AN EXAMINATION OF MENTAL HEALTH POLICY:
A CONTENT ANALYSIS OF CHANGE STRATEGIES FROM INTERNATIONAL TO LOCAL

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PROJECT

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Abstract

of

AN EXAMINATION OF MENTAL HEALTH POLICY:
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to LOCAL

by

April Michelle Jean

This project provides an overview of international, national, and local policy initiatives that support the need for systemic changes within the mental health system in California. California, being the 6th largest economy in the world and one of the largest public mental health systems, has laid groundwork for change strategies both nationally and internationally. The Mental Health Services Act of 2004 (MHSA) has become the instrumental within the state that has set up the framework for the transformation of a wellness and recovery, consumer oriented system. The components of the MHSA support the national recommendations of the President's New Freedom as well as other well-known reports and California has conceptualized and begun to implement those recommendations within their county systems. This project examines the Community Service Plans of the ten counties, which include Sacramento, Solano, Amador, Placer, Napa, San Joaquin, El Dorado, Yolo, Sutter and Contra Costa. This study utilizes content analysis as it research method in order to view how the MHSA is implemented into local community services and supports programs.

Susan A. Taylor, Ph.D., MSW

Date: 8/6/09
DEDICATION

Giving all honor and praises to God, my family and “besties”, without your patience and support I could not have completed this project. I would like to acknowledge and extend my deepest gratitude to my parents who have always encouraged me strive towards and reach all of my goals. With their love, support, and direction, they have guided me and encouraged me to achieve my dreams. I appreciate their unfailing confidence in me throughout my journey in pursuing my education.

I also would like to dedicate this project to my daughter Angel Michelle Taylor who was born during my journey as a graduate student. I have continued to stay encouraged and motivated for her. I love you so much Ladybug, we will continue to reach the top, Mommy promises you that! Remember to always shoot for the stars, and keep God in your heart. As long as you do that, all of your dreams will come true!
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedication</td>
<td>v</td>
</tr>
<tr>
<td>List of Figures</td>
<td>ix</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>1. THE PROBLEM</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>3</td>
</tr>
<tr>
<td>Purpose of Study</td>
<td>4</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>4</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>7</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>8</td>
</tr>
<tr>
<td>Assumptions</td>
<td>9</td>
</tr>
<tr>
<td>Justification</td>
<td>9</td>
</tr>
<tr>
<td>2. REVIEW OF THE LITERATURE</td>
<td>10</td>
</tr>
<tr>
<td>The Need for Policy Reform</td>
<td>10</td>
</tr>
<tr>
<td>Goals of the Presidents New Freedom Commission</td>
<td>13</td>
</tr>
<tr>
<td>Unmet Need for Mental Health in California</td>
<td>14</td>
</tr>
<tr>
<td>Target Populations</td>
<td>17</td>
</tr>
<tr>
<td>Five Key Elements of the Mental Health Services Act</td>
<td>18</td>
</tr>
<tr>
<td>Wellness and Recovery as a Community Issue</td>
<td>20</td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>21</td>
</tr>
</tbody>
</table>
Wellness and Recovery ................................................................. 46
Cultural Competence ................................................................ 48
Integrated Service Experience for Client and Families .......... 50
Client/Family Driven Mental Health System .......................... 51
Community Collaboration ....................................................... 53
Program Strategies ................................................................. 55
Barriers to MHSA Implementation ........................................ 67

5. CONCLUSIONS AND RECOMMENDATIONS ....................... 70
   Summary ............................................................................. 70
   Conclusions ........................................................................ 70
   Implications for Social Work Practice ................................. 73

References ............................................................................... 76
LIST OF FIGURES

1. Figure 1 Napa County Community Services and Supports Plan, 2005...........37
Chapter 1

THE PROBLEM

Introduction

At the turn of the 21st century, the country called for fundamental transformation of the mental health system. The system needed to shift from “one dictated by outdated bureaucratic and financial incentives to one driven by consumer and family needs that focus on building resilience and facilitating recovery” (Presidents New Freedom Commission, 2003). The vision was to transform the system into one where Americans recognize that mental health is essential to overall health; mental health care is consumer and family driven; disparities in mental health services are eliminated; appropriate and early mental health screening, assessment, and referral to services occur; excellent mental health care is delivered and research is accelerated; and technology is used to access mental health care and information (Presidents New Freedom Commission, 2003). In the late 1990s, statistics began to reveal the staggering facts about mental health care and its inadequacies in this country. Statistics revealed that in our nation one out every two persons who needs mental health treatment does not receive it. For ethnic and racial minority groups, the statistics are far worse (California Master Plan). Research indicates that mental health disorders not only entail a higher burden than cancer, but also are responsible for more than 15% of the total burden of all diseases (California Master Plan). As a consequence, over the past decade, mental disorders have ranked increasingly highly on the national agenda.
Since mental disorders account for a significant burden of disease, the need for effective interventions became a necessity. However, these resources needed to be accessible to all individuals. This is where the creation of a comprehensive mental health policy became of key importance. The goal was to create a policy that increased the accessibility and effectiveness of services. Thus, when properly formulated and implemented, the policy would have a positive impact on the mental health of the population. In order to deliver a high standard of mental health treatment and care it is necessary to adopt an integrated system of service delivery that comprehensively addresses the full range of psychosocial needs of people with mental disorders (Funk, Saraceno, Drew, Lund & Grigg, 2004). All of these facts were instrumental in the creation of California’s Mental Health Services Act of 2004 (MHSA), also known as Proposition 63. Modeling the recommendations of the President’s New Freedom Commission, the MHSA has set up the framework for the transformation that has become instrumental in modeling change efforts both locally and abroad (Taylor & Ekman, 2008). The goals of the MHSA are to “create a society in which persons of all ages, ethnicities, and cultures who experience serious mental illness or serious emotional disturbance receive high quality, culturally and linguistically competent, and effective services from the mental health system” (Mental Health Services Act, 2004). As a result of the services, support, and rehabilitation they receive, these persons are able to lead happy, productive, and fulfilling lives.

With California being the 6th largest economies in the world, as well as representing one of the largest public mental health systems, it has become a leader on
both national and international levels in modeling policy reform efforts (Taylor & Ekman, 2008). The MHSA has been the instrument within the state and has helped set up the framework for the transformation.

The researcher believes that if utilized and implemented effectively, this policy can be groundbreaking in mental health reform. By examining the implementation strategies, successes and failures of several key California counties, the researcher will unveil how these counties have integrated the MSHA into community services, and how these services are being provided to the individuals who need them.

Statement of the problem

As established in the preceding discussion and as will be considered in greater detail in subsequent chapters, in California there are over 600,000 adults, older adults, and children and youth in need of mental health treatment that are not receiving services (California Mental Health Master Plan, 2003). According the California Mental Health Master Plan (2003), there continues to be an unmet need for mental health services among children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses. For ethnic minority populations, a greater burden from unmet mental health needs exist. Due to this, these groups suffer a greater loss to their overall health and productivity (Surgeon Generals Report, 2001). There is a need to begin to confront the discrepancies in the system and improve the capacity and effectiveness of the system. The overall goal is to create a system that enables all individuals to equally access services from a seamless system of care. In order to do so there must be a fundamental set of values that guide the development and implementation
of the mental health system (California Mental Health Master Plan, 2003). This study will examine the effectiveness of the system by seeing if the needs of the underserved are being met through community-based services.

*Purpose of the study*

The purpose of this study is to examine the recent developments in Mental Health policy in California; specifically, how current policy is being implemented via the MHSA. This study will provide insight as to how the counties researched in this study are implementing the MSHA and its five key components into their County Community Service Plans (CCSP’s). The five key components include 1) Wellness and Recovery, 2) Cultural Competence, 3) Integrated Service Experience for Clients and Families, 4) Client/Family-Driven Mental Health System, and 5) Community Collaboration.

*Theoretical Framework*

In order to conduct a content analysis of the CCSP’s it is important to understand how macro and micro systems function and interact with the individual. Systems theory also allows us to understand how policy is enacted and implemented into systems. To completely understand this phenomenon, Systems Theory will be used to as the basis for this study.

Systems are defined as organized wholes comprising component parts that interact in a distinct way and endure over time. System perspective is an interdisciplinary concept that was developed to identify common principles of organization that can be applied universally to all phenomena (Johnson & Rhodes, 2005). It implies that there is
an order to everything in the world. Other basic assumptions of the systems perspective include the following:

- “Each system has a structure; the parts have a relationship to each other.
- The whole is more than the sum of its parts.
- Everything is connected; changes in any one-part affects the system and are parts of larger systems.
- Each system has a boundary that separates it from other systems and it gives it its identity.
- As systems evolve, they become more complex, and the parts become more specialized” (Johnson & Rhodes, 2005 p. 79).

With these principles, systems theory analyzes large systems and their interactions with individuals. Communication in this perspective can be seen as an integrated process, not as an isolated event (Johnson & Rhodes, 2005). When creating and shaping policy, law becomes enacted, then states require the agencies and counties to implement policies into their services. Concerning the MHSA, the policy was developed under national recommendations of the Presidents New Freedom Commission. With this recommendation California then created its own structured policy, which was enacted into law. The policy now impacts the county systems, which then impact the community and the individual.

There are five essential aspects of systems theory. The first aspect of systems theory is that systems theory examines how interrelated parts make up a whole system (Hutchinson, 2003). For example, divisions in the mental health system include funding sources, program directors, mental health practitioners, consumers and families, interpreters and clerical staff.

The second aspect includes how each part of the system impacts all other parts of the system. Each part serves a function in maintaining the system (Hutchinson, 2003).
For example, the clients are a part of the mental health agency where their role is to be the consumers of the services, as well as another part of the agency. Another aspect of this example is the mental health practitioner’s who provide the services to the clients. Each role can affect the overall functioning and structure of the whole system.

The third aspect is that all systems are subsystems of another large system. The parts in a system can also make up a subsystem (Hutchinson, 2003). Subsystems are relationships that break a system down into smaller systems within the larger one. For example, within the mental health system there are different mental health agencies. These mental health agencies also have subsystems within their systems. For instance, there are children, dual diagnosis, or other programs within the agency.

The fourth aspect is that systems maintain boundaries to indicate who is in or out of the system and maintain their identities (Hutchinson, 2003). Boundaries can also be defined by social roles, relationships, rules that can define system. Roles are defined through social expectations of behavior through patterns dependant on a particular social position. Roles also help the system’s balance and affect relationships within the system. Rules can help the system maintain structure and keep the system functional. Systems maintain homeostasis through adaptation and restoration of stability in order to remain functional (Zastrow & Kirst-Ashman, 1997).

