County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

JEAN M. SHEPARD
DIRECTOR

SUSAN BOWER
DEPUTY DIRECTOR

ALFREDO AGUIRRE
DEPUTY DIRECTOR

BEHAVIORAL HEALTH SERVICES
3255 CAMINO DEL RIO SOUTH, SAN DIEGO, CALIFORNIA 92108

ALCOHOL AND DRUG SERVICES
(619) 584-5007 • FAX (619) 584-5080

CHILDREN'S MENTAL HEALTH SERVICES
ADULT/OLDER ADULT MENTAL HEALTH SERVICES
(619) 563-2750/2700 • FAX (619) 563-2775/2705

April 14, 2008

Deputy Director, Systems of Care
California Department of Mental Health
1600 9th Street, Room 130
Sacramento, CA 95814

Dear Deputy Director:

The County of San Diego, Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) submits the following request to augment the Mental Health Services Act (MHSA) Agreement. This augmentation is in response to DMH Information Notice No: 07-21, Additional One-Time Funding Augmentation to Expand Local Mental Health Services.

Implementation of the local Community Service and Supports (CSS) Plan

Since DMH approved the County of San Diego's CSS Plan in May 2006, services have begun in 100% of direct service CSS programs. New MHSA services were offered to clients as early as Quarter 4 of Fiscal Year 2005-06. In the case of any delayed programs, stakeholder input was sought to improve the Request for Proposal process and to expedite service delivery. As additional CSS funds have been allocated to San Diego County, new and expanded services have been planned with stakeholder input; 96% of these programs have been implemented.

Summary of MHSA Performance Contract Augmentation/Funding Request

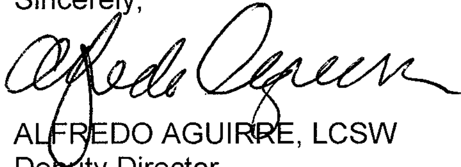
We request an amendment to the MHSA Agreement to include additional one-time funds of $3,675,900. These funds are being requested in accordance with DMH Information Notice 07-21. The funding will allow the expansion of the County of San Diego's Full Service Partnership program serving unserved/underserved adults who have been diagnosed with a serious mental illness (A-1, Homeless Integrated Services and Supported Housing).

Community/Stakeholder Review Process

This request to update the Three-Year Program and Expenditure Plan was presented at numerous public meetings, which were attended by public, private, family/client, education, housing, and public safety community representatives. After incorporating input from these community meetings, the CSS augmentation was made available for public review and comment for a 30 day period (pursuant to Welfare and Institutions Code §5848(a)), via presentation at the Mental Health Board, Housing and other Council

meetings, posting in public buildings, posting electronically on the Network of Care web site, and via e-mail distribution to local stakeholders, Councils, Mental Health Board and the Board of Supervisors.

Sincerely,



ALFREDO AGUIRRE, LCSW
Deputy Director
Mental Health Services

ONE TIME FUNDING AUGMENTATION TO EXPAND LOCAL MENTAL HEALTH SERVICES FOR THE COUNTY OF SAN DIEGO

I. General Requirements

a. Update for the County of San Diego

- Services have begun in 98% of the initial Community Services and Supports (CSS) programs. The remaining programs are related to the Mental Health Management Information Services and training and are close to completion.
- CSS Enhancement Plan #1: Increased CSS dollars allowed enhancement of existing programs and establishment of new services. 96% of programs have begun to provide enhanced and new services.

b. Request to amend existing MHSA agreement

The County of San Diego requests an amendment to our existing Agreement to include additional one-time funds of $3,675,900. These funds are being requested in accordance with DMH Information Notice No.: 07-21. The funding will be for expansion of the County of San Diego's current Full Service Partnership programs that serve unserved/underserved homeless adults who have been diagnosed with a serious mental illness or a co-occurring disorder with serious mental illness and substance abuse.

II. Update to the Three Year Program and Expenditure Plan

a. A list of the proposed new and/or expanded programs/services, identified by the service category under which the program/service will be funded.

Workplan A-1-Homeless Services and Supported Housing, Full Service Partnership

b. A description of each program/service, including the population to be served, number of clients served, services to be provided and methods of service delivery.

