MHSA ADULT PLANNING PANEL PROPOSAL
WELLNESS RECOVERY WORKGROUP
Alameda County Behavioral Health Services

This proposal for a Wellness Recovery Resource Center was prepared for Peter Alevizos, Director, Adult System of Care, and includes a complete written account of the deliberations of the Wellness Recovery Workgroup. Two parts are included in this document:

- Part One – Summary: Wellness Recovery Workgroup Proposal for a Wellness Recovery Resource Center. Page 1 of this document. The summary has three sections: name of workgroup, summary of community issues and priority populations; and program description.

- Part Two - Full Proposal: Written by the Wellness Recovery Workgroup. Page 6 of this document. This full proposal has seven sections: (i) introduction; (ii) project scope; (iii) program overview; (iv) staffing and facilities; (v) three year implementation timetable; (vi) appendix (Wellness Workgroup participant list and meeting timetable; (vii) attachments (Consumer Conference Summary- April 2005), position paper from Alameda County Family Coalition, Adult Planning Panel roster).

PART ONE: "SUMMARY – WELLNESS RECOVERY WORKGROUP PROPOSAL FOR A WELLNESS RECOVERY RESOURCE CENTER"

This summary has three sections: name of workgroup, summary of community issues and priority populations; and program description.

I. NAME OF WORKGROUP: Wellness Recovery Workgroup

II. SUMMARY OF WORKGROUP COMMUNITY ISSUES & PRIORITY POPULATIONS: This section has two parts: Introduction and Community Issues; and Analysis of Mental Health Needs in the Community.

Introduction

The Wellness/Recovery Workgroup recognized from their first meeting that the scope of their MHSA planning responsibility was broad: framing how to move the ACBHCS from a culture of maintenance and stabilization towards a culture of wellness recovery. All of the MHSA core concepts resonated strongly with this role: cultural competence; client/family driven services (including strong peer support programs and family education organizations); integrated service experiences; wellness/ recovery/ resiliency values permeating all services; and collaborative community. With this in mind, the workgroup recognized in its early meetings in July that "transforming" the system would require a process that would need to be defined by stakeholders and administered through an accountable organization.

Workgroup members generated a list of system-level issues that included:
- The need for a common language of wellness/recovery that would inform the client/provider relationship and our organizational culture (this is a critical first step in creating the kind of dialogue necessary for wellness/recovery system transformation)

- The need for recognizing and collaborating with county and contract organizations that have taken on leadership roles in the provision of wellness recovery services;
- The need for county and CBO business practices that incorporate wellness/recovery in language and policy (i.e. Change reference of "case manager" to "service provider," rewrite service plans to reflect W& R language). This would include a Code of Ethics/Engagement that provides guidelines for how consumers/providers work together
- The need for a leadership core that can collaboratively define wellness and recovery principles and how they might be implemented in the mental health system. This leadership core often takes the form of a task force that reports to the mental health director.

Workgroup members listened to families and consumers, whose feedback was echoed by the providers in the room:

- Consumers and family members are overwhelmed by the myriad of county services and programs, and at a loss of how to access them when in need;
- Poor provision of both family and peer support services for all levels of need from crisis to employment; there's no one to help navigate transitions of wellness, which often leads to relapse; the absence of advocacy and lack of peer and family support in the PES system, intensifies fear and increases isolation for the consumer.

The workgroup proceeded to review the findings from the Consumer Forum (see attachment) that was sponsored by the County and CBOs during Spring 2005. The Consumer Forum asked consumers how they would like to improve the mental health system upon entry, while in transition through levels of care and upon exit. With findings from this Consumer Forum in mind, workgroup members reviewed 7 areas where the mental health system needs to improve its capacity to provide Wellness and Recovery services:

- Treatment (includes medication, case management, crisis, etc.)
- Accessing Services/PES
- Provider Relationships
- Peer and Family Support
- Housing
- Maintenance and Follow-up Care
- Employment, Education and Training

The Workgroup also reviewed a position paper developed by the Family Coalition (see attachment) that made eight recommendations regarding the role of families within the mental health system.

The Workgroup considered the following criteria for program development.

- Programs and best practices should be identified and implemented that support the individual for their level of "wellness" in their entry and exit in system;
- Programs need to support collaborative relationships between Consumers, Providers, and Family members;
- Programs developed need to incorporate a method of continuous improvement, which addresses effectiveness in all services provided;.
- Continue to pursue system-level consumer and family involvement throughout planning, evaluation, and evolution of system transformation;
- Focus on identifying the programs that have highest probability to shifting the system toward Wellness & Recovery.

Programmatically, the vision of the workgroup for the mental health system included:

- Make WRAP (Wellness Recovery Action Plans) available for all clients
- More support for families, create more resources for them to address crisis
- Providing services that are designed to support healing modalities of different cultures

- Incorporate Wellness and Recovery within board and care system; better checks and balance process with board and care housing i.e. inspections, citations, follow up with fines and corrective action
- Communication between Psych emergency services, clinics, board and care, and CSM; Give people more direct assistance and advice while in crisis
- Increase the number of support groups, and self-advocacy groups that increase fellowship and community
- Develop website/800 number where these resources can be accessed.
- Develop a peer organizing model/structure where consumers can learn to create needed programs for themselves

Community Issues: Mental Health Services Act

The Wellness Recovery Workgroup identified the following community issues are germane to their responsibility for identifying programs that will further MHSA objectives:

Homelessness (DMH Issue)**:** Accessible housing was voiced as the most important resource to develop within wellness and recovery oriented programs. Clients can not progress with wellness and recovery without adequate housing. Housed clients need access to services and supports that connect them with the system and assist with recovery. Supportive housing programs need to include peer support and include personnel of diverse ethnic backgrounds.

Treatment : Crisis Prevention. Collaboration with families and consumers is needed to avoid return to hospital settings. Families and consumers are overwhelmed. Programs might include: Stress Motel; education programs regarding awareness of onset (families and consumer); peer support and a Family Crisis/Support Line; development of an alternative assessment process with a home service-rehab focus; increase resources that provide mental health supports that "meet clients where they are" and are strengths based.

Accessing Services**:** Non-Crisis levels of entry needed as options, paired with anti-stigma information. Website, hotlines, service meetings and brochure (network of care, future site) to promote what exists to clients and families, and offered in various languages. Public access TV promoting MH services; some counties already have such a resource, again offered in variety of languages

Peer and Family Support: Peer Support is a critical component of a client's path to wellness/recovery. Clients require peer support to provide the hope required that wellness recovery is possible. Families also benefit from "family to family" contact. Peer support and family support personnel can be used to help clients and family members use and understand the system from hospitalization to work. Peer and family support infrastructure includes a training base that will work to train and support peer and family workers, and consult with supervisors and co-workers to assist with organizational culture changes required for successful collaborative working relationships between clinical staff and non-clinical staff.

Provider Relationships: Programs with a psycho-social emphasis are needed in the mental health system; they promote healing in ways, and are preferred. Improve support between provider/consumer and family outside clinic, other connections. Increase ability of providers to do outreach to homes and communities. Create system guidelines to increase provider's wellness and recovery cultures. Create different levels of care options prior to crisis. Reduce caseloads to allow more time between providers and consumers. Improve accessibility of psychiatrist to consumers to ask questions; even if only 2x per month at sites. Increase use of RN's and other practitioners (PA, LVN)) with intention to improve response time for crisis services. Increase consumers and family as provider, peer support, peer recovery specialist

(b) Analysis of Mental Health Needs in the Community

Unserved Populations

Homeless; Exoffender; Rehospitalized Latino and Asian Communities;TAY: Input from the Wellness and Recovery Planning Panel and from the Criminal Justice and Crisis Panels support that these group are unserved. Prevalence data from the county indicates that TAY, Asian and Latino consumers are served least within the existing system based on statistics from existing programs and services.

Narrative Analysis
Homeless individuals with mental health disorders are least likely to access treatment in the system because they lack the basic access to services that can support basic needs such as housing, health care, etc. Without these essential needs met, they have no access to begin addressing their wellness and recovery goals

The system does not give social service supports to ex-felons. There are no existing supports built into transition plans within prison systems, so individuals are not connected to needed services upon release. These additional barriers prevent exoffenders from addressing their wellness and recovery goals as well as basic needs.

Early release of hospitalized individuals in the unserved group go without transition plans which connect them to health monitoring as well as recovery and wellness resources.