The fifth aspect of systems theory is that the dynamic interaction within or between systems produces stability and change (Hutchinson, 2003). Interaction can be defined as input or output between systems. The interaction can alter the systems homeostasis. Input refers to the communication, information and energy received from
external systems. Output refers to the communication, information or energy that is processed by the system and can create modifications within the system. For example, an input would be if a school system contacts a family system stating that the student is being referred to receive mental health services due to their behavior at school. This input will cause the family to re-evaluate how it will handle behavior at home, what the consequences of behavior will be, as well as how they will help the student heal. The family system output may be to find the student mental health services, trying behavior modification at home, and being more involved with the student’s education system and mental health system. Feedback mechanisms are the processes that information about past behaviors, effectiveness or performance in a system that are fed back into the system in a circular manner (Hutchinson, 2003). Feedback mechanisms are another form of interaction between systems and can be either positive or negative. Negative feedback loops feedback information that the system is deviating from homeostasis. Positive feedback loops feedback information that the system is deviating to stability that resounds through the entire system. Positive feedback can be change producing and can come from within or from an external system (Zastrow & Kirst-Ashman, 1997).

Limitations of the study

All studies have limitations on how the research is conducted as well as the possible biases the researcher may have. Each of these factors may have a significant effect on the quality of the study and its results. For example, due to the fact that this study is a content analysis there are no research subjects in this study. Also, no specific agencies or professionals were contacted to provide their insight on the effectiveness of the
implementation strategies of the MHSA. Additionally, there is no previous research on this subject; therefore comparisons across time cannot be made.

**Definition of terms**

**Mental health:** A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

**Wellness and Recovery:** To have a healthy balance of the mind-body and spirit that results in an overall feeling of well-being.

**Policy:** A deliberate plan of action to guide decisions and achieve rational outcomes.

**California Mental Health Services Act:** Voters in California passed proposition 63, The MHSA, which has been designed to expand and transform California’s county mental health service by increasing the taxes of high-income individuals. The MHSA will be funded by imposing an additional one percent tax on individual, but not corporate, taxable income in excess of one million dollars (Mental Heath Services Act, 2004).

**World Health Organization:** The World Health Organization (WHO) is an international organization that is recognized as a research authority on international, public and mental health.

**President’s New Freedom Commission:** George W. Bush established The President’s New Freedom Commission on Mental Health on April 2002. This commission was created as part of the president’s pledge to eliminate inequality for Americans with disabilities. The Commission was directed to identify policies that could
be implemented by Federal, State and local governments to maximize the utility of existing resources, improve coordination of treatments and services, and promote successful community integration for adults with a serious mental illness and children with a serious emotional disturbance. (Taylor & Ekman, 2008)

Psychiatric Rehabilitation: is the process of restoration of community functioning and wellbeing of an individual who has a psychiatric disability (Anthony, 2000).

Assumptions

This section will identify the facts that will be considered true without providing any further evidence: This study assumes that there is significant variation among counties and how they implemented the five essential elements of the MHSA. These variations may affect the ability to accurately engage Regional Partnership Planning due to the differences in county structuring target populations and funding as well as implementation strategies.

Justification

It is important to continue to advocate the policies and services that assist those who are disadvantaged and whose needs are not being met within the system. This study begins to confront the discrepancies in the mental health system in order to find ways to improve the capacity and effectiveness of the system. It may justify the need for the creation of a system that enables all individuals to equally access services from a system of care that is seamless.
Chapter 2

REVIEW OF THE LITERATURE

The Need for Policy Reform

During the 1990s increasing numbers of states and counties adopted a recovery vision as the overriding vision for their system planning (Anthony, Rogers & Farkas, 2003). As systems strive to create new initiatives consistent with this new vision of recovery, new system standards are needed to guide the development of recovery oriented mental health systems. Based on research on previous system initiatives and current consensus around accepted recovery practices and principles, a set of system standards that are recovery focused are suggested to guide future system developments (Anthony, 2000).

Over the past decade, the United States has witnessed the development of several reports on mental health services and the need for transformation within the system. Reports such as the World Health Organization Report on Mental Health, the Surgeon General’s Report on Mental Health, the Presidents New Freedom Commission on Mental Health, have all made recommendations for improvements in mental health policy and programming by promoting the philosophy of enhancing psychiatric rehabilitation by promoting wellness and recovery. The main objective is to allow those who suffer from mental illness and or serious emotional disturbances to live, work, learn, and participate in their communities without having to continuously encounter barriers.

In 1999, the World Health Organization began to develop a report on mental health titled “New Understanding, New Hope”. This landmark report identified the need
for the creation of policies, which would ensure that barriers surrounding stigma and
discrimination are broken down, and that effective prevention and treatment programs are
put in place (World Health Organization, 2003). Its intent was to raise public and
professional awareness of the real burden of mental disorders and to offer new insight on
psychiatric disability and rehabilitation.

At the time that the World Heath Organization was developing its report, the
Office of the Surgeon General developed and released its first national report on the state
of mental health treatment its services in the United States. The report, “Mental Health: A
Report on Mental Health” began a national discussion of the nature and scope of systemic
challenges, as well as the psychiatric disabilities affecting individuals seeking treatment
within the public mental health system (Office of the Surgeon General, 2001). That report
was followed by another report in 2001, “Mental Health: Culture, Race, and Ethnicity”, a
supplement to the above named report. Both reports mirrored the international trends
seeking to define challenges and identify recommendations for the development of best
policy and practices in order to maximize psychiatric rehabilitation and recovery in the
United States (Taylor & Ekman, 2008).

With mental health reform being seen as imperative both internationally and
nationally, in October 2002 the President’s New Freedom Commission on Mental Health
revealed that in our nation, one out every two persons who needs mental health treatment
does not receive it (Presidents New Freedom Commission, 2003). For many Americans
with mental illnesses, the mental health services and supports they need are fragmented,
and often inadequate, interrupting the opportunity for recovery. The mental health system
was viewed as a makeshift relic, the result of unorganized reforms and policies in this country. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities (Presidents New Freedom Commission, 2003). Additionally, for ethnic and racial minorities, the situation is even worse. As reported in 2001 by the Surgeon General, ethnic and racial minorities receive treatment at a rate that is even lower than that of the general population. Ethnic minority populations bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity. All points indicated the need for drastic systemic change.

This Commission was constructed with the Bush administration's commitment to eliminate inequality for Americans with disabilities. The President directed the Commission to identify policies that could be implemented by Federal, State and local governments to maximize the utility of existing resources, improve coordination of treatments and services, and promote successful community integration for adults with a serious mental illness and children with a serious emotional disturbance (Wikipedia, 2003). A coalition of mental health consumers, families, providers, and advocates supported the Commission process and recommendations, using the Commission's findings as a launching point for recommending widespread reform of the nation's mental health system (Presidents New Freedom Commission, 2003). With all of this in mind, the Commission set forth a concrete set of goals that would revise the structure within the mental health system. Its vision was to create a system where everyone with a mental illness has access to early detection and the effective treatment and supports essential to
live, work, learn and participate fully in their community. The goals are outlined as followed:

**Goals of Presidents New Freedom Commission**

1. **“Mental Health is Essential to Health**: Every individual, family and community will understand that mental health is an essential part of overall health.
   - Everyone takes action to ensure well-being
   - Mental health awareness

2. **Early Mental Health Screening and Treatment in Multiple Settings**: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.

3. **Consumer/Family Centered Care**: Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.
   - Continuous healing relationships will be a key feature of care

4. **Best Care Science Can Offer**: Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.

5. **Information Infrastructure**: The mental health system will develop and expand its information infrastructure. That infrastructure has many purposes:
   - Inform consumers, providers and public policy
   - Improve access, quality, accountability

6. **Eliminate disparities in mental healthcare**: Promote well-being for all people regardless of race, ethnicity, language, place of residence, or age and ensure equity of access, delivery of services, and improvement of outcomes for all communities” (Presidents New Freedom Commission, 2003, p. 19).

These goals would be instrumental in national transformation efforts. If utilized correctly these goals would transform the mental health system into a consumer-driven, wellness and recovery oriented system or care.

Each of the above outlined reports was influential in the creation of The MHSA, also known as Proposition 63. Replicating the recommendations of the Presidents New Freedom Commission, the MHSA tried to do for California what the President’s
Commission did for the nation. The MHSA has set the framework for the transformation that has become instrumental in modeling change efforts both locally and abroad. Its vision is to “create a society in which persons of all ages, ethnicities, and cultures who experience serious mental illness or serious emotional disturbance receive high quality, culturally and linguistically competent, and effective services from the mental health system” (California Mental Health Master Plan, 2003). As a result of the services, support, and rehabilitation they receive, these persons are able to lead happy, productive, and fulfilling lives.

Unmet Need for Mental Health in California

In California, it was found that there was an unmet need for mental health services among children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses. Mental illness affects people from every background and occurs at any age. More than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year (California Mental Health Master Plan, 2003). Research indicates that adults and children, who may have a serious mental illness or serious emotional disorders, are not receiving services. Specific populations such as Transitional Age Youth (TAY), exiting the juvenile justice system and child welfare systems are experiencing first episodes of major mental illness (California Mental Health Master Plan, 2003). Also, individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, are getting minimal services; however, those services do not provide the necessary opportunities to participate, move forward and
pursue their wellness-recovery goals (California Mental Health Master Plan, 2003).

People who are poorly served are at risk of homelessness, incarceration, institutionalization, and out of home placement.

Due to these disparities, in November 2004, California passed Proposition 63. The MHSA became state law effective January 1, 2005. The stated purpose of the MHSA is to “provide state and local funds to adequately meet the Mental Health needs of all children and adults who can be identified and enrolled in programs under this measure…and to provide services that are not already covered by federally sponsored programs or by individuals’ or families’ insurance programs.” (Mental Health Services Act, 2004). The MHSA provides increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families (Mental Health Services Act, 2004).

The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system (Mental Health Services Act, 2004). In order to meet the funding needs for the creation of new innovative programs, the MSHA imposes a 1% income tax on personal income in excess of $1 million (Mental Health Services Act, 2004). According to the MHSA (2004), statewide, the Act was projected to generate approximately $254 million in fiscal year 2004-05, $683 million in 2005-06 and increasing amounts thereafter. These funds are deposited in the State Treasury in the Mental Health Services Fund (Mental Health Services Act, 2004). Funding will be made
annually to counties for Community Outreach and Planning, and then once quarterly after the 3-year Community Services and Supports Plan is approved at the state level. (California Mental Health Master Plan, 2003).

Failure to provide adequate services and treatment can destroy individuals and families. Far too many Californians with mental illness are receiving mental health services and supports that are fragmented, disconnected and often inadequate, which in turn frustrates the opportunity for recovery. The California Mental Health Master Plan identifies that untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Those individuals who are left untreated or with insufficient care are at risk of seeing their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment and adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail (California Mental Health Master Plan, 2003).

State and county governments pay billions of dollars every year in emergency medical care, long-term nursing home care, and unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs. California has drastically cut back its services in state hospitals for people with severe mental illness. Many people have ended up on the streets homeless and incapable of caring for themselves. Presently, thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness (California Mental Health Master Plan, 2003).
With adequate and effective treatment and support, recovery from mental illness is an attainable goal for most people. With all of these factors identified, California has begun to develop effective models of providing services to children, adults and seniors with serious mental illness.