The A-1 Full Service Partnership (FSP) program will expand the number of FSP clients by 250 unduplicated adults, specifically for the Urban Downtown San Diego Area in the Central region that has the highest concentration of homeless persons. The program will provide comprehensive, individualized, integrated and culturally competent services in the region for homeless persons who have a serious mental illness and may also have co-occurring disorders of mental illness and substance abuse. The program will integrate outreach, engagement, 24/7 intensive case management/wraparound services, community-based mental health treatment services, diversion from incarceration services as needed and will provide rehabilitation and recovery services (i.e., supported employment/education, supported housing, peer support, transportation support, expanding natural supports, self sufficiency and

empowerment), and integrated probation services. In addition this FSP will provide a 19-bed residential program for "off-the-street" immediate access to housing and recovery services for clients of the program who have co-occurring disorders.

Services will be provided to adults age 18 and older who have a diagnosis of serious mental illness and are homeless or at risk of becoming homeless, and who are unserved or underserved or are high users of acute inpatient care and medical services. Priority for admission will be given to those persons with the most severe mental illness and the highest incidence of homelessness and/or County mental health service. In accordance with AB599, veterans ineligible for federal VA services may be eligible for this program. Special attention will be paid to persons who are unserved and not receiving mental health services, with an emphasis on active outreach to and engagement with these persons as well as to unserved persons with serious mental illness who are African-American or who are women.

c. **An explanation of how each program/service relates to the issues identified in the Community Program Planning Process, including how each program/service will reduce or eliminate the disparities identified in the CSS assessment in the County's existing Three-year Program and Expenditure Plan.**
This program will address the issues identified in the Community Program Planning Process by providing client-directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, reducing homelessness, reducing contact with the justice system and reducing inappropriate use of acute inpatient care. In addition, this program will advance rehabilitation and recovery practices that assist clients in obtaining self-sufficiency and in seeking and sustaining employment. These strategies will assist in reducing the disparities identified in the original CSS Plan.

d. **An assessment of the County's capacity to implement the proposed programs/services, including the factors listed in Section 3650(a)(1) of the CCR.**
The County of San Diego has implemented 98% of the CSS programs approved in 2006. The original CSS direct service programs have been successfully implemented, and through ongoing stakeholder engagement, additional needs have been indicated. Through increased CSS dollars, enhancement of CSS programs and the addition of new programs have been approved and implemented.. 96% of programs have begun to provide enhanced and new services. The capacity of the MHSA programs is consistently met. Evidence of capacity is also shown quarterly in the required Exhibit 6 report (Quarterly Progress Goals and Reports).

To address the factors listed in Section 3650(a)(1) of the CCR, the tables below from the initial CSS Plan provide estimates of the total number of persons needing enhanced mental health services who already are receiving services, including those fully served or underserved/inappropriately served, by age group, race ethnicity, and gender.

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

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

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

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

** Other includes other, unknown and 2 or more races*

*** County poverty population is based on prevalence data and the percentages are estimated based on percentages for Ages 18+*

**** Fully served are those receiving Wraparound or previously known as AB2034 services according to DMH guidelines.*

e. **A statement explaining how the requirements of the Community Program Planning Process in Section 3300 of the CCR were met.**
The County of San Diego's program planning process was extensive. A broad range of input was collected about community issues, needs, and services from clients, family members, service providers, and other stakeholders. During the initial CSS community program planning phase, San Diego County Mental Health Services (SDMHS) conducted 11 Community Forums, 25 meetings for special populations, and participated in 30 meetings with consumers at clubhouses, Board and Care and other

facilities. Consumers and family members were hired to help develop the plan, and to collect over 900 surveys from consumers. MHSA Workgroups for Children and Youth, Adults, and Older Adults were established to review community input, prioritize and make service recommendations to the SDMHS Director. The Cross Threading Workgroup (CTW) composed of clients, family members, and advocates was also established to review and finalize the workgroup recommendations, and made recommendations for the Critical Reserve Needs that support additional services and one-time funds.

After deliberation, the MHSA Workgroups recommended an array of services to be funded under the MHSA for all target populations. These new services are consistent with the community input received, and with MHSA and DMH guidelines. All proposed services are anchored in community collaboration, cultural competence, client/family-directed services, and in the principles of rehabilitation, recovery, resilience and children's system of care values.