With the lack of services to the Asian and Latino communities there is also a lack of language appropriate services and understanding of the unique issues inherent of those cultures. Wellness and recovery outreach will need to be culturally specific based on input from those groups which has not yet been done.

Transitional Aged Youth are often the most disconnected in accessing services which support their immediate needs of self-sufficiency and independence. Limited providers exist which can connect TAY to age appropriate W & R services which can link them to education, employment and age-appropriate recovery support.

Underserved Populations

Adult Consumers, including TAY, receiving or that have received some service w/in our MH system: Few Wellness and Recovery services or long term support programs exist within the county system once clients are discharged from treatment by report of adult planning panels and mental health administration

Narrative Analysis:
Clients who have been released from mental health treatment rarely transitioned to Wellness and Recovery options because few exist. Since no long-term independent supports are in place, consumers who have been served are at risk of relapse, homelessness and incarceration – this includes consumers of Latino and Asian cultures. These clients are from Board and Care and subsidized housing, many with substance abuse issues and incarceration histories. Without the needed supports from peers, skills training, and employment options, which encourage these adults to make independent decisions about their wellness, they are statistically inclined towards mental

health crisis. Transitional Aged youth also have no specific Wellness and Recovery options available to them when transitioning from the children's to the adult systems of care, also placing them at risk.

III. PROGRAM DESCRIPTION

1. **Proposal Title and Priority Rank:** Wellness Recovery Resource Center. Rank #1

The Wellness/ Recovery Workgroup choose to submit one proposal to the MHSA planning process. In the course of their deliberations, the Adult Planning Panel ranked the five programmatic divisions of the proposal. Please see the attachment "Adult Planning Panel Meeting Record August 31, 2005" for results of that ranking).

2. **Type of Proposal:** System Development

3. **Problem Identification**:
   - The MHSA community issue addressed by this proposal is "Manage Independence." This proposal addresses the issue of how to adequately prepare and train peer support staff who will be hired by the MHSA direct-service projects. This proposal also addresses the issue of working with peer support supervisors and co-workers to ensure that peer provider roles are understood and flourish at work sites. These issues are addressed in the "workforce development" program of the WRRC.
   - The workgroup was given the mandate from the Adult Planning Panel and by the Co-Chairs of the Adult Workgroups to address, in concrete steps, how to move the ACBHCS from a culture of maintenance and stabilization towards one of wellness recovery. This issue is addressed in each of the WRRC's program divisions.

4. Target Population and Rationale

Underserved: Adult Consumers, and TAY including family members for both groups, receiving or that have received some service within our mental health system (Few Wellness and Recovery services or long term support programs exist within the county system once clients are discharged from treatment. Source: Adult Planning Panel discussions and Mental Health Administration presentations)

Unserved: Unserved clients of the MHSA direct-service projects. The Wellness Recovery Resource Center will provide training and technical assistance required to support the role definition and skill set development of peer support personnel hired by the ***MHSA projects***.

5. Program Proposal and Rationale

Synopsis: Wellness Recovery Resource Center (WRRC)

The primary objective of the Wellness Recovery Resource Center (WRRC) is to influence system transformation, providing the leadership, programming and operational consultation required to move ACBHCS from maintenance/stabilization to wellness/recovery. This will be done through the work of the WRRC's five programs, in consultation with its advisory board and under the direction of the Alameda County Wellness Recovery Task Force.

The WRRC will be managed by a .25 FTE Director who will report to a small advisory board composed of a subset of the WRRC collaborative network. A program manager will work with 5

Recovery Coordinators as the main staff support for all five divisions. The larger collaborative network will include organizations affiliating with the WRRC through its program divisions. The active participation of this collaborative network in WRRC programs is an essential component of "system transformation." A synopsis of the WRRC's five programs and their objectives are found below (the full proposal follows):

Workforce Development Program: The objective of this WRRC division will be to support the hiring and training of peer recovery and family support staff. The division will be a major training and technical assistance resource to MHSA direct service programs that are required to hire peer support staff.

Technical Assistance and Training Program : The objective of this program is to bring wellness recovery approaches into contract and county agencies and administrative bodies on a consultation basis.

Family Caregiver Support Center: The Family Caregiver Support Center (FCSC) has two objectives: (i) to develop a resource center that supports families in their understanding of mental illness, to increase their capacity to support their family members who are in the ACBHC system and to increase their ability to help other family members; and (ii) to establish a leadership development group that advises the ACBHCS.

Peer Support On-Site Direct Services (direct service/billing center): The program objective is to provide the kind of wellness recovery supports that empowers consumers to engage in their strengths, manage setbacks, encourages the use of natural supports, and allows for an enhanced life outside their mental health diagnosis.

Housing Support Program: Objective: In collaboration with the ACBHCS Housing Division, to develop a menu of services and supports that will support consumers find housing and keep housing.

The Wellness/Recovery Workgroup recognized from their first meeting that the scope of their MHSA planning responsibility was broad: framing how to move the ACBHCS from a culture of maintenance and stabilization towards one of wellness recovery. All of the MHSA core concepts resonated strongly with this role: cultural competence; client/family driven services (including strong peer support programs and family education organizations); integrated service experiences; wellness/recovery/resiliency values permeating all services; and collaborative community. With this in mind, the workgroup recognized in its early meetings in July that "transforming" the system would require a process that would need to be defined by stakeholders and administered through an accountable organization.

PART TWO - FULL TEXT: PROPOSAL FOR A WELLNESS AND RECOVERY RESOURCE CENTER (WRRC)

This full proposal has seven sections: introduction; project scope; program overview; staffing and facilities; three year implementation timetable; appendix (Wellness Workgroup participant list and meeting timetable; attachments (Consumer Conference Summary- April 2005), position paper from Alameda County Family Coalition, Adult Planning Panel roster).

I. INTRODUCTION – GENESIS OF THE WELLNESS RECOVERY RESOURCE CENTER: A SUMMARY OF THE WELLNESS RECOVERY WORKGROUP'S DISCUSSIONS

Before the program description for the Wellness Recovery Resource Center is presented, we want to summarize, in a few paragraphs, the extensive conversations held by the Wellness Recovery Workgroup, that provided the context for this proposal.

In order for Alameda County Behavioral Health Care Services (ACBHCS) to achieve system transformation, a way must be found to expand its culture from maintenance and stabilization towards wellness and recovery. This shift requires the development of a leadership culture among system stakeholders in addition to a grassroots consensus building process. The latter can be initiated through the efforts of a Wellness Recovery Task Force. A Wellness Recovery Task Force works with stakeholders to identify a wellness recovery language common to a mental health system, and to identify a strategy and blueprint for system re-design. The value shift from maintenance and stabilization towards wellness recovery is evident as providers become allies to the recovery process of consumers, and in an expanded range of clinical and non-clinical services that include easily accessed transitions and exits.

A critical part of wellness recovery oriented mental health system is often a Wellness Recovery Resource Center. Alameda County will be organizing its Wellness Recovery Task Force in the next quarter, and will be cultivating leadership from all corners of the delivery system to develop the language, vision and blueprint that is appropriate to this county.

The MHSA Adult Planning Panel convened a Wellness Recovery Workgroup that has gathered consumer, family member and provider leadership to identify a range of strategies that can be used to incorporate wellness recovery programming into the delivery system. Acknowledging that this process needs to be fully developed in the context of a Wellness Recovery Task Force, the Wellness Recovery workgroup feels confident that the following `Wellness Recovery Resource Center' proposal includes program components that will be important in the pre-task force phase.

This proposal describes a WRRC that includes a small advisory board and five divisions. The last section of this proposal includes an implementation timeline.

Clients Served: This program will provide direct services to approximately 500 individuals per week (50 people per week, in individual sessions and group trainings, for each of 10 direct service FTEs). Much of the WRRC's programming will focus on system transformation.When fully operational, and depending on the forum, the WRRC could influence several hundred additional people each week via: speakers bureaus, staff training for agencies, collaborative meetings, or WRRC trained consumers who sit on boards and commissions.

Operating Definitions Supporting System Change

The following definitions come from workgroup discussions.

1. "Recovery" = One's individual and ongoing process of illness to wellness, where the intent is to improve our lives, create a spiritual shift, become empowered, become self-aware, engage in meaningful activity, and claim the blessings received from what we've been through.
2. "System of Care" = Includes family members, friends, peer advocates and providers.
3. "Support Services" = Providing wellness and recovery support services, outside of direct treatment, which will enhance a person's quality of life and facilitate their personal identification as other than "client".

