C. WORK PLAN

1. PERSONAL SERVICE PLANS

The Personal Service Plan (PSP) will be the nucleus of any system of integrated services. A well conceived and carefully followed PSP is crucial to the shift from a scattered, process driven, units of service system to an unified, member driven, capitated system.

The Personal Service Plan is not a traditional treatment plan drawn up by a clinician for a mentally ill client. It is a full service plan devised cooperatively by each ISA member, his/her family, appropriate others and his/her ISA Service Coordination Team. Each PSP must be tailored to meet all of the member's unique needs for the services listed in Section 5815 (e). It must emphasize ways to help a member increase his/her abilities as well as reduce his/her disabilities. It must address the member's right to choose the environments where s/he will live, learn, work and play.

The MHA ISA will use the following procedures to evaluate potential ISA applicants, assess members that are accepted and develop each member's personal service plan (See Personal Service Plan Flow Chart in appendix B).

Members will be referred to the ISA from the independent selection panel comprised of representatives from the Integrated Service Agency, the local county mental health department, and the State Department of Mental Health. Upon admission to the ISA, the member will be assigned to one of the five ISA Service Coordination teams and will be assigned a primary service coordinator. Each service coordination team will consist of a psychiatrist, a licensed clinical social worker, a registered psychiatric nurse and two psychosocial specialists. The entire service coordination team will share responsibility for and take part in the assessment process based on the special skills associated with their professional discipline or work experience. For example, the team social worker will assess the member's eligibility for entitlement programs while the registered nurse and psychiatrist will assess his/her medical needs.

Within five days of his/her admission, the member will receive an initial evaluation from one of the team psychiatrists, who will be responsible for taking a clinical history and establishing an admitting diagnosis, and will be referred to an outside physician for a physical examination. Within an additional five days of this initial evaluation and assessment, two ISA staff, one of whom is the member's primary service coordinator, will interview the member and jointly conduct the comprehensive assessment of the member's history and needs.

The assessment will cover the following areas (see appendix B):

A. Legal Status
B. Resource Availability (Benefits, Entitlement, Insurance, etc.)
C. Other Agency Involvement
D. Preferred Language
E. Medical History
F. Psychiatric Hospitalization History
G. Mental Health Status
H. Family/Significant Persons
I. Daily Living Skills
J. Social Supports
K. History of Abuse and/or Neglect
L. Substance Abuse History
M. Residential History
N. Prior Education and Training
O. Vocational and Employment History
P. Criminal Justice History
Q. Additional Comments

The primary service coordinator will have 10 days to complete the comprehensive assessment form and prepare a summary report. S/he will then have five days to contact all parties that will be present for the member's personal service plan meeting. The entire service coordination team (consisting of the five staff described above) will meet with the member and appropriate others (family, legal guardians) to begin formulating his/her Personal Service Plan (PSP). At this meeting the member will be allowed to choose or be assigned a new primary service coordinator from the staff making up his/her service coordination team based on needs determined during the comprehensive assessment. The selection of the team social worker, nurse, or one of the psychosocial specialists as the PS coordinator will depend on the most immediate and central needs identified during the member's assessment. For example, a member with many medical needs will be paired with the team nurse as his/her primary service coordinator. Each primary service coordinator will be responsible to ten members.

Within 10 days of the first PSP planning meeting, the primary service coordinator will draft a personal service plan based on the input from everyone who attended the first meeting, using the PSP form to be determined by the State Department of Mental Health. This draft PSP will detail goals, objectives and strategies for each category of service delivery outlined in 5815(e). For example, under the category: <u>vocational</u>, the main goal might be "to increase the member's ability to work through on-the-job experience" and the strategies might include obtaining a part-time position (3 hours a week) working as a food preparer with the ISA Village Vocational Program (See Section <u>C. 11.</u>). The strategies would need to state clearly <u>what</u> service(s) will be delivered, <u>who</u> (the ISA or an outside contractor) will deliver them, <u>where</u> and <u>when</u> the services will be delivered and for <u>how long</u>.

When the service coordination team has completed the draft PSP, the primary service coordinator will distribute the relevant portions of the draft to all outside service providers and to ISA village programs from whom they intend to seek services. Each service provider will have ten days to reject the service plan, admit the member to the program without changes to the service plan, or provisionally admit the member to the program subject to modifications in the PSP.