Homeless integrated services and supportive housing was a top priority of stakeholders during the initial planning process. This is still the case three years later. Stakeholders recognize the importance of homeless integrated services and have expressed this in numerous public venues. A 30 day public review and comment period occurred with a kick-off at the Housing Council and Mental Health Board meetings on March 6, 2008. The expansion was discussed at additional public meetings including the Adult Council. The memo describing proposed changes and the workplan were posted on the Network of Care website and by the Clerk of the Board for public review. Finally, the memo and workplan were also e-mailed to the County's Stakeholders list which includes over 1,000 community members and stakeholders.

f. **Documentation of the local review process required by Section 3315.**
See Attachment A. Notice was posted on the County of San Diego Network of Care website, emailed to stakeholders and distributed at various community meetings.

g. **Certification by the County Mental Health Director that the County will comply with the non-supplantation requirements of Section 3410 of the CCR.**
See Attachment B.

h. **For each new CSS program(s) or service(s) not already included in its Three Year Program and Expenditure Plan, in addition to the elements set forth in section 3650 (a)(6), the update shall also include:**
Not applicable; program is an expansion.

i. **A brief description of the proposed program expansion (e.g., population to be served, increased number of clients served, new services added, new methods of services delivery, etc.), the amount of funding being requested, and the proposed effective date.**

This Full Service Partnership (FSP) program will expand the number of FSP clients by 250 unduplicated adults, specifically for the Urban Downtown San Diego Area in the Central region that has the highest concentration of homeless persons. The program will provide comprehensive, individualized, integrated and culturally competent services in the downtown, urban area of San Diego for homeless persons who have a serious mental illness and may also have co-occurring disorders of mental illness and substance abuse. The program will integrate outreach, engagement, 24/7 intensive case management/wraparound services, community-based mental health treatment services, diversion from incarceration services as needed and rehabilitation and recovery services will be provided (i.e., supported employment/education, supported housing, peer support, transportation support, expanding natural supports, empowerment), and integrated probation services. In addition this FSP will provide a 19-bed residential program for an “off-the-street” immediate access to housing and recovery services for clients in the program with co-occurring disorders. This program advances the MHSA goals to reduce incarceration and institutionalization, to increase meaningful use of time and capabilities, to reduce homelessness and to provide timely access to needed help by providing intensive wraparound treatment, rehabilitation and case management services, through provision of services following the SAMHSA evidence-based practice of Assertive Community Treatment (ACT) in combination with provision of an array of housing options (e.g., Residential Services, Single Room Occupancy, short term stay shelter, Board and Care, permanent housing). A continuum of housing options will be provided to include short-term housing, transitional and permanent supported housing.

The County of San Diego requests an amendment to the existing Agreement to include additional one-time funds of $3,675,900. These funds are being requested in accordance with DMH Information Notice No.: 07-21. The funding will expand the County of San Diego’s current FSP programs that serve unserved/underserved adults who have been diagnosed with a serious mental illness. The goal is to begin services with these new dollars on July 1, 2008.

j. **The net cost per client resulting from the proposed expansion. If the net cost per client is greater than the originally approved program, the County must also complete and submit a revised MHSA CSS Budget Worksheet (Exhibit 5a), Detailed Staffing Worksheet (Exhibit 5b), along with a budget narrative for the proposed expanded**

program. If the net cost per client for the expanded program is the same or less, there is no need to resubmit the Budget Worksheets.

The net cost per client is $15,677, which is less than the cost of $16,313 previously approved in San Diego County's Community Services and Supports Amendment submitted to the State in March 2007.