II. PROJECT SCOPE

The Wellness/Recovery Workgroup recognized from their first meeting that the scope of their MHSA planning responsibility was broad: framing how to move the ACBHCS from a culture of maintenance and stabilization towards one of wellness recovery. All of the MHSA core concepts resonated strongly with this role: cultural competence; client/family driven services (including strong peer support programs and family education organizations); integrated service experiences; wellness/recovery/resiliency values permeating all services; and collaborative community. With this in mind, the workgroup recognized in its early meetings in July that "transforming" the system would require a process that would need to be defined by stakeholders and administered through an accountable organization.

The Wellness and Recovery Resource Center (WRRC) will be positioned as a "resource hub" for all five regions of the mental health system. The WRRC will enter into collaborative relationships with county and contract programs who want to start or expand wellness and recovery services. The WRRC will develop training materials and methods and then disseminate wellness/recovery approaches to organizations in all five geographic regions of the county. Its primary role will be to provide education, training and consultation, although it does have a direct service component. The WRRC will provide assistance to county and contract providers, family members, consumers and decision makers throughout the ACBHCS system. The WRRC incorporates five programs, including one designed in collaboration with ACBHCS families.

The WRRC will support system transformation in three ways:

1. Provide consultation, training and technical assistance for **providers and administrators** in County Operated and Community Based organizations who wish to strengthen the wellness/recovery orientation of their work-sites. To provide outreach services and training to organizations providing services and supports in the five geographic regions of ACBHCS. This consultation will include services spanning entry into the system, transitional services and exits (ie. from psych emergency through supportive education and vocational services)

2. Provide worksite training for **consumers and family members** who work as peer support staff and family support staff within the mental health system. This work will include consultation with supervisors and co-workers. Test and develop training curricula and implementation methods in wellness recovery and organizational change.

3. To provide direct billable service to consumers who are located in the geographic region served by the WRRC.

III. PROGRAM OVERVIEW

The Wellness Recovery Resource Center is made up of five programs and an advisory board. The five programs include: Workforce Development Program (including a project oriented to training peer support personnel hiring by MHSA direct service projects); Technical Assistance and Training Program; Family Caregiver Support Center; Peer Support On-Site Direct Service Program; and Housing Support Program.

The WRRC will be managed by a .25 FTE Director who will report to a small advisory board composed of a subset of the WRRC collaborative network. Organizations with membership on the advisory board will have demonstrated a capacity to operationalize wellness recovery and cultural competence in their

day-to-day business practices. The advisory board and will meet with the Center Director and Manager monthly. It focus is operational: to discuss progress, program plans for ongoing system transformation, and outreach and marketing strategies.

The larger collaborative network will include organizations affiliating with the WRRC through its five divisions. Network members will include a wealth of experience and knowledge and as a group, have a range of expertise in providing wellness and recovery in culturally competent settings. The active participation of this collaborative network in WRRC programs is an essential component of "system transformation." A high priority will be the participation of county and contract consumer managed agencies and programs including BESTNOW and PEERS.

Supervision, staff training and monitoring will be the responsibility of a Program Manager. Outreach and on-site services will be provided by paid WRRC staff and a collaborative network of county and CBO providers, Peer Run Organizations and Family members.

WRRC's Five Program Divisions: Objectives and Brief Descriptions

A) Workforce Development Program

The objective of this WRRC division will be to support the hiring and training of peer recovery and family support staff. The division will be a major training and technical assistance resource to MHSA direct service programs who are required to hire peer support staff.

For non-MHSA programs, the provider and the WRRC staff will collaborate on defining job roles that are consistent with wellness/recovery philosophies.

- 10 FTEs (20 workers) that are paid for through the WRRC budget will be placed in agencies where they will have permanent staff roles as "peer recovery specialists" that culturally and linguistically reflect client and family backgrounds. These staff will have the following duties: peer support, facilitating peer recovery groups and on-call peer outreach. These workers will be hired by the agency they will be supporting and will train and receive supervision and support at the WRRC as well as with their home agency. These outreach workers need to be hired in pairs and would be asked to work 20 hours per week. They will provide general and crisis support services, facilitate wellness recovery groups, and provide multi-disciplinary staff input at the agencies they serve. They may also provide home-visits to families who need additional support for their family members.

Non MHSA organizations who apply for peer support positions will be selected using the following criteria:

- Current capacity in incorporating wellness/recovery programs and practices in their agencies.
- A statement of their willingness to commit to an ongoing collaboration with the WRRC to continue the transformation of their agency. This commitment will include willingness to create structured support to Peer/Family providers, allow ongoing access of training (on and off-site) and process for both management and professional staff, and agree to include WRRC programs as program options to their consumer base.
- An agreement to join in the effort of system transformation by extending staff and management for committee work and program development.

- WRRC Program Manager (I FTE) senior staff will collaborate with employers to develop job descriptions and hiring procedures that are cohere wellness recovery principles. They will also provide orientation for co-workers and supervisors of peer support staff.

- *This WRRC program will also be the "home" for training and support for the Peer Support staff hired by the MHSA direct service projects.* 1 FTE Recovery Coordinator will be assigned to the MHSA component. The WRRC will provide a support group for the MHSA peer support staff as well as consultation and training at the MHSA sites. This consultation and training will be developed in collaboration with the employer. Job descriptions and interview protocols for hiring of peer support personnel will be offered to the MHSA sites.

B) Technical Assistance and Training Program

The objective of this program is to bring wellness recovery approaches into contract and county agencies and administrative bodies on a consultation basis.

Providers of the system will need access to training and consultation in order to adopt business and clinical practices that create a shift towards wellness and recovery. New business and clinical practices may range from writing treatment plans that include wellness and recovery practices to participating in multi-disciplinary consultation groups with consumer and family providers along with professional staff, assistance with implementing a provider code of ethics that assists staff and clients in efforts to be in alliance with one another, and taking tours of other programs that are currently successful at integrating W&R into their work.

WRRC staff will meet with organizations and collaborate to assess their current wellness and recovery orientation and design a consultation which will lead to improved wellness recovery outcomes for clients. This consultation will be based on "best practices" identified by SAMSHA and organizations that have researched methods of facilitating organizational change towards wellness/recovery.

1 FTE "Recovery Coordinator" will be assigned to this program and will work with the staff and consumers of county and contract agencies. This consultation will also include on-site direct service training for consumers and family members who work within the mental health system.

A provider consultation team will be also be implemented to provide support organizational and cultural change for providers. The goal of this team is to improve skills, provide an outlet for addressing the challenges with a changing system, and share resources. A "train the trainer" model will be used; peers train peers and manager will train managers.

The Training and Technical Assistance Program will include an *education and training component* that will develop and coordinate speakers bureaus made up of consumers, providers and family members. Speakers bureaus will developed from existing programs (i.e. stamp out stigma). This program will also provide the training and technical assistance required to implement Wellness Recovery Task Force recommendations which may include updating business practices to incorporate wellness recovery orientation (i.e.: contract monitoring, supervision protocols, implementation of a peer provider code of ethics, and new staff training).

C) Family Caregiver Support Center

The Family Caregiver Support Center (FCSC) has two objectives:

- To develop a resource center that supports families in their understanding of mental illness, to increase their capacity to support their family members who are in the ACBHC system and to increase their ability to help other family members; and
- To establish a leadership development group that advises the ACBHCS.

The Family Caregiver Support Center (FCSC) program is a new initiative that has been developed by the Family Coalition that will provide outreach, education and support to the families of people with mental illness. This families-operated program will assist those caring for a child, adolescent, adult or older adult with mental illness. By assisting these caregivers, FCSC will play a critical role in helping families to cope with and to be able to care for a mentally ill member. This will help avert out of home placement, unnecessary hospitalization and homelessness. By giving families timely access to system resources, treatment will begin earlier, resulting several positive outcomes, including reduced severity of illness.

The Family Caregiver Support Center was designed as a reaction to the following concerns of ACBHCS families:

- a need for the orientation of new families into the BHCS, public education and other relevant service systems, particularly around the crisis of "first breaks";
- a need for the encouragement and support of family partnership, participation and involvement; and education of families (including information about resources, housing, interventions, coping, mental illness, medications, etc.)