Modeling the program suggestions of the President’s Commission on Mental Health, new and innovative services have been constructed. These programs combined preventative services with a vast range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come (California Mental Health Master Plan, 2003). These programs encompass the ideology of wellness and recovery. They address services to underserved populations such as traumatized youth and isolated seniors. These programs also emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

*Target Populations*

The target populations to be served by the MHSA funds are adults who are individuals 18-59 years, older adults who are 60+ years, with serious mental illness and children/youth ages 17 years and younger with serious emotional disability who are currently not receiving mental health services (California Mental Health Master Plan, 2003). The MHSA also strives to service the underserved and unserved which are those individuals and families not receiving adequate mental health services.
Five Key Elements of the Mental Health Services Act

As stated in above paragraphs, the MHSA was modeled after recommendations made by the Presidents New Freedom Commission. Using the recommendations, the MHSA established five key elements that were design to meet the needs of California consumers. It was established that each county in California must integrate these components into its CCSP’s. These programs, services, and supports are designed to serve adults with serious mental illness and children and youth (and their families) with serious emotional disturbances. The emphasis is to eliminate disparities in access and improving mental health outcomes for racial/ethnic populations in California (California Mental Health Master Plan, 2003). In order to effect change in the mental health system, the state directed programs that are to be consistent with the philosophy, principles, and practices of the recovery vision for mental health consumers as well as the five fundamental concepts of the MHSA. These concepts are as follows:

Five Key Concepts of the MHSA and goals of each component:

1. Wellness and Recovery:
   - Focus on recovery based services.
   - Planning that encourages and supports hope.
   - Implementation services that reduce or eliminate symptoms.
   - Services that provide individuals with the ability to live fulfilling and productive lives despite a disability.
2. **Cultural Competence:**

- Creation of methods to eliminate racial and ethnic mental health disparities.
- Improving quality and effectiveness of services.
- Utilization of culture as strength in service delivery.
- Implementation of culturally competent programs and services that enhance the ability to incorporate the language and cultures of its clients.
- Establishing cultural awareness.
- Encourage knowledge of different cultural practices, worldviews and cross-cultural skills.

3. **Integrated Service Experience for Clients and Families:**

- Services are coordinated through a single agency or a system of care.
- Uses joint planning process to best address the individuals/family’s need.
- Address the individual/family needs using the full range of community-based treatment, case management, and interagency systems.
- Integrated services will provide tend to those who have mental illnesses, co-occurring disorders, including substance abuse problems and other chronic disabilities and conditions.

4. **Client/Family-Driven Mental Health System:**

- Integration of a system, which allows adults clients and families of children and youth to identify services and supports that are most effective for them.
- Creates opportunities for clients and families to have greater choices over types of service, providers, and facilities.
- This system will promote learning, self-monitoring, and accountability.
- Increases choices protect individuals and encourages quality.

5. Community Collaboration:
- Groups of families or individuals, citizens, agencies, organizations and businesses work together to share information and resources.
- Members of the community collaborate in an atmosphere of support.
- Systematically solve existing and emerging problems (Mental Health Services Act, 2004).

Wellness and Recovery as a Community Issue

Wellness and Recovery has become the main ideology for mental health services in California. It is also the driving force of the MHSA. Deegan (1997) defines recovery as a process, a way of life, an attitude, and a way of approaching the day’s challenges. Research by Funk, Sacraceno, Drew, Lund & Grigg (2004) suggests the need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution. The concept of recovery is viewed as a journey, not a cure (Anthony 2000). The goal is to ensure that one recover not only from mental illness, but also from internalized stigma, low expectations and dehumanizing clinical practices (Deegan, 1988). A recovery vision of service in California is grounded in the ideology that people can recover from mental
illness. However, the manner in which the services are delivered must be altered within the system. In the past, mental health systems were based on the belief that people with severe mental illness did not recover; and that the course of their illness was essentially a deteriorative course, or at best maintenance course (Deegan, 1996). As systems strive to create new initiatives consistent with this new vision of recovery, the new system standard of the MHSA is to guide the development of recovery oriented mental health systems.

Cultural Competence

Cultural competence has been described generally as the ability to appreciate and recognize culturally different people and to be able to work effectively with them (Carey 2005). Also, a client’s culture is relevant to the provision of mental health services because it affects the assessment, etiology, and symptom expression of mental illness and it affects the client’s treatment preferences (Office of the Surgeon General, 2001, p. 4). Research by Cross, Bazron, Dennis, & Issacs (1989) supports that cultural competence is a congruent set of attitudes, behaviors, and policies that enable a system, agency, or provider to treat culturally diverse clients effectively.

A culturally and linguistically competent system of care acknowledges and incorporates the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Cross et al., 1989). A culturally and linguistically competent system of care promotes for itself and among its providers the following characteristics:
• “Awareness of the value of diversity and developing adaptation to diversity
• The capacity for continuous self-assessment
• Institutionalized cultural knowledge
• Awareness of the dynamics inherent when cultures interact
• Congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities” (Cross et al., 1989, p. 278).

The mental health system at all levels must have the capacity to provide services that are sensitive and responsive to clients’ gender, cultural and ethnic background, language, beliefs, and lifestyle (Anthony, 2000). The need for California to integrate and infuse cultural competence into California’s public mental health system is imperative due to California’s changing demographics. Since California’s population has grown in size and diversity, the mental health system has strained to keep up with the need for quality culturally competent care (California Mental Health Master Plan, 2003). Barriers to mental health care regarding cultural and language are particularly significant. These barriers can be as simple as not being able to communicate due to the lack of providers who speak the client’s language (Office of the Surgeon General, 2001). The Surgeon General reported that other formidable barriers that discourage racial, ethnic, and cultural populations from using mental health care include cost of services, lack of health insurance, fragmentation of services, culturally mediated stigma or patterns of help-seeking, mistrust of mental health services, and the insensitivity of many mental health care systems (U.S. Department of Health and Human Services, 1999). The Surgeon General’s Report, further states that culture influences many aspects of mental illness, including how patients from a given culture express and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek
treatment. The cultural identities and worldviews of consumers shape health and healing beliefs, practices, behaviors, and expectations. The commitment of the public mental health system to cultural competency is vital to meet the needs of all of its residents and to overcome the unique barriers many racial, ethnic, and cultural communities face (Office of the Surgeon General, 2001).

Integrated Service Experience for Clients and Families

An integrated system of care is a system that includes family partnership, cultural proficiency, a full range of community-based services and supports, cross-agency collaboration, and evaluation of outcomes (California Mental Health Master Plan, 2003). The systems of care is responsible for collaborative programs that are promoted by other service systems, including child welfare, juvenile justice, schools, and public health. However, many communities have service delivery systems made up of collaborative, but fragmented, programs. This fragmentation results from rapid expansion and hurried strategic planning. For this reason, the local collaboration sometimes loses its focus on how to integrate all these efforts.

“Due to the fact that mental health is critical to a person’s success as an individual, a family member, and as part of the community, it is critical for the system to function in an all-inclusive structured manner. This promotes increased motivation, planning, learning, improved social interactions, empathy, and altruism” (California Mental Health Master Plan, 2003). Impairing these functions can result in unemployment, child neglect, poor social functioning, and not meeting basic needs for food, shelter, health, and clothing, school, and abiding by the law. Agencies have been established with
resources and specialized staffing and expertise to address problems, such as homelessness, unemployment, child abuse and neglect, crime, access to health care, and failure to benefit from schooling, however, it is most valuable for these services to function collaboratively.

“Failure to benefit from typical services offered by the responsible agencies can be explained by the profound effects of mental disorders and substance abuse. As a consequence, success with these children and families will require the combined efforts of several agencies working to address areas of impairment and underlying mental health disorders” (California Mental Health Master Plan, 2003).

A functional integrated system of care requires a theory of change results in better outcomes for adults, children and families (US DHHS, SAMSHA, 2005). Collaborative programs are formed in this system to achieve better individual, child and family outcomes at the same or lower cost. Members of the collaborative must work collectively and build on each other’s strengths, resulting in a product that is greater than the sum of its parts (California Mental Health Master Plan, 2003). The integrated system offers promise for mental health systems of care as well as collaborative who are being promoted in other service systems (California Mental Health Master Plan, 2003).

Client/Family-Driven Mental Health System

It is virtually impossible for an individual to recover from mental illness without an adequate support network. In the past, many individuals have been isolated from their families while in the recovery process. Recent studies conclude that this method is ineffective. Current research shows that persons who suffer from mental illnesses that have family support and interactions have a better recovery rate than those persons who do not have family support and interactions. Research found by Uba (1994) showed that
families play an important role in providing support to individuals with mental health problems. A strong sense of family loyalty means that, despite feelings of stigma and shame, families are an early and important source of assistance in efforts to cope, and that minority families may expect to continue to be involved in the treatment of a mentally ill member (Uba, 1994). Research by Hough, Landsverk, & Karno, (1987) found that lower levels of expressed emotion and lower levels of relapse when families are involved in the client’s recovery process. Other research has demonstrated an association between family warmth and a reduced likelihood of relapse (Funk, Minoletti, Drew, Taylor & Saraceno, 2005). With that stated, California has incorporated client and family driven mental health services into its system. This promotes individual and family strengths and the goals of the individual and family. Its further by encourages hope, child and family participation, and sharing of information.

Community Collaboration

At the center of transformation is a promise to be guided by the voices and preferences of the diverse communities of consumers and family members who rely on local mental health systems. To fulfill this promise, counties are learning, developing and implementing strategies to reduce disparities in access to services by ethnic and cultural communities. Counties are strengthening current relationships and building new partnerships in order for the MHSA to result in improved services and supports that community members seek (Hoge & Morris, 2002).
Regional Partnership Planning

Its partners include public mental health providers, educators, consumers and family members, and community partners. Its focus is on developing joint strategies and initiatives to address training, education, and workforce needs. The objectives of the Regional Partnership Planning Council are as followed:

- “Strengthening partnerships between county mental health departments, community-based organizations and educational institutions.
- Increasing employment and career advancement opportunities for consumers and family members.
- Increasing the diversity and cultural competency of the workforce.
- Develop curriculum at all academic levels that support wellness and recovery.
- Create pipeline strategies from high schools to colleges and universities.
- Improve employers’ staff recruitment and retention.
- Promote public understanding and awareness of mental illness and the damage caused by stigma and discrimination.
- Serve as the infrastructure for public mental health training and education activities.
- Identify and secure workforce resources, such as grants and in-kind support.
- Evaluate successes and lessons learned and sharing this knowledge with others”(http://www.dmhh.ca.gov/Prop_63/MHSA/Workforce_Education_and_Training/default.asp).