Within five days of receiving each service provider's decision, the primary service coordinator will meet with the member and his/her appropriate others to approve or reject the PSP, service element by service element. As stated in Section 5815 (4), "The Personal Service Plan is a service contract between the member and the agency. The member, or the member's legally designated conservator or guardian on behalf of the member, shall agree by signature to each service element of the plan. Acceptance of one service shall not be contingent upon acceptance of another service. Personal service plans may be modified by agreement between the agency and the member, or his or her conservator or guardian on behalf of the member, at any time as required." If the member rejects one or more service elements in the draft PSP, then another agreed upon service element must be substituted before the PSP can reach its final form.

After the member, his/her appropriate others, and the service coordination team have reached agreement on a personal service plan, the member's primary service coordinator will contact outside service providers designated in the PSP to arrange for purchasing their services. Service coordination teams will have the autonomy and authority to sign contracts with providers for the purchase of services providing at least two team members sign the contract and the service is within budgeted ISA guidelines and is not considered unusual or extraordinary.

Both outside service providers and ISA Village social and vocational programs will be required to submit a Program Specific Service Plan (PSSP) to the member's primary service coordinator within 30 days after the service contract has started. This program specific service plan will expand on and detail the goals outlined in the member's personal service plan by describing the role the service provider or Village program will play in accomplishing the service plan goals. Each member's primary coordinator will monitor "purchased" services by staying in close contact with outside service providers and ISA Village program staff by visiting members at service delivery sites at least monthly.

Each member's Personal Service Plan will be reviewed, evaluated and modified quarterly by the member, his/her appropriate others, the entire service coordination team and the ISA research psychologist. Outside service providers may also be asked to attend, if appropriate. The PSP will be modified based on verbal feedback from everyone attending this review and other evaluation

tools available. Changes to the PSP will be approved by member signature, service element by service element. If there is unresolved conflict relating to the PSP, the member or the service team may use the grievance process described in section C.14., "members' rights."

In addition to accountability and evaluation tools and procedures required by the State Department of Mental Health to test the effectiveness of the ISA pilot as a whole, service coordination teams will fill out Daily Contact Logs, self-report checklists about relevant service delivery actions like the one used in the Madison, Wisconsin "Training in Community Living" model. The daily contact log (see appendix B for copy of the "Training in Community Living" form) will help staff evaluate the member's PSP by providing daily data on the content, duration, frequency and location of all staff contact with members. For example, one tenet of the ISA is for member-staff contact to take place outside of the ISA and in the member's environment. The daily contact log will provide this information as well as comparison of member-staff contacts relative to the different dimensions of treatment/services detailed in the PSP.

The ISA Research Director will be responsible for compiling and maintaining the PSP data base and for reporting to the State Department of Mental Health.

2 (a). METHODS OF SERVICE DELIVERY

Preamble: The Village Concept

The ISA Service Delivery System will be framed by the Village Concept. Symbolically, the old fashioned village was a community that gave its inhabitants a sense of belonging, of support and of opportunity. A village is an integrated system of service delivery where most of a villagers daily needs are met. It is also an economic model. By providing services and goods for each other, the villagers' collective wealth is enhanced. For example, if one villager sells goods to another then the Village as a whole can use the same dollar more than once.

In using the Village concept to frame the ISA, MHA envisions the village as a community within the mainstream community, which does not geographically isolate members from the mainstream, but actually increases their social and vocational opportunities to interact with the community at large. As a simulation community, the Village introduces members to the concept of being a part of the community, allowing them to explore realistic roles they can play and teaches them that those roles can be significant and worth their efforts. In most cases, members need a supported environment in which to practice skills and abilities before they can confidently live and work in the mainstream community. The Village offers this supported environment as well as helps members build bridges to opportunities outside the Village.

The ISA Village will be comprised of coordinated components designed to meet the member's personal, social and vocational needs as defined by the members' Personal Service Plan.

Structurally, the village will consist of a "town hall" or civic center, a domestic economy (services/goods produced by members for members), and an export economy (sale of goods/services outside the village).

The civic center, like the old fashioned village town hall, will be the hub of activity. This 12,000 sq. ft. building will house the ISA staff and administrative offices, the Village Center's general meeting hall and recreational rooms used for daily living and vocational classes, club meetings, Village Council meetings, weekend dances and other activities. The civic center will also house businesses making up the domestic economy and some activities associated with the export economy.