The intent is to have the FCSC be transgenerational; the center will serve the family caregivers of persons of all ages with SMI or SED. In addition, the FCSC would strive to be culturally competent and linguistically accessible, by hiring staff with background that reflect the service population and through collaborations with agencies and programs that specialize in serving individuals from different cultural and linguistic backgrounds.

Two options for administrative auspice of the FCSC include: the FCSC would be an independent division of the Wellness Recovery Resource Center; OR the FCSC would have the WRRC or another agency be it's financial fiduciary.

It is critical that the administrative home for the FCSC enable it to maximize its role as a transformative agent for the entire mental health system. Under any of these scenarios, the WRRC would have a seat on the advisory board to the WRRC and will work closely with existing services in ACBHCS, such as the ACCESS program. The vision of the FCSC also includes strengthening the family to family support resource that is now minimally financed through NAMI and other sponsors. Under this vision, the FCSC would substantially increase the family support group network throughout the county. At the same time, the FCSC would collaborate closely with county and contract agencies. This collaboration would involve: providing staff with orientation about how use family members as a resource; giving staff information about the family support groups, to ensure timely referral into this valuable resource.

Specific services will include:

1) Telephone information line would be operated during hours when working families would be most likely to use a phone information line. (Exact hours and days of operation will be identified when funding is in place and a management team can assess the optimum hours). This phone line would be considered a "warm line", rather than a crisis line, and would respond to questions about resources, education, support groups, etc. It would be staffed by trained professionals. (It might be considered a "case management" advisory service for those families who don't have access to such BHCS services).

2) Educational training programs, along the lines of the comprehensive NAMI-sponsored Family to Family training classes and classes offered by UACC. The 12-week, 30-hour Family to Family classes could be modified to be accessible to a broader range of families in terms of length, level of content, etc. Funds to pay for room rental and material copying would be included in the budget. Volunteers would continue to teach some of the courses, as appropriate. FCSC will conduct trainings in various areas (east, south, central and north) of the County for family caregivers; training would include locally designed courses, designed to meet the specific needs of Alameda County's caregivers.

3) Resource center (along the lines of a one-stop shop) to contain wide range of informational materials - across all access venues. This could include development of new appropriate materials as needed. A library with a wide range of informational materials, including pamphlets and books as well as audio and videotapes. FCSC will also produce guides to facilitate access to these materials, such as annotated bibliographies. FCSC will develop new educational materials specific to Alameda County services to help families orient themselves.

4) Assistance to families in their role as caretakers in providing pertinent historical information (ala AB 1424) about their ill family member to mental health care providers. Since FCSC is a new initiative, BHCS will ask all of its providers to display information about the program where family caregivers are likely to see it. FCSC staff and volunteers will work with BHCS on staff training.

5) Use of family member volunteers, as possible, to promote FCSC services, provide a regular presence at BHCS programs and public school sites, and participate in FCSC program maintenance and outreach.

6) Assist family members who are advising or seated on ACBHCS decision making bodies.

D) Peer Support On-Site Direct Services (direct service/billing center)

The program objective is to provide the kind of wellness recovery supports that empowers consumers to engage in their strengths, manage setbacks, encourages the use of natural supports, and allows for an enhanced life outside their mental health diagnosis.

This revenue generating program will also function as place to train new peer recovery staff in facilitating WRAP groups and other wellness recovery groups, in providing peer recovery services and other wellness services. New curricula to be disseminated through other WRRC programs can be tested in this direct service center.

Te beginnings of a peer recovery network will be based in this division under the program manager and managed by 1 FTE Recovery Coordinator. Volunteer peer recovery staff will work in the direct service unit, and will provide a base to encourage the “collaborative network” to train and use peer recovery volunteers.

This program will primarily serve the geographic region where the WRRC is located. This program will include a variety of wellness recovery support services that are based on “best practices.”

A sample of services provided through this program might include:

Peer Recovery Meetings
WRAP Training
Benefits Consultation
Meds-Only Consult
Peer Advocacy and Support
Clinical Targeted Support Groups
Dual Diagnosis Group
Cultural Specific Support Group
Spirituality Support
Gay and Lesbian Support
Adult Education – literacy, ESL
Community College Support
Employment Services and Referral

Skills Building Classes:
- independent living (life skills)
- interpersonal relationship
- money management
- time management
- employment readiness
- nutrition and exercise
- crafts

Referral Process: Consumers and family members may participate in the W&R Center services in a number of ways:

1. Self-referral to center
2. Participate at a community location or home agency
3. May be referred by clinical staff

E) Housing Support Program

Objective: to provide services that place and support consumers in housing programs.

The need for this program came up over and over again in Wellness and Recovery Workgroup discussions. However, the same topic was also addressed by the MHSA Homeless and Housing Workgroup. This proposal design presents a collaboration between these two workgroups of the Adult Planning Panel. This program will be implemented in partnership with BHCS administration, the MHSA Homeless and Housing Workgroup, and the Alameda County Special Needs Housing Plan and the Continuum of Care Council.

1 FTE Recovery Coordinator would address wellness recovery in residential care and board and care facilities. Specifically:

Improvements/Expansion in Residential Care facilities

- Involve consumers and family members in the oversight of the facility expansion and improvement efforts, including quality review of housing sites.

Develop mechanisms for improving existing Board and Care

- Develop a clear inventory of the existing board and care homes, including numbers served and current conditions
- Work with the rest of the Department to improve licensed Board and Care .
- Work with Wellness and Recovery Group to have peers and family members who can go into the Board and Care setting.
- Provide ongoing training and support to Board and Care homes in order to improve the quality of care and support the continued operations of the homes. Survey Board and Care homes about their training needs as a first step.

1 FTE Recovery Coordinator will be a housing ombudsman and manage the following functions, in collaboration with 2 FTE Peer Support Staff (all staff will have expertise in housing issues in addition to wellness recovery) - to develop a system of centralized housing information and to provide assistance to clients, providers and family members who are trying to find housing. Specifically:

Develop Housing Centralized Housing Information System

- *Website and Handbooks* (content would also be available on the website):

Training/Housing Retention Support . A comprehensive training approach to improving housing outcomes will include:

- Training for case managers/services providers on the fourteen service teams that do not have housing expertise
- Training for consumers.
- Training for housing providers.

IV. STAFFING AND FACILITIES

This section includes two staffing patterns. One for the Family Caregiver Support Center and one for the other four programs of the Wellness and Recovery Resource Center

The staffing pattern of the Wellness and Recovery Resource Center will include 20 FTEs:

- **.25 FTE** Agency Director: Has general oversight of program
- **1 FTE Program Manager**: Hires, trains and supervises staff, monitors and coordinates services, initiates outreach to the community
- **1 FTE Clerk**: Supports the administrative operations of the WRRC
- **.5 FTE Psychiatrist**: Does medication counsel and prescribes, provides family and consumer consultations and groups
- **2 FTE Counselors:** Open consumers to program, develops and maintains wellness and recovery plans, suggests options, documentation of consumer participation, minimal case management of 150-200 cases per counselor
- **5 FTE Recovery Coordinators**: (PT or FT) Are teachers with ability to develop and write curriculums, teach specific target programs, can facilitate groups and market concepts, have worked or have personal experience with wellness and recovery. Each Recovery Coordinator will be dedicated to one of the five WRRC programs.
- **10 FTE (PT) Peer Support Staff and Family Support Staff:** These peer support and family support staff will be chosen by County and Contract providers that wish to have trained peer support staff on-site to assist consumers and family members. These staff will receive group supervision and training at the WRRC in addition to that of their home agency. These workers will have 20 hour per week positions, making this 10 FTE allocation generate 20 jobs.
    - 8 FTE Peer Support Staff. Duties and skills may include:
        - role models of wellness and recovery,
        - may have special areas of expertise i.e. work with youth, older adults, families, crisis experience, etc.
        - they can assist consumers to identify and attend recovery meetings, help with acquiring essential documents (ssi card, birth certificates, id), travel training
        - provide peer recovery groups
        - provides on-call outreach services as needed i.e. goes to John George to provide peer support
        - May be consumers or family members
        - Will have language capacity to meet the needs of the community they work i.e. Spanish speaking, Chinese
    - 2 FTE Family Support Staff. Positions will be developed in collaboration with the FCSC division. Duties and skills may include:
        - Role models of wellness and recovery
        - Provide support and referral to other families
        - Marketing and outreach to community to increase awareness of service availability
        - Provide family support groups
        - Participate in provider education
        - Provides on-call outreach for families in crisis
        - Will have language capacity to meet the needs of the community

The staffing pattern of the Family Caregiver Support Center includes 5 FTEs.