Oversight and Accountability

During the creation of the MHSA it was found that there was a need to establish an Oversight and Accountability Commission (OAC). The OAC is a collaborative effort between county mental health and education. The goals of the Mental Health Oversight and Accountability Commission are reflected in the Purpose and Intent (Section 3) of the MHSA. Its goals are as followed:

- “To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.
• To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.
• To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations.
• To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure.
• To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public” (Mental Health Services Act, 2004, p. 8-13).

The responsibilities as defined by the MHSA are to provide oversight and accountability for the implementation of the MHSA among all counties in California. Its primary focus is to redirect the mental health system toward transformation, by ensuring that all mental health activities and programs incorporate wellness, recovery and resilience (www.dmh.ca.gov/MHSOAC). The OAC also ensures that the perspective and participation of those living with mental illness and their family members are a significant factor in all of their decisions and recommendations. It promotes a systems approach to the provision of multicultural and multi-linguistic mental health services, activities and programs to eliminate disparities in access to and quality of mental health services (www.dmh.ca.gov/MHSOAC). The OAC also focuses on developing public education strategies to overcome the stigma associated with mental illness, as well as promoting programs and activities that maximize the impact of the MHSA funding. The OAC must also keep the public and stakeholders informed as to the progress that is being made toward a transformed mental health system that has prevention, wellness, recovery and resilience as its primary goals.

With 16 voting members, the composition is as follows:
1. “The Attorney General or his or her designee.
2. The Superintendent of Public Instruction or his or her designee.
3. The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.
4. The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.
5. Two persons with severe mental illness, a family member of an adult or senior with severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees, a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments the Governor shall seek individuals who have a personal or family experience with mental illness” (Mental Health Services Act, 2004, p. 8-13).

California Planning Council

The Planning Council is mandated in state law to provide oversight of the public mental health system, to advocate for adults and older adults with serious mental illnesses and children and youth with serious emotional disturbances and their families, and to make recommendations regarding mental health policy development and priorities.

Pursuant to the MHSA, the Planning Council, advises the Department of Mental Health on education and training policy development and provides oversight of the Department’s education and training plan development. The Planning Council also must review and approve each Five-Year Education and Training Plan.

The Planning Council is an invaluable instrument for public involvement in mental health planning and policy development. It has been particularly effective as a vehicle for the direct involvement of consumers and family members in statewide policy
development. In addition to the federal planning duties, state law mandates additional responsibilities and duties that include:

- “Advocate for effective, quality mental health programs
- Review, assess, and make recommendations regarding all components of the mental health system
- Review and approve performance indicators
- Review and report annually on the performance of local mental health programs based on data from performance indicators
- Advise the Legislature, Department of Mental Health, and county boards on mental health issues and the policies and priorities that this state should be pursuing
- Make recommendations to the Department on awarding grants to county programs to reward and stimulate innovation
- Periodically review the State's data systems and paperwork requirements to ensure they are reasonable
- Conduct public hearings on the State mental health plan, Community Mental Health Services Block Grant, and on other topics as needed
- Participate in recruitment of candidates for Director of Mental Health
- Advise the Director on the development of the State mental health plan and its priorities.
- Assist in the coordination of training and information to local mental health boards
- Mediate disputes between the State and counties when requested
- Accept federal or private grants and donations”


County Community Service Plans

County Community Services Plans are required by all counties in accordance to the MHSA, sections 5813.5 and 5878.1-3. The purpose of these plans is to implement change in the system of care on state and local levels. The MHSA requires that "each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health after review and comment by the Oversight and Accountability Commission” (www.dmh.ca.gov).

The MHSA further requires that the department shall establish requirements for the
content of the plans. Annual updates of this plan will be required pursuant to MHSA requirements. In their MHSA Three-Year Program and Expenditure Plans, counties are required to submit a listing of all work plans for which MHSA funding is being requested that identifies the proposed expenditures for each type of funding (Full Service Partnership, System Development, and Outreach and Engagement) and for each target age group; adult, children and youth, older adult, and transitional aged youth.

County mental health programs must submit a complete CSS Program and Expenditure Plan and request funding for three years in order to receive money for this part of the MHSA. The CSS Program and Expenditure Plan Requirement document is extremely detailed and includes many elements that counties need to write their plans. The CSS Plan requirements are intended to change the public mental health system in the following ways:

- "There will be more participation from people who have mental health problems and their families. People who have or have had serious mental and emotional problems will participate in every part of the public mental health program in California. This will include things like being members of committees that help to plan programs, develop policies and new rules and even help to provide services and to evaluate mental health programs.
- More mental health services and supports will be organized and run by people who have or have had mental health problems, and their families.
- There will be more appropriate mental health services and supports for people of all different racial/ethnic and cultural backgrounds. People will get the needed mental health services and supports in their own language and services will be provided in ways that are sensitive and understanding of their different cultural beliefs and values. People from different cultures do not always get the mental health services and supports that they need. Unequal services for diverse racial/ethnic populations are not acceptable. Programs must make a specific effort to design and provide services in ways that are culturally appropriate and sensitive to all people. This is called "cultural competence."
- There will be more mental health services and supports and different types of services so that people can get the services they want when they want them
There key concepts or ideas must be included throughout the CSS Plans submitted by the counties. They are:

- "Community collaboration, which means working together with interested and involved agencies, groups, organizations and individuals in the community. These people are sometimes called “stakeholders.”
- Cultural competence
- Client/family-driven services, which mean programs where the people who receive the services and their families make the decisions about the services, programs and policies that affect them.
- Wellness focus, including the concepts of recovery and resilience
- Integrated service experiences, which mean that people get all of the kinds of services they need at the same time and these services, are coordinated” (www.dmh.ca.gov/.../MHSA/Community_Services_and_Supports/).

With all of the key components discussed in this chapter, the MHSA has established a foundation for change in the mental health system by requiring alterations in the services rendered to consumers and their families. These key system changes have begun to restructure the way in which consumers and families are able to recover from their illness, and are further able to live productive lives. The hopes for this system are that it becomes one that is culturally competent, seamless and one that employs the wellness and recovery model. California has made great strides thus far, and the following chapter will examine how the ten counties researched have implemented the goals of the MHSA.
Chapter 3

METHODS

Study Objective
The purpose of this study is to examine the recent developments in Mental Health Policy in California; specifically, how current policy is being implemented via the California Mental Health Services Act (MHSA). Currently, there is limited research that evaluates the implementation or across counties. This study will attempt to identify similarities, parallels, and contrasts to begin generate a comprehensive strategic method of employment of this policy in California.

Research Design
This study employs content analysis as a research technique. A content analysis is an in depth analysis using quantitative or qualitative techniques of messages using a scientific method and is not limited as to the types of variables that may be measured or the context in which the messages are created or presented (Neuendorf, 2002). The content analysis is used to examine the descriptive programming and planning elements grouped within the five essential elements of MHSA. The five essential elements are used as data collection points to examine how the goals and objectives of the MHSA are being met on local levels. The five data collection points are 1) Wellness and Recovery, 2) Cultural Competence, 3) Integrated Service Experience for Clients and Families, 4) Client/Family-Driven Mental Health System, and 5) Community Collaboration.
Sources of Data

Although no human subjects are involved, the current study has been reviewed and approved by the committee for the Projection of Human Subjects at California State University, Sacramento. This study strictly utilizes the CCSP’s of ten counties which include: Sacramento, Solano, Amador, Placer, Napa, San Joaquin, El Dorado, Yolo, Sutter and Contra Costa. Analysis of the plans is expected to show variation and similarities among counties. These findings are important as counties begin to do Regional Partnership planning, and try to anticipate ways of partnering in the implementation of this Act. The researcher uses this data and attempts to identify information where comparisons and conclusions can be made.

Limitations of the Study

This study utilizes existing research in an attempt to derive new information in an analytical approach. The validity of this study may be limited by the lack of live respondents and quantitative data. To counter these limitations the researcher uses well-structured existing research and documentation and follows an established theoretical framework.

Protection of Human Subjects

The application for human subjects was submitted to the California State University, Division of Social Work Committee for the Protection of Human Subjects. The application was accepted and approve for this study. The study did not include any human subjects and relied only on the content analysis of secondary data. The data was
collected using various Internet resources from county mental health websites. There was no risk of discomfort or harm of any human subjects.
Chapter 4

ANALYSIS OF DATA

Introduction

This section will elements within ten County Community Service Plan’s for the following counties; Sacramento County, Solano, Amador, Placer, Napa, San Joaquin, El Dorado, Yolo, Sutter, and Contra Costa. As stated in the previous chapter, this Context Analysis of County Community Service Plans examining five key elements of California’s Mental Health Services Act and how the goals and objectives of the MHSA are being met on local levels. The components of these elements include; wellness and recovery, cultural competence, integrated service experience for clients and families, client/family-driven mental health system as well as community collaboration. This content analysis examines the recent developments in Mental Health Policy in California, various strategies used within these counties, as well as program development and implementation. All data used in this section were public county documents, extracted from the Department of Mental Health Services websites of the ten counties researched.

As a part of the statewide transformation process, California’s Mental Health system has proposed significant changes to the way that mental health services and supports are developed and delivered. In order to significantly increase consumer and family involvement in the ongoing planning and monitoring of services, a strengths-based approach to collaborative planning was used. Local organizations and agencies representing various constituencies were used as a bridge to the community for training and input through forums, surveys, interviews, and presentations. This approach reflects a
well-established trend to move toward a strengths-based relational model of partnering with individuals and families in health and human services and supports.

The State of California, voter approved Prop 63 initiative was written into state law and is now known as the Mental Health Services Act (MHSA or the Act). The MHSA represents a comprehensive approach to the transformation of community-based mental health services and supports. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. To provide for an orderly implementation of MHSA, the California Department of Mental Health planned for sequential phases of development for each of the components. Eventually, all these components will be integrated into comprehensive plans with a continuum from prevention and early intervention to comprehensive, intensive interventions for those in need. The MHSA provides funding for six broad components of new or expanded activities and services 1) Community Program Planning, 2) Community Services and Supports for children and youth (including transition aged), adults and older adults, 3) Capital Facilities and Technology, 4) Education and Training Programs, 5) Prevention and Early Intervention Programs and 6) Innovative Programs that incorporate the wellness and recovery model. The planning process is structured in figure 1 seen on the following page:
Research found that a key component of the Act was that it required public mental health programs to work in partnership with all the people affected by the programs in the transformation process. People affected by the programs are referred to as “stakeholders” since they have a stake in the outcome of the process. Stakeholders include consumers, family members, providers, other public and private agencies, and the general public.

Task forces included, Children and Youth Task Force, Adult Task Force, Older Adult Task Force, and Cultural Competence Task Force. Each Task Force prioritized recommendations within its particular area of focus and forwarded the recommendations to the MHSA Steering Committee. The Steering Committee then reviewed all the recommendations during an intensive four-day process and identified those deemed most critical to system change.