Attachment A

JEAN M. SHEPARD
DIRECTOR

JENNIFER SCHAFFER, Ph.D.
BEHAVIORAL HEALTH DIRECTOR

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

BEHAVIORAL HEALTH DIVISION

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

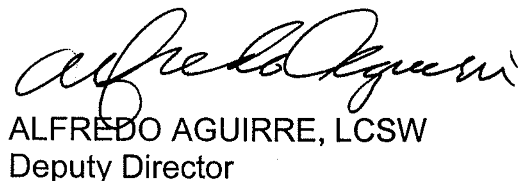
March 6, 2008

NOTICE OF INITIATION OF THIRTY DAY PUBLIC REVIEW PERIOD

A 30-day public review and comment period is required for the County of San Diego Behavioral Health Services to expand Full Service Partnership (FSP) services for homeless adults with serious mental illness, funded by the Mental Health Services Act (MHSA), Proposition 63. This expansion of services under work plan A-1, *Homeless Integrated Services and Supported Housing* necessitates an update to the County's Community Services and Supports Three-Year Program and Expenditure Plan. A work plan describing the proposed service expansion is attached for public review. The review period begins March 6, 2008, and will end April 5, 2008.

Under the proposed plan, services will be expanded for an additional 250 unduplicated adults in the Urban Downtown/Central San Diego Region, which has the highest concentration of homeless persons. The FSP program provides comprehensive, individualized, integrated, and culturally competent services for homeless persons who have a serious mental illness or co-occurring mental illness and substance abuse disorders. This expansion will also serve Transitional Age Youth and Older Adults. Additionally, the expansion will provide integrated probation services to divert clients from incarceration and a 19-bed Safe Haven residential program for "off-the-street" immediate access to housing and recovery services for clients with co-occurring disorders. One hundred permanent project-based housing subsidies will be available through collaboration with San Diego City Housing Commission.

Comments may be sent to the MHSA Comment/Question Line: (619) 584-5063, toll-free at: (888) 977-6763 or via e-mail at: MHSProp63.HHSA@sdcounty.ca.gov



ALFREDO AGUIRRE, LCSW
Deputy Director

PIEDAD GARCIA, Ed.D., LCSW
Assistant Deputy Director

Attachment B

JEAN M. SHEPARD
DIRECTOR

JENNIFER SCHAFFER, Ph.D.
BEHAVIORAL HEALTH DIRECTOR

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY
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ALCOHOL AND DRUG SERVICES DIRECTOR
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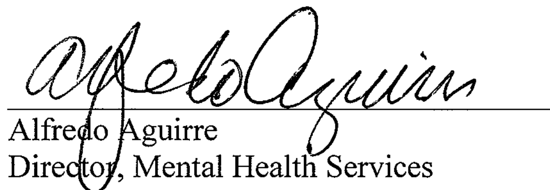
ONE TIME FUNDING AUGMENTATION TO EXPAND LOCAL MENTAL HEALTH SERVICES FOR THE COUNTY OF SAN DIEGO

RE: Expansion of Mental Health Services Act Community Services and Supports Workplan A-1, Homeless Integrated Services and Supported Housing

I hereby certify that the County of San Diego will comply with the non-supplant requirements of Section 3410 of the California Code of Regulations.



Alfredo Aguirre
Director, Mental Health Services

4-14-08
Date

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Diego	Fiscal Year: 2008-09	Program Work Plan Name: FSP Expansion for Homeless Integrated Services and Supportive Housing
Program Work Plan #: A1a - FSP Expansion		Estimated Start Date: July 2008

1a) Description of Program:

This Full Service Partnership (FSP) program will expand the number of FSP clients by 250 unduplicated adults, specifically for the Urban Downtown San Diego Area in the Central region that has the highest concentration of homeless persons. The program will provide comprehensive, individualized, integrated and culturally competent services in the region for homeless persons who have a serious mental illness and may also have co-occurring disorders of mental illness and substance abuse. The program will integrate outreach, engagement, 24/7 intensive case management/wraparound services, community-based mental health treatment services, diversion from incarceration services as needed and rehabilitation and recovery services will be provided (i.e., supported employment/education, supported housing, peer support, transportation support, expanding natural supports, empowerment), and integrated probation services. In addition this FSP will provide a 19-bed residential program for an "off-the-street" immediate access to housing and recovery services for clients with co-occurring disorders This program advances the MHSA goals to reduce incarceration and institutionalization, to increase meaningful use of time and capabilities, to reduce homelessness and to provide timely access to needed help by providing intensive wraparound treatment, rehabilitation and case management services, through provision of services following the SAMHSA Evidence-Based Practice of Assertive Community Treatment (ACT) in combination with provision of an array of housing options (e.g., Residential Services, Single Room Occupancy, transitional shelter, Board & Care, permanent housing). A continuum of housing options will be provided to include short-term housing, transitional and permanent supported housing.