The FCSC will have a 5 person staff and will enlist volunteers to help conduct and to advise the program. Volunteers will be recruited and trained to: reach out periodically to mental health and other health care providers to promote the service; provide a regular presence at the main acute and crisis mental health programs; conduct educational/ training programs for families; operate the telephone information line; and participate in community education and stigma reduction efforts, such as the MH Board's Public Awareness Committee.

The family advocate staff listed in the WRRC above will coordinate closely with the FCSC, however the family advocate positions will be funded through the main WRRC budget.

Estimated annual cost of FCSC is approximately $400,000. About 75% of this would be for staff salaries. Staff will include:

- 1 FTE: program director;
- 1 FTE: volunteer coordinator/trainer;
- 2 FTE: information line workers;
- 1 FTE: secretary/receptionist.

Facilities

The space selected for the Wellness Recovery Resource Center should be roughly 5,000sf, have office or cubicle space for workers permanently assigned, and 3 group/classroom spaces. Location should be central county, and easily accessible to public transportation.

The Family Caregiver Resource Center will be located at a space separate from the WRRC. It will consist of roughly 1,000 sf and have office or cubicle space for permanent workers and one group/classroom space. The FCRC will be located separately from the WRRC and be accessible to public transportation.

V. THREE YEAR IMPLEMENTATION TIMETABLE

Year I (Wellness Recovery Task Force is recruited and organized by ABHCS Administration in Collaboration with Consumer and Family Representatives).

- WRRC hires enough staff to sets up infrastructure: WRRC hires agency director; program manager; clerk; 1 counselor; five recovery coordinators (5 – one to jumpstart each WRRC division), 1 peer support staff, 1 family support staff.
- Develop curriculum for outreach services;; sets up collaborative network and advisory board
- Works with Wellness Recovery Task Force to complete system assessment: identify system strengths in wellness recovery
- Start up of Workforce Development program for MHSA agencies (staff hiring, training, and worksite development)
- Start up of Housing Program
- Start up of Family Caregiver Resource Center

Year II:

- Start up of Workforce Development program for contract agencies.
- Start up of Training and Technical Assistance
- Start up of Peer Support On-Site Direct Services
- Implementation of Year 1 Start-ups

Year III

- Start up of Workforce development for county agencies.
- Implementation of Year 2 Start-ups

6. **Outcomes**
   - o By the end of year 3, 10 MHSA and non MHSA providers have 20 peer support staff who report high job satisfaction.
   - o By end of year 3, ACBHCS has an established speakers bureau program
   - o By end of year 3, the Family Caregiver Support Center is supporting the work of at least five support groups in every geographic region of the county
   - o By end of year 3, it is standard business practice for every service team to refer clients to housing and vocational programming

7. **Program Budget Summary or Detail - *(BHCS Finance Financial Template)***

a.	Client, Family and Caregiver Support Expenditures:	$ 69,900
b.	Personnel Expenditures with Staffing Detail:	$589,226
c.	Operating Expenditures:	$297,638
d.	Program Management (5% of total costs)	$ 50,058
e.	Estimated Revenues: (peer support on-site program)	(303,784)
f.	One time and Capital expenditures:	$ 44,400
g.	Total Funding Requirements	**$707,438**

VI. APPENDIX

A) MHSA Adult Planning Panel: Wellness Recovery Workgroup Participants

Participant Name	Organization Represented (Management or direct-service staff?)	Consumer? (Y/N)	Family-member? (Y/N)	Ethnicity
Theresa Razzano	Management – ACVP	N	N	White
Katrina Killian	Manager – Best Now	Y	Y	Black
Margaret Walkover	Manager – BHCS	N	Y	White
Millie Alvarez	Manager – BACS	N	N	White
Khatera Aslami	Manager – Villa	N	Y	Middle Eastern
Steven Bucholtz	Provider – ACVP	Y	N	White
Carla Danby	Manager – Support Centers	N	N	White
Margo Dashiell	Family Member	N	Y	Black
Bob Gilden	Provider – Alameda Sup	N	N	White
Noriko Inagaki	Provider – Asian MH	N	N	Asian
Darwin Price	Provider – DOR	N	N	White
Andre Reyes	Manager – PEERS	Y	N	Hispanic
Phyllis Sakahara	Manager – BOSS	N	N	Asian
Tep Sauyuth	Provider – Asian MH	N	N	Asian
Marion Simpson	Family Member	N	Y	White
Don Vierra	Provider	Y	Y	White
Marcie Ruble	Provider – La Familia	N	N	White

B) Schedule: Community Meetings and Workgroup Meetings

Wellness and Recovery Community Meeting	**Thursday 6/9/05**	**6:00 PM – 8:00 PM**
Wellness and Recovery Community Meeting (and Work Group Meeting)	**Thursday 6/23/05**	**1:00 PM – 3:00 PM**
Wellness and Recovery Community Meeting	**Thursday 6/23/05**	**6:00 PM – 8:00 PM**
Wellness and Recovery Community Meeting	**Thursday 7/21/05**	**6:00 PM – 8:00 PM**
Wellness and Recovery Work Group	Thursday 5/19/05	1:00 PM – 3:00 PM
Wellness and Recovery Work Group	Thursday 6/9/05	1:00 PM – 3:00 PM
Wellness and Recovery Work Group	Thursday 7/7/05	1:00 PM – 3:00 PM
Wellness and Recovery Work Group	Thursday 7/21/05	1:00 PM – 3:00 PM
Wellness and Recovery Work Group	Thursday 8/4/05	1:00 PM – 3:00 PM
Wellness and Recovery Work Group	Thursday 8/18/05	1:00 PM – 3:00 PM

VI. ATTACHMENTS

- Alameda County Mental Health Consumer Conference Summary; April 20th, ,2005

- A Statement of Concerns by the Alameda County Family Coalition for Mental Health July 2005; "To Be Addressed: Issues in the Treatment and Care of Clients in Alameda County"

- Adult Planning Panel Roster

ALAMEDA COUNTY MENTAL HEALTH CONSUMER CONFERENCE SUMMARY

April 20, 2005 – Oakland, California

I. INTRODUCTION: CONFERENCE PURPOSE AND AGENDA

A consumer conference was held on April 20, 2005 in Oakland to provide input into the planning process for Alameda County's response to the Mental Health Services Act (MHSA) of 2004. MHSA, also known as "Proposition 63," mandates that consumers have a voice in designing programs that will transform the mental health system.

With this in mind, *the goal of the conference was to provide Alameda County mental health consumers with the opportunity to share ideas and recommendations regarding:*

- *Overall mental health system transformation*
- *Services resources and supports needed to support consumer mental health wellness and recovery*

Support for the conference was provided by Building Opportunities for Self Sufficiency (BOSS), Bay Area Community Services (BACS) and the Alameda County Behavioral Health Care Services.

Over two hundred consumers attended the day-long conference, whose theme was identifying improvements needed to ease or reduce entrance into the Mental Health System of Care, facilitate recovery and support exiting the system.

Participants were divided up into small groups and asked three questions:

- *Question 1*: What system changes, services, programs and supports at the ENTRY to the mental health system would support improved wellness and recovery for consumers?
- *Question 2*: What system changes, services, programs and supports in the ON-GOING SERVICE DELIVERY SYSTEM would support improved wellness and recovery for consumers?
- *Question 3*: What system changes, services, programs and supports to support EXIT to the mental health system would support MAINTENANCE OF wellness and recovery for consumers?

The summary below presents ideas and recommendations from the consumer community regarding what it would take to transform the Alameda County Mental Health System.

II. SUMMARY OF IDEAS AND RECOMMENDATIONS

The results of the consumer conference are presented below in two sections. The **first section** presents topics that surfaced in each of the three questions. These topics included: housing, education and training of staff/ community; support services; alternatives to hospitalization;

mental health practitioners and case managers; self-empowerment; family integration; communication; and accountability. The **second section** summarizes verbatim answers to each question.

A) Topics Addressed by Consumers Answering all Three Questions

Topics common to answers given in each of the there questions included: housing, education and training of staff/ community; support services; alternatives to hospitalization; mental health practitioners

and case managers; self-empowerment; family integration; communication; and accountability. Details are found below:

Housing

1. More Section 8 housing funds and access.
2. Housing accessible to transportation corridors.
3. Safe housing in decent neighborhoods.