Outreach Efforts to Target Populations

Prior to the implementation of the five key elements of the MHSA, all counties had to strategically create methods for involving the community. The researcher found that these methods included outreaching to certain target populations such as children,
transitional aged youths, adults, older adults, and minority populations. Counties also used media resources such as flyers, press releases in all major newspapers, web sites (exclusively for MHSA information), email, telephone, surveys, community forums, and well as outreach to community centers. Research also found that in every county, each target group was outreached to in a specific manner these strategies are as followed:

**Children:** In all Counties, family partnerships were encouraged through teaming with local family resource centers to promote and co-host community forums. Research found that families were also reach through the schools and community centers. For example, in Napa County, one school district distributed flyers to families via their students.

**Transition-Aged Youth:** In all Counties, the participation of transition-aged youth was encouraged by teaming with a various community agencies that took on the challenge of developing and funding a comprehensive service system for this largely underserved group. The TAY team includes both transition aged youth leaders and youth service providers.

**Adults:** Each County reached out to individuals who may or may not use services, but who cannot or are not likely to attend a community forum or respond to a survey were reached by going to where they live and congregate. Consumers also were recruited to assist with facilitation of discussion groups and these individuals sit on the Stakeholder Advisory Committee along with the Client Rights Advocate.

**Older Adults:** In all Counties, older adult participation was facilitated through the distribution of flyers and worked to facilitate participation of older adults at community forums and in stakeholder work groups.
Minority Families: In each County representative from minority communities were recruited through both a nonprofit social service agencies and a local minority networking systems. These representatives, in turn, supported the community planning process through getting the word out about community forums, the planning survey, and stakeholder work groups. They have also helped plan and implement the stakeholder work group process.

LGBT Population: Lesbians, gays, bisexuals and transgender persons cross almost all age groups. Their characteristics and their needs are complex. Research found that within this population, there are many dynamics to consider when offering programming such as the differing mental health needs of ethnically specific LGBT communities and the complexity of the issue of the “Down Low” dynamic where stigma affects the health of the general community. The needs of the HIV/AIDS-infected LGBT consumer were also considered. In order to better serve youth, focus groups suggested a greater presence in the schools. Research showed that not all counties targeted this population. Sacramento and Contra Costa counties made significant efforts to target the LGBT community. Some of the more rural counties such as Placer, and Sutter counties did not target this population actively.

Outreach Methods Used Among Counties

Media: News releases were provided to major areas, specific to the Counties targeted population agenda. All major newspapers in each county released information to provide general information about the MHSA, announce community forums, outline the stakeholder work group planning process, and inviting participation in all of these
activities. In addition, a program featuring the Mental Health Services Act, including a representative from the Mental Health Board as well as Health and Human Services, was aired on local access cable television throughout the month of March of 2005. The purpose of the program was to inform the public of the opportunities the Act presents, as well as a request for public participation, with a special emphasis on consumers and families, and information regarding scheduled consumer and family meetings.

**Website, E-Mail and Telephone:** Research found that each County created a ‘quick link’ website that was linked to county home pages. Email addresses and a phone contact number were established to provide alternative ways of distributing information, gathering input via the survey, and answering questions about the MHSA planning effort. Information on the websites is provided in various languages including, English and Spanish, Hmong, Cantonese, Chinese, Vietnamese, Russian, and interpreters are available when phone inquiries are in other languages. For example, Sacramento County has its Community Services and Supports Plans drafted in six different languages that include, English and Spanish, Hmong, Cantonese, Chinese, Vietnamese, Russian.

**Information Brief:** Each County also sent out letters and flyers in various languages regarding MHSA and upcoming opportunities for community input.

**Alternative Methods of Distributing Information:** Counties reached out to individual consumers and families who may not belong to organized advocacy groups or use mental health services. Public notices regarding community forums, and stakeholder work groups were distributed or posted in locations frequented by consumers and families such as churches, schools, primary care clinics and Minority community organizations.
Gathering of Information Received Through Outreach

Research found that with the various methods of outreach indicated above, the counties then gathered the information and it was facilitated and supported largely through existing community agencies, organizations and alliances. The counties used the following methods to collect information.

Community Networks: Consumer, family and Minority representatives from local organizations and agencies provided ongoing input from their networks of constituents to the Stakeholder Committee. Additionally, these representatives, with assistance from Mental Health Services staff and consultants, have acted as liaisons in providing information to their constituencies regarding updates to MHSA activities, on-going state and local trainings, etc. (All Counties).

Community Forums: Research found the counties used publicized community forums. Counties focused their forums on trainings on the current array of mental health services, the Mental Health Services Act and the future of mental health services and supports. Research established that in all counties the community-at-large was under informed about mental health services. Forums were structured to provide an overview of the current mental health system, services and supports provided across age groups and how they are funded. At all forums and presentations, individual, family and Minority participation in stakeholder work groups was encouraged through distribution of stakeholder information sheet. In addition to input gathered at the forums, consumer, family and Minority participants were provided with a survey and a self-addressed and stamped envelope for additional comments.
Surveys: In order to gather input from community members who may not have participated in community forums or wanted to express their input in greater detail than a forum would allow, a survey was developed and distributed (in various languages).

Research showed that all Counties utilized the following six questions:

1. “What community mental health services and supports are needed in this community? What would help you and/or others the most right now?
2. Have you or others had any problems getting mental health services in your community? If yes, what happened? What would have helped you or others in this situation?
3. What changes would make mental health services and supports better?
4. What are the most important things that can be done to honor your culture and build your trust in using community mental health services?
5. What things can be done to reach out to people who might need, but don’t use mental health services?
6. What new or additional community mental health services and supports would you like to see in your County”? (Napa County Community Services and Supports Plan, 2005, p. 11)

Consumer Facilitators: An adult mental health service user (who was hired to provide administrative support to the MHSA project) visited and held discussion groups with individuals at residential programs, supportive housing, supported living and adult day health programs, and Self Help Centers (All Counties).

Family Resource Centers: Resource centers were co-hosts of the community forums held in various counties. For example, Yolo County distributed information flyers, set up the meeting rooms, located childcare and provided a brief presentation of their efforts and interests in establishing additional mental health resources. In addition, in Napa County, one of the centers called families of children with mental health needs and completed a phone interview using the community survey questions.
Youth, Adults and Families Involved in Alcohol and Other Drug Service: In order to solicit input from individuals and families, The Counties implemented focus groups that were conducted with individuals involved in the alcohol and drug service system. Parents, youth in treatment, and providers participated in separate focus groups in order to determine the extent to which individuals with co-occurring disorders were receiving services for both disorders particularly with regard to accessibility issues related to the mental health system.

Individuals Living in Locked or Intensive Treatment Settings: In each County Mental Health Services staff completed a number of interviews with individuals that use mental health services and are unable or unwilling to attend community forums. In addition, a local family resource center completed phone interviews with families who could not attend community forums.

Minority Families: Since data indicates an under-representation of Minority families in mental health service use, the counties created a work group the underserved minority communities in their County. These workgroups were developed to solicit specific input about how services and supports could be tailored for this population. MHSA materials and information were translated into Spanish and other various languages, and interpreter services were obtained as needed.

Mental Health Board/Stakeholder Committee: Each County also created a Mental Health Board or Stakeholder Committee that was comprised of a number of consumer and family member representatives as well as interested community members, training and communication regarding the progress of the MHSA. The Board or Committee
conducted a brainstorming sessions and prioritized ways to allocate MHSA funding in ways that meet local needs for mental health services and supports. For example, Sacramento County held several trainings, including a webcast on public hearings.

**Stakeholder Committees and Stakeholder Workgroups**

The research found that Stakeholder Groups and Stakeholder Workgroups were consistent through all county CSSP's. These Committees meet monthly or more often as needed. Their purpose was to provide continuous input to the planning process. The Stakeholder Committees used a consensus process to review and prioritize the strategic recommendations of the Stakeholder Work Groups. The agenda for these Committee meetings include an opportunity for representatives to report on activities within their constituencies regarding the MHSA (e.g., training, presentations, input). In all Counties the structure of the committee members includes:

- Client Rights Advocate.
- Representative of Minority community-based social service organizations.
- Law Enforcement Representative representing the courts, local sheriffs/police associations, the jail and juvenile hall and the probation department.
- School Representative representing local school districts and the Special Education Local Planning Area.
- Physical Health Representative representing Public Health, local non-profit medical hospitals, and the local community based primary care clinics.
- Mental Health Board Representative chosen by the Mental Health Board.
- County non-mental Health representatives who represent Social Services, Alcohol and Other Drug Services, Child Welfare, and Older Adult services,
- Vocational Services and the Chief Executive Officer.
- County Health and Human Services representatives from the Fiscal Department.

**Work Groups:** Research showed that all counties implemented five Specialized Stakeholder Work Groups established to review community information and available data; and make recommendations to the Stakeholder Committee regarding strategies for services and supports that respond to identified community issues. Work group membership was open to anyone in the community who expressed an interest. Each community forum included an overview of the work groups, function, and time commitment. Potential members were asked to complete an information sheet (in order to support a balance of representation), but no one was turned away and work group assignments were not enforced. In all Counties the work groups included:

- **Children:** Work group which included representatives of families who use mental health services, family advocacy organization, public and private children and family mental health service providers, family courts, schools, and child care resource and referral (All Counties).

- **Transition-Aged Youth:** Work group that included youth who do and do not use mental health services as well as members of a local TAY coalition. This work group moved around the community to meet with different groups of youth (e.g., Latino youth leaders, court school, Boys and Girls Club) and
gather information. Discussions at each site were led by youth who had been trained as facilitators. Incentives (retail gift cards) were used to encourage participation (All Counties).

- **Adult:** Work group was comprised of individuals who use mental health services and public and private mental health service providers. Adults using services were typically half of the participants at any given meeting. Incentives (gas money, retail gift cards) were used to encourage ongoing participation (All Counties).

- **Older Adult:** Work group included representatives of advocacy and planning organizations, mental health providers, and individuals who are currently or who have used mental health services (All Counties).

- **Cultural Competency/Cultural Outreach:** The Cultural Competence/Ethnic Workgroup developed a sub-groups consisting of members of the Asian/Pacific Islander, Indian, African American, and Latino community. Workgroup members went into the community to meet with concerned community members through focus groups to receive feedback and to educate these populations about the MHSA and distribute Issues and Concerns Surveys. Data collected was used to recommend strategies to meet the needs of this population (All Counties).

**Wellness and Recovery**

This section focuses on recovery-based services and program planning that encourages support and hope. The implementation of these services seeks to specifically
reduce or eliminate symptoms. They also provide individuals with the ability to live fulfilling and productive lives. Recovery and resilience are the goals of the system of treatment and supports provided to each client and family who is served. The concept of recovery refers to a process in which people who are diagnosed with a serious mental illness are able to live, work, learn, and participate fully in their communities.