1b) Priority Population:

Services will be provided to adults age 18 years and older who have a diagnosis of serious mental illness and are homeless or at risk of becoming homeless, and who are unserved or underserved or are high users of acute inpatient care and medical services. Priority for admission will be given to those persons with the most severe illness and the highest incidence of homelessness and/or County mental health service. In accordance with AB599, veterans ineligible for federal VA services may be eligible for this program. Special attention will be paid to persons who are unserved and not receiving mental health services, with an emphasis on active outreach to and engagement with these persons as well as to unserved persons with serious mental illness who are African-American or who are women.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	**1d)** Fund Type			**1d)** Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1c) ✓ ACT services, with three 83-person ACT Teams serving persons in the Downtown Urban area of San Diego. ✓ Community-based, integrated, comprehensive, individualized wraparound services, provided 24/7 by the ACT Teams; ✓ One probation officer will address justice system issues and provide justice-related case management services; ✓ Services include outreach and engagement, mental health services, intensive case management, rehabilitation and recovery services, care coordination, skill development, supported education, supported employment, and housing supports; ✓ 19-bed residential services for "off-the-street" immediate housing ✓ Access to ACT training and other recovery-oriented training to include Copeland's Wellness Recovery Action Planning (WRAP) ✓ Linkage and care coordination with physical healthcare providers; ✓ Staff to consumer ratio is approximately 1 to 12; ACT Team members share responsibility for the treatment, support and rehabilitation services; ✓ Includes comprehensive and integrated mental health and substance abuse services and individualized treatment/service plan with client centered treatment planning; ✓ 100 project-based Section 8 Vouchers from the City of San Diego will be provided for clients in this program. In addition an array of housing options will be provided to include a variety of short-term and long-term housing options: short-term emergency shelter, Single Room Occupancy (SRO), Board and Care (B&C), subsidized housing and/or master leasing; ✓ All services will serve clients with both mental illness and substance abuse disorders.	☒	☐	☐	☐	☒	☒	☒

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

San Diego County Mental Health Services (SDCMHS) will contract with a community-based organization to provide integrated mental health, rehabilitation and recovery services, utilizing Assertive Community Treatment (ACT) Team services to serve persons with serious mental illness and who are homeless. This program will cover the Downtown Urban area in the Central region and is charged to do 'whatever it takes' to support adults age 18 and older (including Transitional Age Youth, Adults, and Older Adults) in the community and help them work toward their recovery goals. ACT is an evidence-based practice that has repeatedly demonstrated its effectiveness with people who have serious mental illness who have not been adequately served by the usual service system. SAMHSA's ACT Implementation Resource Kit (2003) describes:

> "Assertive community treatment (ACT) is a way of delivering comprehensive and effective services to individuals who are diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. At the heart of ACT is a trans-disciplinary team of 10 to 12 practitioners who provide services to approximately 100 people. Services are delivered directly by the team as opposed to being brokered from other agencies or providers. To ensure that services are highly integrated, team members are cross-trained in each other's areas of expertise to the maximum extent possible. Team members collaborate on assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure each person receives the services he or she needs to support his or her recovery from mental illness.
>
> The course of recovery from severe mental illness and what it means to have a life that is not defined by a severe mental illness differs among people. Consequently, ACT services are highly individualized and there are no arbitrary time limits on the length of time an individual receives services. Most services are provided in vivo, that is, in the community settings where problems may occur and support is needed rather than in staff offices or clinics. By providing services in this way, people get the treatment and support they need to address the complex, real world problems that can hinder their recovery. Each person's status is reviewed daily by the team so the nature and intensity of services can be adjusted quickly as needs change. At times, team members may meet with a person several times a day, but as the individual's needs and goals change, the nature and frequency of contacts with the individual also change."