Education and Training of Staff / Community

1. Intensify publicity campaigns to educate the public on mental illness with the objective of reducing labeling, stigmatization, and job discrimination.
2. Increase education for consumers on resources and how to access.
3. Increase provider staff knowledge of available resources for productive service referrals. Provider staff should use checklist with consumer to ensure all resources are covered.
4. Emphasize recovery model and provide more provider training in this model; test and audit providers annually to ensure model is understood and followed.
5. Increase medical doctor sensitivity to those with addiction and/or MH issues.
6. Improve differentiation between individuals with MH issues only and those in the criminal justice system who have MH issues, particularly dual diagnosed.
7. Increase the number of programs and counselors trained to work with violent individuals.
8. Train staff and clients together to provide input on adequacy/accuracy of material and/or have consumers lead the training.

Support Services

1. Increased availability of medical, dental, and optical services for the un- and under-insured.
2. More peer counselors (consumer role model) at all stages of process.
3. Liaison advocates and/or personal assistants to facilitate access to and procurement of services and assist in continuing access. Advocates can be peers. Advocates can be at centers or home-visit. Must have some authority to reduce the run-around for those not on Medi-Cal.
    a. Medical services, including MediCal enrollment.
    b. Benefits (VA, SS, SSI, GA, etc.)
    c. Education.
    d. Jobs.
    e. Bankruptcy proceedings and legal advice.
    f. Chronic physical and visual problems.
    g. Services for seniors with special issues.
    h. Memorial/burial support.
4. Grants for those transitioning to GA, SSI, SSDI as cushions for the long waiting periods.
5. Training and transportation subsidies to train for living wage employment.
6. Make locating of resources and patient application to those resources more Internet integrated so consumers can do more on their own.

Alternatives to Hospitalization

1. Resource facilities/community centers with '800' number or hotline that is easily accessed (location, 24-hour) with case managers, medical services, referral services, entertainment vouchers, socialization, recreation/exercise, and transportation resources available. Allow peers to manage some of these services. Peers include war veterans, those with criminal justice histories, etc.
2. Access to psychiatrists via hotlines.
3. Provide support group services and facilitation at homeless shelters.
4. Facilities for short-term stress relief that include sleeping accommodations.
5. Anger management training.
6. Wellness training through out-patient programs.

Mental Health Practitioners and Case Managers

1. More practitioners available for evaluations and medication prescriptions.
2. More frequent evaluation/re-evaluation for medication dosage.
3. More case managers with lower case loads.
4. Better access to psychiatrists particularly for patients without health insurance or MediCal.
5. Increase pay to attract more case managers and psychiatrists.
6. More case managers and psychiatrists who are multi-lingual.
7. More condition-related services, i.e. services specifically for those hearing voices or who are combative or seriously mentally challenged.
8. Provide staff "real life" experiences by having them visit homeless shelters, soup kitchens, etc.
9. More staff to provide one to one counseling and support services.

Self-Empowerment

1. Consumers should help design their own recovery programs and be part of the entrance, treatment, and exit strategy.
2. Ombudsman/advocate to assist patient in changing treatment methods or assigned doctors, case managers, etc.
3. More volunteer or job program opportunities.

Family Integration

1. Improve communication between Child Protective Services (part of Children and Family Services) and Mental Health to support family well-being and integration. Provide patients with advocates to assist with their interactions with CPS
2. Ensure family is involved and knows what's happening at all stages of the process.
3. Increase family counseling services and provide more therapy that includes the family and patient together.

Communication

1. Improve communication between service providers to ensure client's care is consistent when seeing more than one provider.

2. Communications to the public, medical practitioners, case managers, and other entities involved in the MH system of care should be developed and/or reviewed by client peer groups.
3. More consumer input at every level.

Accountability

1. Ongoing political analysis of systemic problems.
2. Watchdog oversight.
3. Political organization for those who have experienced the MH system.
4. Independent mediator/enforcer to evaluate services/programs.
5. Client feedback on their own assessments, services provided, etc.
6. All agencies coordinating the provision of services should have client advisory committees.
7. Consumer driven performance measures that reflect patient well-being, self-determination and self-empowerment.

B) Answers to Individual Questions Regarding Entry, Treatment and Exit.

QUESTION 1: What system changes, services, programs and supports at the ENTRY to the mental health system would support improved wellness and recovery for consumers?

Answer:

- **Education and Training of Staff / Community**
  1. Sensitivity training for front line staff in provider and county mental health organizations regarding talking with individuals who have mental illness. (“Treat us like everyone else.”)
  2. Train law enforcement to better assess extent of person’s mental issues before deciding on involuntary confinement. Separate units in jails for those with addictions and those with MH issues.
- **Outreach**
  1. Contact homeless on services available with presentations at the street level.
  2. Ample advocates, easily accessed, to champion and support the patient at the first rejection (Medi-Cal, SSI, etc.) to prevent ending up on street.
- **Alternatives to Hospitalization**
  1. More crisis centers, crisis hotlines, and mobile crisis teams.
  2. Detox centers for the dual diagnosed that have MH assessment services on site that can be used without the person being involuntarily confined for evaluation (5150’d).
  3. Ensure law enforcement knows about alternative services, hotlines, etc. Reduce John George confinements from law enforcement activities.
- **Mental Health Practitioners**

1. Accurate diagnosis at the beginning of treatment. (Editor Note: Some method to verify, by practitioner, initial diagnosis was correct?)

- **Communication**

1. Map of services and where the client fits in so clients will understand "What's going to happen to me?"

QUESTION 2: What system changes, services, programs and supports in the ON-GOING SERVICE DELIVERY SYSTEM would support improved wellness and recovery for consumers?

Answer:

- **Housing**

1. More Transitional/Independent residential programs such as Transitional Living Centers (TLC), Supported Independent Living (SIL), and Center for Independent Living (Berkeley CIL) that have real supervision, not "just be good."
2. More clean and sober living facilities with structured/creative activities on the premises.
3. More homes that have school/educational facilities for SED youth and teens.
4. More licensed Board and Care with improved oversight such as:
    a. More attention to activities and programs offered.
    b. More thorough inspections.
    c. Reduce charges so patients have some SSI or other benefits available for personal needs.
    d. Better management of residents to prevent violence.
    e. Definition of acceptable meals to provide for special nutritional needs, i.e. vegetarians.
5. Increase residential time allowances to allow patient time on a case by case basis.

- **Transportation**

1. Free or reduced fee bus cards.

- **Services**

1. More dual diagnosis treatment and recovery funding.
2. Integrate mental health services into addiction recovery programs.
3. Move extended day care services from three-day to five-day programs.
4. Vouchers from businesses for recreation and social events.
5. Inter-disciplinary teams, including drug counseling programs, should have a peer (inside experience) counselor/participant.
6. More creative activities at recovery programs.
7. Increase group counseling and creative activities at acute hospital-level care facilities.

- **Mental Health Practitioners**

1. Provide alternative forms of treatment such as acupuncture, medical marijuana, vitamin therapy to keep medications to a minimum.

2. More humane treatment of patients. (Don't treat like guinea pigs, don't treat like they're always on probation.)

- **Family Integration**
  1. Space and services for families to have family time while a family member is in treatment.
  2. Support services for children of adults in treatment.
  3. Ensure communication between agencies providing support services and integration of those support services for adults and children in a family.
  4. Consider the family as a unit during the treatment program.
  5. Emphasize treatment and training for resiliency, healthy relationships, and handling conflict.

QUESTION 3: What system changes, services, programs and supports to support EXIT to the mental health system would support maintenance of wellness and recovery for consumers?

Answer:

- **Housing**
  1. Ongoing aftercare half-way houses, particularly following a residential care program.
  2. Halfway housing available for longer than six-months.
  3. Expanded shelter facilities for homeless.
  4. Grants for those transitioning from SIL's to independent housing such as more Section 8 or move-in grants (deposit, first and last month's rent).
- **Education and Training of Staff/Community**
  1. Identify "success" and "quality of life" to ensure person is really stabilized.
- **Outreach/Jobs**
  1. Educate employers and provide incentives for hiring people with MH issues at living wages.
- **Services**
  1. More programs such as Job Consortium to find jobs/re-enter workforce.
  2. Expansion of vocational rehab and other training programs.
  3. Education on running a small business and support for starting small businesses so consumers can have more opportunities for training or starting a business themselves.
  4. Back to school programs.
  5. Training on money management, social functioning, time management, goal setting, mentoring.
  6. Hire consumers as consultants to programs such as training, running community centers, etc.