Research found that every service plan aimed toward recovery goals identified by the consumers and families as well as MHSA Task Force Teams, and Stakeholder Committees. The plans were also structured around the concept of resilience, which refers to the personal qualities of optimism and hope and the personal traits of good problem-solving skills that lead individuals to live, work, and learn with a sense of mastery and competence. Resiliency was a critical goal for children and young people especially and each plan implemented these frameworks within their plans.

Research also found that all ten counties made a significant effort to implement the wellness and recovery model. The Counties implemented themes and programs that were based on hope, empowerment, and services were specially tailored to meet the needs of consumers and their families. Below is a collective view of strategies that were used by the all Counties:

- **Wellness and Recovery**: Incorporation of Wellness and Recovery Model in *all* newly implemented programs (All Counties).

- **Information and Feedback Groups**: provided background information about the mental health system, described the MSHA planning process and offered
training on key concepts of recovery and wellness, resiliency as well as cultural competency (All Counties).

- **Facilities created to be used as Wellness & Recovery Centers:** consumers and families can be connected to resources and provided with services (All Counties).

- **Crisis Services:** Full Partnership clients will have access to 24/7 crisis services provided by MHSA trained staff (All Counties).

**Cultural Competence**

This section focuses on the creation of methods to eliminate racial and ethnic mental health disparities by improving quality and effectiveness of services. The key focus is utilization of culture as strength in service delivery, implementation of culturally competent programs and services that enhance the ability to incorporate the language and cultures of its clients, establishing cultural awareness and encouraging knowledge of different cultural practices, worldviews and cross-cultural skills. A successful implementation strategy was to contract with ethnic specific community based organizations that are connected and trusted by communities of color. This enabled counties to reach out to individuals that have not been reached in the past and to penetrate deeper into cultural, faith and tribal based communities. San Joaquin, Yolo and Sacramento Counties were exceptional in creating programs to specifically target underserved populations in their County. Research found that San Joaquin County broke new ground in the Central Valley for developing full service partnership programs dedicated to improving access to specialty mental health services for African Americans,
Native Americans, Muslim / Middle Eastern Americans, Gay, Lesbian, Bisexual and Transgender individuals. All counties made an effort to recruit staff to reflect and represent the ethnic, cultural and linguistic diversity of the consumers. However, research indicated that the Counties faced barriers in staff recruitment, which will be discussed in the later part of this chapter. Programs were developed in collaboration with community stakeholders, including community and faith based organizations, consumers, family members and staff. Research showed that the Counties addressed cultural competency in the following ways:

- **Cultural Competency Training:** Emphasis on understanding consumer culture and recovery concepts provided to all CSS staff (all Counties).

- **Recruitment:** More than 30 program staff from both partner agencies and the county proper will be added under CSS programs with a special emphasis on the recruitment of bilingual Spanish- and other minority staff and part-time Consumer and Family Members (Napa County).

- **Workforce Education Training:** Programs implemented on college campuses where students can gain training that includes cultural competency (Sacramento County).

- **Cultural Competence Committees:** Ensures that all components and programs implemented in the planning process are culturally and linguistically competent (All Counties).

- **Year-Round Trainings:** All Mental Health Staff are trained in cultural competence (All Counties).
• **Training and Education:** county and community staff to develop culturally sensitive skills and promote multi-cultural understanding (All Counties).

• **Services & Outreach:** Services, policies and practices in the client’s preferred language and respectful of the client’s culture (All Counties).

• **Cultural Competence Task Force:** Members of diverse groups to focus on issues in their communities and from stakeholder groups that developed cultural/ethnic specific recommendations (All Counties).

*Integrated Service Experience for Clients and Families*

This section focuses on services that are coordinated through a single agency or a system of care. It focuses on a joint planning process to best address the individuals/family’s need. This section also addresses the individual/family needs using the full range of community-based treatment, case management, and interagency systems. Integrated services provided to those who have mental illnesses, co-occurring disorders, including substance abuse problems and other chronic disabilities and conditions.

Research found that due to staffing shortages, not all programs have psychiatric coverage or other multidisciplinary services. Staff with each County worked together to acquire needed services between programs and teams, including MHS core, MHSA and SAS to increase the ease of access to needed services for consumers. This is an ongoing challenge for the Counties, but staff is motivated to decrease the impact to consumers and families. Research showed that these are the ways in which this data point is implemented into all County community services:
- **Family/Client Advocacy Groups**: primary vehicle for outreach to family members. Used to receive input and involvement.

- **Outreach Involving Clients & Families**: efforts to involve clients and families, including those who are un-served or under-served.

- **Client and Family Surveys**: developed and administered surveys to obtain information and feedback from current and former mental health clients and their families regarding workgroup and Steering Committee recommendations for services and supports which might be funded by the MHSA.

- **Technology Upgrade**: Enhancement of computer technology in order for our departments to move to paperless client records and improved data management for CSS programs.

- **MHSA Questionnaire**: Community members offered feedback on services and programs they thought were necessary to the transformation of the mental health system under MHSA.

*Client/Family Driven Mental Health System*

This element focuses on the integration of a system, which allows adults clients and families of children and youth to identify services, and supports that are most effective for them. It creates opportunities for clients and families to have greater choices over types of service, providers, and facilities. This system will promote learning, self-monitoring, and accountability. It increases choices that protect individuals and encourages quality.
Throughout the implementation process, consumers and family members were recruited, encouraged and supported to be ongoing participants in committees, workgroups and program operations. Each individual’s participation was positive and very meaningful for implementation success. Research found that the level of concern shared by consumers and family members empowered a level of awareness that the counties would not have been able to achieve in their absence. Successful transformation and reaching the goals of MHSA certainly were strengthened with consumer and family input. Consumers, family members and community stakeholders participated at every level of this process. Research showed that all Counties clients and families were utilized in the following ways:

- **Client Workgroups:** comprised of 16 clients and families individuals participated in a workgroup in order to identify and prioritize overarching values, needs, and services. The Client Workgroup continued to meet after the workgroup process was completed to support and provide input to client and family members of the Steering Committee (All Counties).

- **Community Services and Supports Steering Committee:** The Steering Committee serves as the umbrella over the MHSA planning, implementation and evaluation of the three-year process. The committee is made up of 22 members of whom 50% (11) are consumers and family members. The leadership of the committee included two family members as co-chairs. The Steering Committee oversees the planning process (All Counties).
- **Community Services and Supports Task Forces:** There are four Task Forces within the MHSA structure and governance. The membership of each Task Force mirrors that of the Steering Committee, with 50% of the members being consumers and family members, for a total involvement of 44 additional consumers and family members. The Task Forces are, Children and Youth/Transition Age Youth Services and Supports, Adult/Transition Age Youth Services and Supports, Older Adult Services and Supports, Cultural Competence (All Counties).

- **Consumers and Family Members as Trainers:** Consumers and family members, from diverse communities, were active trainers along with a Division of Mental Health staff in all of the MHSA trainings (All Counties).

- **Outreach and Engaging:** Consumers, family members, and other community members who historically do not utilize services (All Counties).

- **Recruitment of Consumer and Family Members:** Opportunities for consumers and family member to gain meaningful full employment (All Counties).

*Community Collaboration*

This section focuses on groups of families or individuals, citizens, agencies, organizations and businesses working together to share information and resources. Members of the community collaborate in an atmosphere of support in order to systematically solve existing and emerging problems. Research of the implementation process found that Community collaboration was the driving force of the MHSA process.
Community agencies across all counties made a tremendous effort to team up to reach the goals of the CCSP’s.

For example, in San Joaquin County, the Co-Occurring Treatment program is an excellent collaboration between County Office of Education (COE), Juvenile Probation, Juvenile Justice Bench, and Behavioral Health Services, which includes both Mental Health and Substance Abuse Services. Without these agencies partnering together this program design would not be possible; each component is inter-related. These are other method all Counties used to facilitate community collaboration:

- **Distribution of Questionnaires**: Distributed MHSA Questionnaire throughout the counties, and often used the questionnaire as an outreach tool (All Counties).

- **MHSA Stakeholders Committees**: 40 groups were created out of the 4 CSS Task Force groups. Theses 40 groups were generated by their concerns in the community (All Counties).

- **Outreach Work Plan**: Developed to guide the outreach activities. The Work Plan targeted several populations in within the county and outreach workers were assigned to go into the community to meet with small groups or one-on-one (All Counties).

- **Community Outreach**: committed to a transparent, community-based planning process involving clients, families, community partners/stakeholders, and staff. Outreach efforts to inform the community about the Mental Health Services Act (MHSA) and to solicit involvement in the planning process.
These efforts focused on reaching clients already obtaining services (consumers); individuals, families, and groups who are under-served or not receiving services, community partners, and stakeholders (All Counties).

- **MHSA Steering Committees**: represents the interests and various populations throughout all Counties. Members are expected to have knowledge of mental health issues and are expected to be able to communicate the perspectives and issues of individuals, groups, and organizations involved with mental health. Committee consists of 6 clients of the mental health system, 2 family members of mental health clients, 5 providers, and 9 community members involved with health, 3 representatives of under-served communities, 9 representatives of community coalitions, 1 representative of the Courts, and 4 County administrators.

- **County Program Re-Structuring Committees** ("PRSC") was comprised of representatives from throughout the community, including a broad range of department staff (clinicians, managers, advocates), representatives of the Little Hoover Commission, a county Supervisor, county administrators, county agency staff, contract providers, NAMI representatives, consultants, consumers and family members (All Counties).

*Program and Strategies*

Research found that each County focused on four target populations, children/youth, Transition-aged youth, adults, and older adults. All Counties identified and incorporated
programs to service these target populations. Below are the issues and strategies identified in these target populations (these methods were used in all counties):

**Children/Youth:**

1. **Youth Support Groups**, including life skills instruction and anger management, was a clearly identified need in our questionnaires and in public discussions. The community perceives that our youth need these supportive services, which are not adequately provided in our community, to help them manage their personal issues and behavior.

2. **Crisis Intervention and Crisis Stabilization Services and Supports** was an identified need in our public forums and stakeholder discussions. Necessary services include after-hours response and support for client and family when a child or youth with SED does not meet 5150 criteria. Family members expressed need for assistance with their children before behaviors escalate to major crisis, in hopes of avoiding long, costly and traumatic visits to the hospital Emergency Room.

3. **After-School Programs**, offering organized activities, sports play, mentoring programs, pro-social activities for children and youth, were a high priority with all audiences. There is a need for after-school programs to involve youth and provide healthy activities to engage youth into the community. Suggestions included specialized programs for Latino youth; lesbian, gay, bisexual, transgender, and questioning youth; and youth experiencing violence, trauma, and bullying. Youth in juvenile detention expressed an overwhelming need for positive activities in their communities, citing boredom as a key factor in prompting the negative behaviors that led to arrest.
4. **Comprehensive Benefits Assistance** is a critical need for children and families, according to MHSA community forum participants. Benefits assistance for clients of all ages is one of the key recommendations of the Program Re-Structuring Committee (PRSC).