Services to be provided TAY, adults and older adults include age and developmentally appropriate outreach and engagement, 24/7 intensive case management/wraparound services, community-based outpatient mental health services (including medication management, individual therapy, and group therapy as needed), rehabilitation & recovery services (including skill and resource development in acquiring and sustaining housing/employment/educational/social goals), supported employment, supported education, and peer support services. Program will serve 250 clients in the Downtown Urban area of San Diego, including 19 clients housed in the transitional residential program. The vast majority of services will be delivered through outreach to the client. Referrals will primarily come from programs that serve the homeless, including the police, and extensive outreach and engagement with persons who are homeless is a core component of connecting with clients.

The Comprehensive Continuous Integrated System of Care (CCISC) treatment model will be integrated with the ACT Team model and will be used for clients with co-occurring disorders of mental illness and substance abuse. CCISC is an integrated and comprehensive treatment, training and administrative approach that supports the coordination and integration of mental health and substance abuse services for persons with co-occurring disorders. The CCISC model of practice espoused by Dr. Kenneth Minkoff is a nationally recognized consensus best practice anchored in a person-centered, diagnosis-specific and stage-specific treatment for each disorder. This model is based on the following eight clinical consensus best practice principles: 1) dual diagnosis is an expectation, not an exception, and the interaction with the client shall be welcoming; 2) the treatment relationship is empathic, hopeful, continuous; 3) treatment services can be planned by using the four quadrant national consensus model for system level planning; 4) within the context of a treatment relationship, care and empathic detachment/confrontation are appropriately balanced; 5) each disorder should be considered equally important and integrated dual primary treatment is required; 6) both disorders can be understood from a disease and recovery model with parallel phases of recovery and matched interventions; 7) there is no one type of dual diagnosis program or intervention that is correct, and treatment services are matched to client needs; and 8) outcomes are individualized.

This program will advance MHSA goals by providing client-directed services that are individualized, reducing the effects of untreated mental illness, increasing access to care for ethnically diverse individuals, reducing homelessness, reducing contact with the justice system and reducing inappropriate use of acute inpatient care. In addition, this program will advance rehabilitation and recovery practices that assist clients in their recovery, in self-sufficiency and in seeking and sustaining employment.

Staff will reflect the evidence-based practice model's recommended staffing pattern, and will include a team leader, a program assistant, psychiatrist, and a variety of mental health professionals that will include the specialty functions of nursing, employment specialist, peer specialist, and substance abuse specialist. At least six FTE peer specialists will be part of this program. Approximately one-third of the staff is expected to be bilingual. The program will have a Program Advisory Group (PAG) that consists of at least 51 percent clients to advise the program on the implementation of recovery-oriented services.

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

In Allness and Knoedler's "A Manual for ACT Start-up (2003)", they state, "One of the most important needs for all persons is safe, comfortable, and affordable housing. In traditional treatment, persons with severe and persistent mental illnesses live in institutions or in specialized housing. In the ACT model, persons with severe and persistent mental illnesses can successfully live in normal housing with frequent and consistent team contact. The ACT team helps clients find and reside in the kind of housing situations which best meet their needs at any particular time." Housing specialists are embedded in the ACT Team model.

According to the San Diego Gap Analysis, it is estimated that approximately 4,000 homeless individuals with serious mental illness reside in San Diego County; over 60 percent of these people may have co-occurring disorders of mental illness and substance abuse. It is estimated that there are approximately 2,765 adults per year with serious mental illness who were homeless or may have been homeless during the year and were underserved or inappropriately served by the mental health system. The highest concentration of homeless persons is in the Central Region of San Diego, and this program will address homeless needs in the

Central region. Based on statistics taken from the InSyst system, African Americans who are homeless are overrepresented in mental health services, and this program will address this disparity by having an increased outreach effort for African Americans. Affordable housing for persons with very low income is a huge challenge in San Diego; the Contractor will identify an array of supported housing that will include approximately 100 Section 8 units in the Central Region for clients enrolled in this program. Additional housing options that the Contractor may provide include: temporary stay in short-term housing; transitional supported housing to include a variety of short-term and long-term housing options including short-term stays at shelter, Single Room Occupancy (SRO), Board and Care (B&C); subsidized housing; and/or master leasing. Multiple approaches will be considered (e.g., scattered housing, clustered housing, and mixed use housing). A 19-bed residential program will be provided to clients with co-occurring disorders brought by the City of San Diego HOT team and the program ACT teams.