7. Support groups run by peers to provide ongoing support for maintenance or relapse. Alumni visits to share experiences, encourage improvement.
8. Support systems (groups, housing, socialization, etc.) geared to special needs, i.e. those without family or those estranged from family, seniors, transition age youth, etc.
9. Require weekly check-ins for those who've exited a program to ensure follow-up and provide role models for those still in system.

- **Mental Health Practitioners**

  More follow-up by case managers to prevent/reduce re-entry to the system. More programs like Shelter Plus Care that require case management.

  1. Collaboration with social services to ensure continuation of social services and mental health services as needed after re-entry to work force.

To Be Addressed: Issues in the Treatment and Care of Clients in Alameda County

A Statement of Concerns
by the Alameda County Family Coalition for Mental Health

July 2005

What is the Alameda County Family Coalition for Mental Health?

The recommendations below flow from collective brainstorming of family caregiver-advocates, organized under the banner of the Alameda County Family Coalition (ACFC*). The Coalition is comprised of representatives of family support groups throughout Alameda County and from the two local affiliates of the National Alliance of the Mentally Ill. In all cases, the representatives of these groups have been active advocates for their own family caregivers. Most also have significant volunteer histories as teachers of a curriculum geared to family understanding of mental illness, or as facilitators of support groups. Caregiver organizations provide referrals, plan informational meetings on the myriad aspects of care necessitated for those appreciably disabled by mental illness, and advocate on behalf of clients and their families.

Many of the family caregivers represented by the ACFC are related to people who are, at present, challenged significantly by the maladies that they face and are not at a stage where they can live independently. Cognitive impairment or delusional thinking, temporary or long-term, can lend itself to negligence or endangerment of self or others. Vigilant family caregivers know what they need to maintain stabilization, help improve the chances of recovery or to prevent decompensation; they also know how difficult it can be to find adequate partnership in the process of locating good diagnostic, crisis, treatment, or housing services. The ACFC hopes, through the MHSA process to win respect and support from the mental health establishment.

Process for Developing Recommendations

The ACFC met over two Saturdays, specifically to download its collective experience--both personal and as volunteers-about crucial needs of family members at key phases of severe mental illness. And while the group probed its memory to capture critical information about what is optimal for offsetting the progression of illness, stabilizing people and aiding recovery, it did not rely on memory alone. Many representatives came from groups that already had gone through a process of identifying important family or community needs, so they arrived at the sessions with prepared priority lists. The meetings were facilitated by Martin Paley and recorded by Amy Graybeal. This report is based on the discussion at those meetings.

The Family Role

Whether family member or other devoted caretaker, thousands of individuals in our county are often so critical in the life of one beset by mental illness, that they make the difference between withdrawal from social life or any quality of life at all, between jail and in-patient (or outpatient) treatment, between living on the street or having shelter from the rain; between hospitalization or stabilization and death. For those outsiders who don't know first hand the terrors of mental illness, this may seem overly dramatic, but for untreated clients or those not responding well to medication regimes, inattention, absence of self-care, internal preoccupation, fear or suspicion of others, deep depression, or low self-esteem can result in danger to self or others. Some people in these states are fortunate to receive adequate treatment and move forward to recovery; others may resist treatment, some are treatment refractory or sufficiently disabled to require, if they are to be stabilized and off the street, more assertive treatment

along with nurture and care (most likely provided by a family or a decent board and care.) Providing this kind of monitoring and care which requires taking responsibility for encouraging people to accept treatment, to take medication, to seek mental stimulation, to follow hygiene and health regimes, to exercise, to grasp reality, to combat the effects of profound stigma and to identify the signs of crisis, falls heavily on the shoulders of families and concerned caretakers in Alameda County. According to Gary Spicer, 80% of clients utilizing Alameda County clinic services live with family caregivers**. The message here is that the insights of family caregivers are critical in the development of comprehensive, humane mental health services and that family caregivers seek full recognition of the role they play and to utilize their potential more fully within the system of care.

Notes:
* ACFC members include representatives from the: African American Family Support Group, NAMI-East Bay, FAMI/NAMI Alameda County, Family Support for Healthy Minds (Chinese Family Support Group), Tri-Valley Family/Caregiver Support Group, South Alameda County Family Support Group, and the Berkeley Families Support Group.

** Oral Report from Gary Spicer, January, 2005; Family Meeting with BHCS

Recommendations for Adult Mental Health Services

Overarching recommendation: All projects herein recommended should be filtered through explicit policies, practices and training so that cultural competence and anti-discriminatory work is the order of the day. In-service workshops should be mandated for front-line Behavioral Care and contracted staff so that services are rendered in a manner that is nondiscriminatory of race, gender, sexual orientation and ethnicity. The aim is to render services in a culturally competent manner, one in which personnel have insights to cope with stereotypes and bias. At the same time service providers will have a multicultural orientation that enables them to respect and learn about a range of cultural approaches to coping with mental illness.

I. Support families and recovery prospects with early diagnosis and treatment aimed at preventing full-scale decompensation.

A. Develop a public education campaign in partnership with educational (K-12, Community College and 4 year-college) and medical institutions (pharmacies, clinics, private practitioners including pediatricians) to educate the public about early warning signs of mental illness; make materials available for posting or distribution in medical offices, clinics, libraries and pharmacies. Public educational program content would include risk factors for development of mental illness including family history, recreational drug use, unusual stress, etc, information lines to call and directions on seeking help from an appropriate professional.

Issue: Early treatment, particularly treatment that is initiated at the onset of a mental illness, before symptoms are fully manifested, is often, according to psychiatrists, crucial in preventing the more severe presentations of an illness. Family and community awareness could be useful in leading to early identification and referral of young people with vulnerabilities.

B. Pre-Crisis Intervention

Issue: Families or teachers often observe the decline in a person's mental status, but do not know how to seek evaluation or are frustrated in persuading the affected individual to submit to an evaluation. Health institutions typically refuse to respond to family caregivers if an ill adult will not initiate requests for care. Early identification and treatment can mean avoidance of the

severe forms of mental illness, which are emotionally and financially costly to individuals, families and communities.

1. Develop process for psychiatric/psychological examination early on, when behavior appears consistent with signs of severe mental illness.

A. Utilize in-home visit, when necessary, to coax individual to treatment (In-home visit team may include peer and clinician or case manager.)

II. Coordinated educational opportunities about severe mental illness for family caregivers

Issue: One predictor of stabilization and eventual recovery is adequate support in a client's personal environment. Severe mental illness is catastrophic illness, one with which few caregivers are prepared to cope. Classes for family caregivers, which include understanding symptoms, medications, and access paths to social services, form the basis of a survival kit for families and caregivers. The **local** Mental Health Association and NAMI organizations currently support classes with volunteer teachers. The county, which now provides voluminous copies of the National Alliance for The Mentally Ill curriculum *Family to Family* for classes led by volunteers, can leverage more in a closer partnership with family organizations, volunteers and the MHA by creating a corps of more effective family caregivers. This can be accomplished through joint development with family organizations of a modified curriculum (to avoid copyright infringement of the presently used *Family to Family* curriculum), provision of classroom space in South, East, Central and North County locations, and an advertising campaign and a systematic referral system of families utilizing county services to classes.

III. Crisis Intervention and Post-Crisis Stabilization: Adequate Treatment which includes dialogue with family member/caregiver

Goal: Prevent danger to self and others; prevent debilitating, extended or repeated decompensation with early, adequate intervention with client in crisis.

Issue: The "revolving door", the recurrent, premature dismissal of a client from hospital treatment and without an adequate discharge plan, is damaging for a client and demoralizing for a family members; these episodes, which result in high financial costs to the county (in repetitive visits) also result in lost opportunities for treatment. Real treatment with early intervention, adequate hospitalization when necessary and post-hospital stabilization efforts are of high priority to family members.

A. Expand crisis response services in the county; specifically expand mobile crisis hours so that services are available on a daily basis, including weekends and evenings

1. Review crisis response policy, and alter practice, which prohibits referral for 5150 services for all but case managers, when client is case managed. At present family caregivers report inability to obtain mobile crisis services as long as a case manager is assigned. In cases of urgent need, vital services are delayed and crucial opportunities for intervention are lost as a result of this bureaucratic requirement.