The Village's domestic economy will provide goods and services to members and to the ISA. These business operations will provide work adjustment experience. The income generated from these activities will be used to pay members' work stipends and be used to continue the operation of these domestic, "in-village"

businesses. These businesses will include a general store which will sell low ticket items such as snack foods and toiletries; an in-house thrift store which will sell clothing and housewares; a coffee shop where members will be able to buy low-price meals and which will serve as a social gathering spot; and the members' clerical pool that will work throughout the ISA Village.

Central to the domestic economy will be the "bank" or "credit union" which will offer check cashing, savings accounts and general money management. Members with accounts will be able to use the "bank" to pay their bills. The bank would also serve as the representative payee for members requiring that service. Through the bank, members will learn about money, its value and its usefulness, which will increase their motivation to work to earn additional dollars. The "bank" will offer bookkeeping trainee positions for members.

The Village's export economy will provide employment opportunities for members through its operation of income generating businesses which sell services and goods outside of the Village. For example, MHA's Homeless Assistance Program, funded by the Department of Mental Health, employs members as food preparers and peer advocates for its service to the homeless. Other examples of export economy will include a catering business, which will use the coffee shop kitchen, an apartment maintenance business, assembly work and a thrift store located outside of the Village Center.

A unique feature of the Village is its potential to offer social and vocational opportunities to members functioning at all levels. It will offer lower functioning members entry level employment within its domestic economy. Higher functioning members will be able to assume leadership roles and gain community based work experience in its export economy. All members will be able to modify their participation as dictated by the condition of their illness without fear of losing their role or status. As members grow in their capabilities and confidence, the ISA service coordination team staff and other Village staff will assist them in finding housing and supported employment in the mainstream community.

Making the whole Village concept work is the housing component. The ISA Village, through master lease agreements with landlords, will make apartments available to members who are ready for independent living. These residents will have a flexible level of ISA staff support depending on their individual needs. The housing component is designed to help members assume the highest possible level of independent functioning without being frightened that they will lose their home if they decompensate.

The Village concept and its philosophy which emphasizes a member's abilities rather than his/her disabilities will be at the center of the ISA and its methods of service delivery described below.

Methods of Service Delivery

1. **Diagnosis and assessment of mental and physical conditions.**

   Diagnosis and assessment of mental condition service provided directly by the ISA through the service coordination team psychiatrist.

   One of the ISA team psychiatrists will directly provide the diagnosis and assessment of each member's mental condition. Whenever necessary, the ISA will hire a licensed psychologist to perform subsequent psychological assessments.

   Diagnosis and assessment of physical conditions provided through referral to an independent physician who accepts Medi-cal. for a physical examination.

   All members applying for services through the ISA will be referred for a physical examination from a physician who accepts reimbursement through Medi-Cal. The physical exam will provide a baseline of medical data that will assist the ISA team in determining a treatment plan that is appropriate for the member.

2. **Treatment of mental disorders, including medication.**

   Service provided directly by the ISA through the team psychiatrist and other ISA staff.

   Probably the most basic service required by the psychiatrically disabled individual is the treatment of their mental disorder. The MHA ISA addresses this need by having extensive contact between the team psychiatrist and the members. The team psychiatrist will be available for individual consultation to the members on an as needed basis, and will conduct a weekly medication support group to allow members to discuss their experiences with medication. The primary aim of the medication support group will be to educate the members about their own medication and to help them effectively manage possible side effects. In addition, the presence of a registered nurse on each service coordination team makes it possible to administer medication by injection for members who prefer or require that method of administration.

   The ISA takes a very active, "hands on" approach by having the psychiatrist present at member-staff team meetings and during the preparation of personal service plans. The aim of this extensive contact between the psychiatrist and the members is to enable the psychiatrist to identify the early signs of psychotic

decompensation and to prescribe measures to arrest this decompensation. This can be accomplished through, for example, an increase in medication, an increase in social support and outreach, or admission to a hospital or crisis bed.

In addition to these services, members will also be able to receive brief, crisis-oriented psychotherapy from the team licensed clinical social worker, when necessary.

3. **Crisis response, which shall be available 24 hours a day, seven days per week.**

Service provided directly by the ISA through all staff members.