The ACT Teams will have employment services provided by employment specialists embedded in the teams and will provide an array of supportive employment services including job readiness, job supports and job placement. SAMHSA's ACT Implementation Resource Kit (2003) states: "ACT emphasizes work and vocational expectations for all consumers, while accepting individual differences in capacity and interest in competitive employment…The team's employment specialists are responsible for providing the majority of employment services. They are also responsible for directing and teaching other team members to participate in carrying out individual consumer employment plans. Persons with severe mental illnesses rarely lose jobs because they do not have the skills for the job. More often, jobs are lost because mental illness and related symptoms and behavior affect job performance. For this reason, the assessment process includes a careful review, not only of the consumer's education and past work experience, but also of the specific behaviors or other issues that have been problematic on the job. Initially, many consumers indicate that they do not want to work or that they are unable to work. In addition, because staff cannot predict how well a person is going to do in employment, they may be hesitant to help consumers find jobs. To overcome both consumer and staff resistance or apprehension, it is critical for the employment specialist and all the team members to work together to encourage, support, and provide consumers with opportunities to try work…" independent of their age. Some clients may want to access volunteer opportunities or other employment supports, such as the Department of Rehabilitation or the Regional Clubhouses, and the ACT Team will support those efforts.

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

The average cost per client per year is $15,677 for this expansion, which is less than the cost of $16,313 previously approved in San Diego County's Community Services and Supports Amendment submitted to the State in March 2007.

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

Persons with serious mental illness who are homeless usually have experience with tremendous loss and trauma, and the focus on resiliency is critical to help them travel the path of recovery. This service will be recovery-oriented and strengths-based. Probation

services will work closely with the team, to address the complex issues that may be involved in resolving outstanding justice system issues that pose barriers to recovery.

Rehabilitation and recovery interventions are client-directed, age and developmentally appropriate and embedded with the service array to include: wellness and resiliency focus, individualized wellness and recovery action plan (Copeland's WRAP), skill development, peer supports, social and recreational supports, supported employment, supported education and supported housing. In addition, services for TAY and Older Adults will be specialized according to their age and developmental needs. Training opportunities will be provided for staff and include training on Deegan's 'Intentional Care' standards, which are staff performance standards (developed by a leading consumer advocate) designed to ensure that staff works in recovery-oriented and empowerment-building ways, and on Copeland's Wellness Recovery Action Plan,' which presents a consumer-focused, wellness-oriented strategy developed by and for consumers that supports increased coping skills, increased wellness, and improved relapse prevention skills. The ACT Teams will incorporate peer specialists who can serve as role models, and will provide support in the critical areas of housing, work, school, relationships, recreation and meaningful activities. Training on and technical assistance with the ACT model will be facilitated and will incorporate the values of empowerment and recovery in the delivery of services and will be tailored for TAY, adult and older adults specialized needs. Program evaluation, outcomes, and client satisfaction surveys as well as client focus groups will be some of the strategies that the program will use to ensure adherence to recovery principles and practices. In addition the Program Advisory Group (PAG) will oversee, monitor and provide input and feedback on the implementation of this program.

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

This FSP program will expand the number of unduplicated FSP clients by a minimum of 250 clients, specifically in the Urban Area of Downtown San Diego in the Central region that has the highest concentration of homeless persons. The program will also cover the area's TAY population and will provide "enhanced" services, such as the transitional residential program, integrated probation services and additional housing assistance from the 100 project-based housing vouchers.

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

Contractor shall assure that ACT Team staff includes qualified individuals with experience as mental health clients or family members of mental health clients that reflect gender and age and shall employ a minimum of 6 FTE staff (these could be shared positions of 10 or more hours per week) to serve as ACT Team Peer Specialists. Contractor will positively consider identified personal client and/or family mental health experience as valuable experience for persons to be hired in any staff position. Peer support specialists can be tremendously valuable in promoting hope for recovery, as they can be inspirational role models for persons who are struggling with identifying their path to recovery. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. The program will encourage its clients to link with client-operated services, including local clubhouses (e.g., the TAY Clubhouse), and the Client-Operated Peer Support Services Program.