2. Update training of emergency response personnel and include a component of family-oriented training.

B. Expand intake and admission capacity for psychiatric emergency services.

Issue:
One of the most frustrating and disheartening, and unfortunately frequent experiences for a family is to face release by PES of an agitated, psychotic or severely depressed family member. The inability to obtain hospital and aftercare services for an unstable family member is one of the most oft-repeated sources of concern of families and a large factor prolonging clients in a symptomatic state.

C. Facilitate routine communication between family caregivers and PES personnel via AB 1424 form protocols, telephone or face-to-face consultation.

Issue: In PES evaluation there is no substitute for complete information from a knowledgeable caregiver about past and contemporaneous behavior of the client. During evaluations for involuntary holds, client presentations may become uncharacteristically coherent; thus a more balanced informational profile is one factor that can permit decisions commensurate with the clients' need. This information is rarely sought at the critical decision-making period of hospital intake or, once the client is admitted, by the unit staff. While confidentiality is cited as the issue preventing overtures to families, and clinicians are proscribed from imparting information about patients who object, patient objection does not constitute a legal barrier to a family caregiver providing background information to a clinician

1. Expand the informational gathering capacity at PES and on Inpatient units so that family and caregiver information is included in record.

D. Once admitted to involuntary or voluntary hospitalization, discharge planning should take into consideration, when at all possible, the experience of clients' external treatment professionals and family caregivers.

Issue: Reports are legion of abrupt hospital release, without consultation with family or therapists, and without adequate treatment. This can result in increased suspicion of one's support circle and continuing behavior considered dangerous to self or others or evidence of grave disability.

E. Increase availability of post-hospital care facilities, such as step-down and halfway houses.

Issue: Addressing this issue is of primary importance to family caregivers. The attrition of beds at Villa Fairmont and the reduction of county halfway houses resonate in distress calls from family members to all county advocacy groups. The release of clients from the hospital, many of whom are still psychotic or depressed, is often done after the briefest stay, and without consultation/or advice with outside clinicians, family members or primary caregivers. Healing, life skills, and socialization frequently require more support than is available in a home environment, a board and care, and in the unfortunately common release destination, a shelter.

F. In-service training on family perspectives for clinicians, including psychiatrists

Issue: At present, communication with family caregivers on the part of clinical personnel is spotty, even when a client has waived his/her right to confidentiality. Medications are routinely changed and other recommendations are made to clients without informing or gathering potentially useful information from those in the client's inner circle. In-service sessions, it is hoped, will be helpful in moving family members from a marginal place in the clinicians perspective to one where family is seen for what it is: a valuable partner in a recovery journey

IV. Stimulate development of adequate, safe, affordable, clean housing, appropriate to client's level of independence

Issue: The short supply of decent housing, and a range of housing types appropriate to the capabilities of the client, seriously under-mines the stability of clients and hinders those who might otherwise make progress toward recovery. Since so many clients are dually diagnosed, clean and sober environments should be built-in to housing options.

A. Improve and develop policies to stem the loss of licensed board and care homes in Alameda County

Issue: This category of residential living is essential for clients who are unable to successfully meet the challenges of daily living. It is well documented that there is a decline in the number of licensed board and care homes serving people living with mental illness in Alameda County. This is alarming because for low-income clients unable to safely live independently, unable to consistently follow a medication regime or for clients who no longer have family caregivers able to care for them, an affordable board and care may be the only option standing between client, homelessness and hunger. Housing structured to supervise medications is particularly important in reducing rates of client decompensation and hospitalization. **It is imperative that the county develop a policy and set of strategies to offset the reduction in licensed board and care homes**, **while at the same time working to improve overall quality of this resource**. A workable approach would be to develop an incentive/accountability model, for example, one which offers financial incentives for owners, and which is also tied to a family-agency collaborative monitoring program. It should be noted that many clients are placed in unlicensed board and care homes that are nothing short of squalid. This circumstance should offend anyone's sense of humanity, and must be addressed.

The causes for the decline in the number of board and care operated homes must be addressed in Alameda County.

1. Explore a program of financial incentives to board and care operators

a. Use MHSA funds to extend supplemental rate program; use supplemental rate as incentive for B/C operators to obtain licensure.
b. In the long term, advocate higher rates to match those of homes for the developmentally disabled
c. Seek property tax abatements to Board and Care operators who improve the quality of their service.
d. Have an advocate at county/city level who assists in expediting requirements for building inspections or other code requirements for licensing.

2. Develop training program for Board and Care staff, similar to a certificate program for childcare workers; offer classes for Continuing Education Units which health professional or now teachers receive.

3. Develop monitoring program and rating system for homes,

a. Rating systems should consider: telephone access, sanitation, and access to public transportation, nutritional meals, socialization and mental stimulation, ability of staff to communicate in client's language.

4. Address creative approaches for provision of mental stimulation and socialization for board and care residents.

Idea: create position of traveling activities director for Board and Care residents in County

Idea: Stimulate development of more centers for socialization and meaningful activity, which are not limited to higher functioning clients and which include musical, theater and visual arts.

5. Develop living community models, one for each region of the County, where community and responsibilities are built in to the environment.

a. According to client level of independence and ability to handle medication, create boarding house environment without medication oversight.

b. Develop housing units with boarding and medication oversight features.

V. Court diversion to John George or other secure mental health facilities for those routinely sent to county jail.

Issue: Implement a policy whereby eccentric or aggressive behavior of people living with mental illness does not lead to criminalization, which is an exorbitantly costly and ineffective means of treatment.

A. Institute diversion projects such as the Court Project (participated in by Judge Brosnahan or Judge Rhine, formerly of Berkeley.)

1. Diversion project should include release on condition of participating in outpatient treatment options.

2. Diversion options to be considered are secure step-down facilities, where repeat clients, not a danger to self and others can be stabilized; the intensity of in-patient, locked hospital is not always required.

(The option below spans adult and older adult services)

VI. Continuity of Care When Family Caregivers are no Longer Available

Issue: Families frequently are de facto case managers, arranging appointments, providing transportation, overseeing medications and providing socialization. Anticipation of the absence of family support should be built in so as to consider future care for disabled individuals.

A. Production of form comparable to an “ethical will” which encourages a family caregiver to describe client qualities, likes, needs, responses to treatment for future caregiver/clinician.

B. Housing, esp. Board and Care housing, is especially important for the clients whose families are no longer able to care for them. (see III above)

VII. Even-out the geographical distribution of services

Issue: While the Eastern and Southern portions of Alameda County have experienced significant population growth, mental health services have not shown a commensurate increase.

A. Develop Needs Assessment for Undeserved Areas and add services accordingly

VIII. Facilitate Easy Access to Information and Services for Clients and Families

Issue: Families report a long period of difficulty learning about serious mental illness and in accessing services. People need information to cope with daily challenges and to access such essential services as psychiatry, case management, housing, social security, and transportation vouchers which, in many cases, need to be in closer proximity to one another for effective client utilization.

A. Provide for more adequate telephone information and referral services serving clients and family caregivers

B. Create “psychiatric advice nurse” call center for families and clients

ADULT PLANNING PANEL

Name	Group Represented	Racial/Ethnic Identity	Geographic Identification
1. Steven Bucholtz	Consumer	Caucasian	Cou
2.	Michael Diehl	Consumer	Cauc
3. Andre Reyes	Consumer	Caucasian	Cou
4. Marsha McInnis	Families of SMI	Caucasian	East
5. Austra Gauder	Families of SMI	Caucasian	
6. Joe Shumizu	Families of SMI	Asian	
7. Steve Bishoff	Mental Health Association	Caucasian	
8. Liz Prince	Provider/BACS Housing & SMI		Cau
9. Clive Chambers	Provider/Washington Hosp	African American	Sout
10. Kurt Biehl	Provider/John George Hosp	Caucasian	Cou
11. Pansy Taft-Butkowski	Provider/Sausal Creek/Crisis	African American	Nort
12. Mary Suilmann	Provider/Telecare Corp	Caucasian	Cou
13. Maryann D'Onofrio	BHCS Crisis Svcs	Caucasian	Cou
14. Barbara Lucas	BHCS Adult Svcs	Caucasian	Cou
15. Michael Lisman	BHCS Adult Svcs	Caucasian	Cou

Blue = Not confirmed as of yet

Red = **Group represented:** Not sure of correct descriptor or needs to be completed

Racial/Ethnic: Have not met or not sure of

Geographic ID: Not sure of area