5. **Treatment options** for minors with co-occurring disorders was identified in public forums and by survey respondents as a key issue; often cited were concerns about underserved youth with serious emotional problems self-medicating with drugs and/or alcohol.

6. **Housing Resources** Must Be Developed throughout counties to ensure safe and affordable housing options for individuals with mental illnesses. For adult consumers and for families with SED children, low-cost housing with appropriate supports is often the first step toward wellness and recovery. The importance of affordable housing with supports for clients of all ages was evident throughout the community meetings; this was a key recommendation of the Program Re-Structuring Committee as well.

7. **Parent Education and Caregiver Support Services** are tremendously important to helping families who care for SED children to stay together and/or avoid out-of-home placement while coping with a high degree of stress. Participants in public meetings repeatedly raised this issue. Parent education relating to mental health issues and parenting/parental involvement programs will be offered.

**Transition Age Youth (TAY):**

1. **Housing Resources** developed throughout counties to ensure safe and affordable housing options for individuals with mental illnesses. Transition-age youth may be living
independently for the first time in their lives. They have fewer resources, little or no rental history, and may need extra support to develop independent living skills.

Transition-age youth, in particular, may need transitional housing as a stepping-stone to meeting their long-term housing needs. Of MHSA questionnaire respondents, indicated that transition-age youth need supportive housing services. Housing was dominant concern among public forum participants, and a key recommendation of the PRSC.

2. Comprehensive Benefits Assistance made available for transition-age youth. Young adults with serious psychiatric disabilities often need assistance to access to Social Security and Medi-Cal benefits. Although they have no means of self-support, some youth may still have limited private medical insurance provided by a parent’s employer, thereby complicating their access to public mental health services. Benefits assistance for clients of all ages was a key recommendation of the Program Re-Structuring Committee (PRSC).

3. Job support and vocational services are critical to the health and wellbeing of our clients transitioning to independence. Many youth with psychiatric disabilities are ill prepared to enter the workforce at any level; they need job preparedness, job coaching, vocational training, and assistance with reporting earnings to Social Security and the IRS. Participation in a consumer-run business will help them to develop job skills and help in entering the workforce.

4. Substance abuse services for dual diagnosis clients are an ongoing and growing need for Transition Age Youth with serious mental illness. Services specific to these co-occurring disorders will provide both mental health services and substance abuse services
together to address the combined needs of these youth. Services tailored to address both issues in an integrated service delivery package do not currently exist. Developing services that are culturally relevant and sensitive will be a priority.

5. TAY Need Crisis Intervention and Crisis Stabilization Services and Supports. This issue was identified in public forums and stakeholder discussions. Necessary services include after-hours response and support for the youth who is in crisis but does not necessarily meet hospitalization criteria, or who may avoid hospitalization entirely with assistance from mental health staff.

6. Assistance for Clients Involved with the Criminal Justice System will help youth with psychiatric disabilities to avoid re-arrest. Clients charged with nonviolent, low-level crimes can be provided case management support and offered help with understanding and navigating the courts. If the client receives assistance in accessing other services, a successful exit from the criminal justice system can be facilitated, while promoting wellness and recovery.

7. Socialization and Community Integration Programs are extremely important for transition-age youth. Socialization is often an obstacle for youth with psychiatric disabilities, and a lack of opportunities for social interaction can intensify symptoms and lead to isolation. Youth moving toward adult independence need the encouragement of peers. This issue was raised repeatedly in public forums and community meetings.

8. Peer Support and Self-Help Programs, including support for clients and family. Youth in transition have many challenges, and youth often prefer the support and company of peers to that of family members or professionals. As youth assume control of their own
life decisions and learn to manage independence, family members (parents in particular) need support in dealing with their changing roles. Peer support and self-help programs, for both youth and family members, can help everyone make these readjustments more successfully. There was also an identified need for a program for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. There is no organized, visible therapeutic support system for youth adjusting to gay/transgender identities. A need for support focused on development of coping skills to deal with feelings of alienation, heightened levels of self-consciousness, and low self-esteem has been identified in all counties.

9. Educational Support for Transition-Age Youth with psychiatric disabilities is a priority issue of MHSA, and its importance was echoed in our community meetings. Many SED youth struggle with completing the academic credits and exit exams necessary to complete high school. Rates of dropout and failure to receive diplomas among Special Education students, which includes SED students, are much higher than those of other youth. Those youth clients unable to complete high school have greater difficulty finding employment. Although they may have Special Education status, these youth and their parents may not be fully aware of their rights and responsibilities relative to graduation. Transition-age youth with SED need special supports, counseling and encouragement to complete their high school diplomas or develop a personal plan for their future education and training. Providing services focused on completion of diploma requirements may also prevent youth from falling through the cracks as they approach age 18, when too many youth drop out of the treatment system prematurely. With appropriate assistance early on, youth with psychiatric disabilities who are emancipating from juvenile hall, foster care
placement, residential care, or family care, may develop the necessary skills and resources to live independently, or with a minimum of system supports. When appropriate, youth with higher-end treatment needs can be more smoothly integrated into the adult mental health treatment system.

10. A separate drop-in center for transition-age youth with serious mental illnesses will enable these youth to access support groups, peer mentors, life skills training, educational supports, and other meaningful activities. Such a center would promote wellness and provide a non-traditional setting for service delivery that would have a greater chance of acceptance by transition age youth compared to the traditional clinic setting.

Adults:

1. Housing Resources developed throughout all counties to ensure safe and affordable housing options for adults with serious mental illnesses. Secure housing is an all-important first step toward wellness, recovery and stability for clients. Many clients require supportive services to help them maintain an independent living situation, or to move from more intensive residential settings into independent living. Over half of MHSA questionnaire respondents indicated that the availability of support services in order to maintain independent living was a priority for adults.

2. Consumers with Co-occurring Disorders Need Help that is readily accessible and integrated within their mental health service delivery system. Among stakeholders in all venues, help for adult consumers with alcohol and substance abuse issues ranked high among concerns. Recovery for adult consumers is dependent upon access to appropriate
services. Integrated substance abuse and mental health services should be readily available to consumers participating in wellness and recovery oriented programs.

3. **Job support and vocational services** are critical to the health and wellbeing of our clients. Respondents to questionnaire indicated work and vocational training as important opportunities for consumers. For many clients, the hope of recovery centers on their ability to enter the workforce in some capacity. Without significant or recent employment experience, however, these individuals may not succeed in finding or maintaining a job. Adults with serious mental illnesses need job readiness skills, job coaching and vocational training to help them enter or re-enter the workforce, as well as assistance with reporting earnings to Social Security and the IRS. Participation in a consumer-run business will provide the opportunity to polish their job skills and offer a gateway to better employment.

4. **Assistance for Adult Consumers Involved with the Criminal Justice System** will help clients avoid re-arrest. Clients charged with non-violent, low-level crimes can be provided case management support and offered help with understanding and navigating the courts. Adults with psychiatric disabilities who are homeless and/or not presently receiving services may be provided access treatment options and other related services such as housing, substance abuse services, or vocational assistance. With access to recovery-based services, as well as direct assistance with the court process, consumers will spend less time involved in criminal proceedings and criminal behavior.

5. **Crisis Intervention and Crisis Stabilization Services and Supports for Adults** was an identified need in our public forums and stakeholder discussions. Necessary services
identified include access to after-hours assistance to avoid escalation and support for a consumer who is having difficulty but does not meet 5150 criteria.

6. **Comprehensive Benefits Assistance** was identified as a need for consumers of all ages. In addition to needing assistance in accessing Social Security and Medi-Cal benefits, clients need help understanding how employment affects their benefits status. Clients also need assistance with participating in various employment-related programs offered by the Social Security Administration, such as the PASS Plan and Ticket to Work. Homeless adults need help identifying what needs to be done to reinstate or transfer benefits to newly established residences.

7. **Peer Support and Self-Help Programs**, including support for clients and their families or identified personal communities. Consumers need the support of peers to cope with their illness, encourage them in their efforts toward recovery, assist them with steps toward sobriety, and individuals with whom they can relate and socialize. In these times of financial stress for public programs, few consumers are able to access individual therapy or case management services on a frequent basis. Family members or other loved ones who live with (or provide assistance to) the consumer often need caregiver support, general information, advocacy assistance, or education on mental health issues. In the context of Children’s System of Care, in community meetings and public forums, both consumers and family members favored the provision of similar services to adult consumers and their families or identified personal communities through the expansion of the Family Partnership Program to a Consumer and Family Partnership effort.
8. The Development of System Resources for “Low-Need” and “Meds-Only” Clients was a stated recommendation of the Program Re-Structuring Committee and an issue frequently raised in community meetings and stakeholder planning sessions. Recent budget cuts have made it even more difficult for clients who do not regularly need intensive treatment to receive services beyond medication management, leaving few options for clients who may experience periodic difficulties. Offering supportive services at our Resource will promote engagement and empower clients to exercise choices to participate and select services in a manner not encumbered by the traditional structure of hourly appointments in the clinics.

10. Cognitive Behavioral Therapy, as well as other therapy groups, should be more readily available to consumers. Although CBT techniques are presently utilized by ADMHS clinicians, this therapy is not widely available to county consumers. Community stakeholders specifically requested CBT be made available and offered by professionals to consumers in a group context, using techniques that have been successful in our community.

Older Adults:

1. Older Adults Need Mental Health Services to be provided where they live. Many older adults with mental illness are not able or motivated to access treatment. As they become increasingly homebound, they experience increased loneliness, isolation, and depression. Existing services to older adults need to be expanded to cope with increasing numbers of homebound seniors with serious mental health problems.
2. Mental Health Services Should Operate in Partnership with In-Home Support Services and Adult Protective Services. Integrated care options will facilitate earlier interventions with older adults, especially those with co-occurring physical and mental health problems, and those traumatized by abusive caregivers. For older adults from ethnic minority populations that do not readily accept mental health treatment, and for our unserved older adults, other service providers who are accepted caregivers offer an inroad to mental health clinicians.

3. Help for Aging Consumers with Physical Health Problems is a critical service for older adults. Physical health limitations may bring about a change of lifestyle that limits access to mental health treatment. Integrated services for individuals with co-occurring mental illness and physical ailments may provide the only opportunity for the client to continue to live independently.

4. Crisis Intervention and Crisis Stabilization Services for Older Adults was identified in our public forums and stakeholder discussions. Older Adults in mental health crisis (many of whom are previously un-served) may be traumatized by psychiatric facilities, or it may be difficult for Emergency Room psychiatric technicians to differentiate between mental health conditions and dementia. Stakeholders have requested a secure non-hospital crisis stay specifically for an older adult in crisis who needs further assessment before an accurate diagnosis can be made. If the individual is later determined to be suffering from dementia, or some other physical condition, and not mental illness, IHSS would assume responsibility for the patient, without interrupting care. Other necessary services identified by stakeholders include access to after-hours assistance to avoid
escalation and support for an older adult consumer who is having difficulty but does not meet 5150 criteria.

