**ADULT PLANNING PANEL**
**WELLNESS RECOVERY WORKGROUP**

STAFF SUMMARY - SEPTEMBER 8, 2005

## I. Community Issues (DMH or generated by workgroup)

***Community Issues Re: Alameda County Behavioral Health Care Services System***

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.

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); Accessing Services/Psych Emergency Services; Provider Relationships; Peer and Family Support; Housing; Maintenance and Follow-up Care; and 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 identified the following program development strategies as high priority:
- 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: Re: 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

## II. Analysis of Mental Health Needs in the Community

*The Wellness Recovery Workgroup proposal seeks to serve the needs of unserved, underserved and inappropriately served populations. These populations will be seen in a targeted manner, as programs link up with the Wellness Recovery Resource Center, and The populations described below are those identified by the workgroup that also have high priority for services under MHSA.*

**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.

- 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.

- Transition 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.

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 PROPOSAL

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| **Title of Proposal:** | **Wellness Recovery Resource Center (WRRC)** |
| **Type of Proposal:** | System Development |
| **Rank Priority:** | 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 proposals. Please see the attachment "Adult Planning Panel Meeting Record August 31, 2005" for results of that ranking).* |

**Priority Community Issue Addressed by Proposal:** homelessness, frequent hospitalizations, frequent emergency medical care, inability to work, inability to manage independence, isolation, involuntary care, institutionalization, incarceration

### A. Target Population and Rationale

This proposal supports the MHSA direct-service projects and addresses all DMH Community issues; the primary one being "Manage Independence." The workgroup was also given a direct mandate from the Adult Planning Panel and by the Co-Chairs of the Adult Workgroups to concretely address how to move the ACBHCS from a culture of maintenance and stabilization towards one of wellness recovery. This issue is addressed in each WRRC program division.
**Underserved Populations**: 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 Populations**: 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*.

### B. Program Objectives and Description

The Wellness/Recovery Workgroup recognized from their first meeting in May that the scope of their MHSA planning responsibility was broad: framing how to transform the Alameda County Behavioral Health Care System towards a culture of wellness/recovery. The Adult Planning Panel confirmed this broad scope during its August 10th meeting.

- 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.

With this in mind, the workgroup recognized that successful transformation would require input from stakeholders and administration through an accountable organization (i.e.,a Wellness Recovery Resource Center). This proposal suggests that the work of transformation be directed through 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's five programs include: Workforce Development Program; Technical Assistance and Training Program; Family Caregiver Support Center; Peer Support On-Site Direct Services (direct service/billing center); and Housing Support Program. Two of these divisions have been designed as collaborative efforts with the Family Coalition (Family Caregiver Support Center)and the Adult Planning Panel's Housing and Homeless Workgroup (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. 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.

### C. Staffing & Budget Estimates

- 10.75 FTEs (WRRC)
- 5 FTES (Family Caregiver Support Center)
- $971,115 Program & Infrastructure Costs for WRRC(includes 15% for oversight and administration)
- $460,000 Program & Infrastructure Costs for the Family Caregiver Support Center (includes 15% for oversight and administration)
- $54,400 One-Time Capital and Start-Up
- $303,784 Projected Revenue