSA mailing list that includes community agencies and those who participated in the planning process by attending an outreach meeting or becoming involved in planning.
- Press release to local newspapers.

- Posting of information on the City of Berkeley website.
- Notification to the Mental Health Commission
- Distribution of materials to the public library.

3) A summary and analysis of any substantive recommendations or revisions.