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

Our experience with Homeless Integrated Services has demonstrated successful stakeholder collaboration with multiple community-based organizations that include: homeless providers, mental health providers (including clubhouses), justice and public safety sector entities, housing providers, the business community, faith-based organizations and health providers. The success of this program lies in forging those same collaborations and partnerships to address the multiple needs of the homeless. By collaborating and partnering there will be system improvements in the delivery of care, in the reduction of inappropriate use of services and a reduction in costs for the community. Such collaborations include the Homeless Outreach Team (HOT), the Psychiatric Emergency Response Team (PERT), Inpatient Units and Emergency Room Units, the Sheriff's Department, TAY/Adult/Older Adult mental health providers, the San Diego Police, and the Probation Department. Homeless providers that this program will partner with include St. Vincent de Paul, the Rescue Mission, Veteran's Services, Alpha Project, Rachel's Women Center, and Volunteers of America. This program will also collaborate and work with the MHSA Housing Consultant Contractor (currently the Corporation for Supported Housing) to identify the array of housing options mentioned above.

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

While it is critically important to recognize the individual differences and unique needs of every person served, persons with serious mental illness who have been homeless often share experiences of poverty, victimization, trauma and loss of valued role. Cultural competence and understanding of differences are required expectations of our current providers and are integrated in our current service delivery system and will be a requirement of this program as well. At least a third of the staff is expected to be bilingual, and interpreter services will be obtained as necessary. The ACT Team model has demonstrated effectiveness with persons with serious mental illness and with persons who are homeless, and is seen as an excellent model for service. Staff will possess cultural awareness, knowledge and skills necessary to provide culturally competent services, particularly to eligible African-Americans and women who are unserved, underserved or inappropriately served, as is recognized that African Americans tend to be inappropriately served (e.g., more likely to receive a diagnosis of schizophrenia; receiving a higher rate of mental health services in jail, and fewer outpatient services in several regions, than predicted by prevalence data) and women tend to be underserved by our mental health system. Our gap analysis notes that "African Americans who are homeless are overrepresented in mental health services," and this program will address this disparity through active outreach to African Americans who are homeless and have serious mental illness.

Contractor shall assure that ACT Team staff includes qualified individuals with experience as mental health clients or family members of mental health clients, and shall employ a minimum of six FTE staff (these could be shared positions of 10 or more hours per week) to serve as ACT Team Peer Specialists. The Contractor will ensure that staff are culturally competent to serve the culturally diverse backgrounds of the clients in the geographic regions to be served, and will provide a Human Resource Plan for recruiting, hiring and retaining staff reflective of the major cultural groups to be served, will identify a process to determine bilingual proficiency of staff in at

least the threshold languages for the County (Spanish, Vietnamese and Arabic), will arrange for language translation services when staff do not have the capability to speak a client's language, using the County's contracted interpreter services as necessary, will provide ongoing cultural competency training to staff, and will demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competence Plan.

The Culturally Competent Clinical Practice Standards of SDCMHS are to: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels. The Practice Standards that the program shall implement are:

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

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

The contractor shall demonstrate sensitivity to individual and cultural differences of all clients in the program, including age, sexual orientation and gender, and training in these areas will be facilitated for staff. Referrals and linkages where appropriate will be made to services that are age-specific, gender-specific and/or relevant to needs relating to sexual orientation, such as linkages to the

Rachel's Women's Center , the San Diego Lesbian, Gay, Bisexual and Transgender Community Center, and TAY and older adult services such as the TAY Oasis Clubhouse and Senior Centers.

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

This service will be provided in San Diego County. However, clients from San Diego currently residing in out-of-county long-term care facilities whose discharge plan indicates the need for supported housing and who would otherwise be homeless upon their return to San Diego County will be given priority for admission to this program.

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

All strategies are listed in Section IV.

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

Activity	Date
Mental Health Board Review and Approval	March 2008
30-Day Public Review	March – April 2008
Submit Request to DMH	April 2008
DMH Review	Minimum 30 day process
Upon DMH approval, Begin transition	May – June 2008
Begin FSP expansion	July 2008
Full caseload established	July 2008
Serve minimum caseload of 250 persons	Throughout FY 2008–09 (and all option years)