5. Transportation to Mental Health Services for Older Adults may mean the difference between mental wellbeing and isolation and despair, especially for those older adults who live in remote and/or rural areas of the county. Public transportation is available to disabled seniors in some areas; however, where public transportation is not offered, or where transportation services are offered so infrequently that a bus trip cannot reasonably be made, older adults need transportation assistance to facilitate access to mental health care.

6. Housing Resources for Older Adults Must Be Developed throughout counties to ensure that safe, affordable and appropriately located housing is available to elder consumers. Housing issues frequently arise for older adults with serious mental illness. Supportive mental health services that help older adults maintain independent living skills enable them to continue living at their current level of functioning. Housing was dominant concern among public forum participants and questionnaire respondents, and it was a key recommendation of the PRSC.

7. Mental Health Services for Older Adults Should Be Available at the Senior Centers

Offering services at senior centers would help reduce the stigma of mental health services for those individuals who are not ready to accept that they may need mental health treatment. By offering mental health services along with many other programs and activities, individuals are more likely to discuss issues that may be affecting their mental wellbeing. Offering services in an environment already utilized by seniors will promote
easier access to treatment and greater utilization of services. The Senior Centers also offer culturally appropriate services and an excellent location in which to conduct Outreach and Engagement activities for older adults.

_Barriers to MHSA Implementation_

The most notable and ongoing systemic barrier to implementing the MHSA Plan was finding and hiring culturally appropriate staff with the right training and experience to fill the jobs available. This includes consumers and family members. Ideally, the counties would improve diversity at all levels, including among psychiatrists, counselors, nurses and other professional staff as well as among paraprofessional positions. This is an ongoing challenge that requires not only strong recruitment efforts, but also a long-term workforce development plan. All Counties have addressed these issues by setting multilingual hiring as a priority and conducting wide recruitment efforts. There has been outreach to local community agencies in ethnic communities for assistance in recruitment, and by participating in MHSA-led and other efforts at workforce development at the State and regional level. Counties have also begun to contract with community-based agencies serving non-English speaking communities to provide some services directly.

Additionally, Counties are working with the Mental Health Workforce Education, which is focusing on promoting wellness, rehabilitation, and recovery-oriented principles and strategies that increase the diversity, cultural competence, and skills and knowledge of the public mental health workforce. Membership includes secondary and post-secondary educational institutions, public mental health departments, community based
organizations, consumer and family groups, and California state agencies. This group will be developing region-wide initiatives to achieve its goals.

Another barrier has been retaining Linguistically Diverse Staff. Counties have made great strides in recent years to increase the language capacities of its staff, however, when reductions in workforce occur, these new multi-lingual staff have the lowest seniority and are the first to be laid off. Much ground is lost when this occurs.

Housing has also been a challenge. Counties have struggled in developing the amount and types of housing needed to fully serve our population. Research showed that the counties recognize that it is difficult to engage individuals in a meaningful recovery process if they are homeless. Provision of housing crisis, transitional and long term is a core element of our programs for transitional age youth and adults with the recognition that children, families and older adults will have housing needs as well. Development of enough housing to meet the needs of all clients will take time even with the availability of MHSA funds.

Transportation Infrastructure has also been a barrier in some counties. In Contra Costa County transportation is a critical barrier to care. This County is very large and still partially rural. Even within the three service areas of the county (East, West, and Central County), travel time to established mental health services could be up to one hour. Many low-income residents of the county, including many mental health consumers, do not have cars. Some cannot afford bus fare. And many do not have the understanding of the public transit system required to get to services. For those who have the capacity to take mass transit, some critical buses run only once an hour making the trip for even the
briefest medical appointment a half-day activity. Counties will address this critical barrier by expanding its own internal transportation support systems and those of its subcontractors. Contra Costa as well as other counties facing these issues has begun to budget for bus and taxi vouchers to help get clients to care and community services, and will expand the system of cars, vans and drivers to transport consumers in Full Service Partnerships. Drivers of cars and vans, who may be peers, will also serve as client advocates and translators assisting consumers at their travel destination with support and assistance in accessing the desired services. As part of its MHSA planning process, counties are also establishing a planning process to assess other ways to improve the transportation infrastructure for consumers.

The data concludes that all counties employed the same methods of implementing the MHSA’s five data points into their community-based services. Throughout all ten Counties there were more similarities than differences. The data shows that each county targeted the same populations, which were, children, youth, adults, older adults and minority populations in the same manner. The following chapter will explain this phenomenon in further detail.
CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to examine the recent developments in Mental Health Policy in California; specifically, how current policy is being implemented in ordinance with the MHSA. There is limited research that identifies this policy and its implementation strategies across counties. This study identified similarities, parallels, and contrasts in order to generate a comprehensive strategic method of employment of this policy in California.

Conclusions

This research is helpful because there is little published literature on this topic. There has not been much written on implementation of the MHSA among the local levels or the recovery and wellness model itself. Through extensive research, the researcher explored the implementation strategies of ten counties in California. The researcher found that there were some variations regarding the strategies that were used among these ten counties. The researcher also found that there were more similarities than differences.

Many of the counties followed the lead of the more innovative counties such as Sacramento, Contra Costa and San Joaquin. The researcher found that the CSSP’s constructed from these three counties were more in depth and detailed than many of the other Counties.

The researcher also concludes that among all the Counties there was a significant effort in implementing the five data points and informing their respective communities
about the MHSA and wellness and recovery. Each county had a specific strategy that was used in identifying target populations, outreaching, as well as programs needed within their communities. The research showed that each county created a Wellness and Recovery or Self Help Center for consumers to gain assistance and be connected with services.

One of the most important findings was consumer and family involvement. The research found that each county outreached to consumers and family members by involving them with the MHSA planning process. Consumers and family members were included as stakeholders, which was key in identifying the needs of the community. Throughout the implementation process, consumers and family members were recruited, encouraged and supported to be ongoing participations in committees, workgroups and program operations. Each individual’s participation was positive and very meaningful for implementation success. Research found that the level of concern shared by consumers and family members empowered a level of awareness that the counties would not have been able to achieve in their absence.

The research concluded that there were few differences in outreach, and implementation strategies. Conversely, the most important difference was in minority populations targeted. Many counties targeted their minority communities based on the need. For instance, Yolo County has a vast Latino population. Therefore, they implemented programs specifically structured to target this population i.e. La Familia, Bilingual Spanish-Speaking Staff recruitment, and services. Sacramento County was also an innovator in restructuring the services provided to its minority communities. They
created programs for the Latino, Asian-Pacific Islander, and Russian communities. However, the research found that Sacramento County failed in creating a go-to agency for specifically for its African American Community. This finding was extremely alarming due to the fact that the African American Community leads almost all statistical data regarding being underserved in this County. Also, Research concluded that this failed to meet the requirements of the MHSA.

The data gathered from this study could be helpful for mental health practitioners, consumers and community members. Since we are continuously in the process of transforming our mental health system one that is pursuant to the MHSA and the wellness and recovery model it is important that those persons who are involved in this system understand what challenges and strategies that are useful in implementing stipulations of the MHSA. Recovery and wellness is part of the new trend in shaping the way services are delivered. It is important all counties understand how to effectively utilize the guidelines of the MHSA; this may help issues affecting individuals, families, and communities. This study could also help provide information on what issues the Counties need to address in order for agencies to provide recovery driven services. Not all mental health agencies are embracing this model, which creates inconsistencies within the vision that lawmakers and consumers have envisioned in the passage of Proposition 63, which addresses the problems with our mental health system in the California.

This study is also a great starting point for persons interested in further researching MHSA implementation among Counties. These findings in this study are specific used to gain knowledge about the strategies used among Counties. Further
application of the knowledge gained in the study can assist future planning county planning processes.

**Implications for Social Work Practice**

Persons with mental illness are stigmatized, criminalized and discriminated against. These societal problems stem from the lack of efficient care from the mental health system. One of the problems in mental health is the approach of service delivery within the system. The mental health system has been punitive, harsh, and produces unequal relationships between the practitioners and the client. The results for persons with mental illness have been homelessness, jail time, school failure, high drop out rates, unemployment, prolonged suffering and early death. Introduction of new approaches such as the recovery model encourages consumer friendly; preventative services and allows the community services to meet the needs of the clients. Its is important for practitioners self examine their role as a service facilitators, all social workers need to be knowledgeable about the MHSA and its guidelines. They must also remind themselves that competence is an important aspect of the NASW, Code of Ethics (1996). The NASW Code of Ethics directly states, "Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession". It is our responsibility as social workers to seek new ideas that would best serve the population. Mental health practitioners should be keeping up with current research in the mental health field. Recovery is the new trend in California mental health. Counties are being encouraged to use the recovery model due to the implementation of The MHSA.
There are significant advantages in acquiring knowledge about the MHSA. It will benefit social workers on all levels be them, community services, or legislation. On the community level, professionals may be employed by various agencies that are in the process of implementing services that are in ordinance with the MHSA, wellness and recovery-based services. Professionals entering the field will need to gain awareness of model in order employ it in practice and assist clients in navigating through systems of care. In addition, the implementation of recovery will have practical benefits such as revealing the quality of services consumers are receiving.

On a macro level, social workers should have knowledge of the MHSA so they are able to advocate for social policy that gives clients a voice, more credibility and allows clients a choice in treatment. Consumers should be acknowledged as experts in their process of recovery, and their participation needs to be greatly emphasized. Social workers must also support clients in gaining adequate housing, and improved resources with the community. Building a partnership with consumers is a vital role to gaining many desired goals. Use these principles in policy development work could help create consumer-driven programs that will benefit those who are coping with a mental illness. If social workers make use of recovery in micro, meso, and macro level work, the profession may see favorable outcomes with programs and clients.

Future researchers may be interested in exploring more about the implementation strategies in counties all over California or in other States that are making the same changes within their mental health system. Internationally and Aboard the MHSA is setting a foundation for change strategies. Future research may show how these other
Countries are changing the way in that mental health services are being delivered. The Presidents New Freedom Commission stated that “mental health is a key part of ones overall health”. This principal is beginning to set a foundation for recovery-based services being implemented on many levels.

Future researchers may also find it beneficial to examine the consumer’s perceptions on how the guidelines of the MHSA are implemented into agencies in California. Future researcher may want to examine if the policy has been effective, and what barriers have been encountered and how the counties approached and resolved these barriers. This researcher hoped to create new findings in the realms of mental health policy; specifically pertaining to how the communities are meeting the five data points of the MHSA. This study may offer valuable information about change strategies. Social workers could broaden knowledge of the MHSA, and the implementation process of policy in community based services. This acquisition of knowledge will be beneficial in continuing to move towards a mental health system that is seamless without discrepancies, that continues to service the underserved, and one that most importantly that incorporates the ideology of wellness and recovery.
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