Because medical emergencies and psychiatric decompensation can take place at any time, it is necessary to ensure that members have access to these services at all times of the day or night.

The ISA will provide a hotline number manned by an ISA staff member 24 hours a day, 7 days a week. Night and evening shifts will be covered by staff on a 20 day rotation basis. The hotline will connect members, families, hospitals, police and others with the appropriate service coordination staff team for any member who is in crisis.

One of the five ISA psychiatrists will be on call in the evenings, nights, weekends and holidays. The psychiatrist will be able to assess the seriousness of the psychiatric or medical crisis and arrange for medication, hospital admission, etc. A service coordinator from each of the five teams will also be available on evenings, nights, weekends and holidays to help members experiencing psychiatric crises. This service coordinator will be well acquainted with the member who is in crisis and will be able to supply the psychiatrist with essential details if the on-call psychiatrist is not from the member's team. ISA staff will transport the member to the hospitals if needed or call the police or PET if they can not transport the member safely.

In addition to psychiatric and medical crises, the members will also experience other types of crises usually not encountered by the population at large. They may lose their place of residence, be unable to provide food for themselves, or their benefits may suddenly be reduced or eliminated. Because these crises can occur at any time, it is necessary to ensure that members have the resources to cope with these situations at all times, day or night. To meet this need, the

member's service coordinator on call will assist the member in meeting these non-medical and non-psychiatric needs.

The ISA will establish a "Guest Room" available for members who have no where to go for a night or need to escape their living environment for a night. The ISA intends to locate a couple in the Long Beach area who will agree to keep one of their bedrooms free for use by members in crisis situations in exchange for free rent. A service coordinator will accompany the member to the "Guest Room" and will stay with him/her for up to 12 hours if necessary. If the member is unable to stabilize within 12 hours, the ISA team will initiate hospital admission. Otherwise, the member will return to a community living setting. MHA is anticipating that members will experience significantly fewer crisis situations because of the amount of staff support they will be receiving.

4. **Self-Help and Peer Support Services.**

Service provided directly by the ISA through a network of self-help clubs and peer advocates. See section C.6. for a more detailed description of these services.

5. **Emergency Care.**

Service provided directly by the ISA through the team psychiatrist and team registered nurse.

The presence of a psychiatrist and a registered nurse on the ISA team will permit a "first-line" response to medical and psychiatric emergencies through immediate treatment where necessary and appropriate disposition and follow up after the emergency situation has been brought under control. The ISA program will be equipped to handle basic medical emergencies (first aid and CPR) and all staff members will be required to receive training in first aid and CPR. Transportation to a hospital emergency room will be provided for the member when needed.

6. **A continuum of residential services.**

Service provided directly by the ISA through placement in one of five levels of residential care, ranging from skilled nursing facilities to independent living in the community. See section C.9., Residential Services, for a more detailed description of this system.

7. **Vocational assessment, supported employment, and other employment services.**

Service provided directly by the ISA through placement in one or more of the vocational settings offered by the ISA Village Vocational Program. See section C.11., for a more detailed description of these settings.

8. **Socialization and recreation.**

Service provided directly by the ISA through participation in the ISA Village Social/Recreational Program.

When left to their own devices, many members find it difficult to use their leisure time constructively. We believe that the constructive use of leisure time is an important facet of the mental health needs of all members. The MHA ISA intends to meet this need by providing members with a diverse range of social and recreational opportunities.

The ISA Village Social\Recreational Program will operate five days per week, Wednesday through Sunday and on major holidays, and a high percentage of the activities will be offered in the evenings and on weekends. It will be staffed by the Social/Recreational Program Director (1/2 time) and two full time Activity Leaders, in addition to members who will be asked to volunteer to lead activities. The staff will offer a wide range of activities both at the facility and out in the community, including arts and crafts, community meals, movies, trips and outings, and informal drop-in opportunities to play games and socialize with friends. The social/recreational program will also serve as the setting for the weekly meeting of the Village Members' Council, which will be an elected body from the general membership that will provide input to the staff on the operation of the ISA and plan events and activities.

9. **Transportation for essential services.**

Service provided directly through the ISA through the use of a van system.

Members will be encouraged to make use of public transportation as much as possible as a means of developing their ability to meet their own needs. However, the proposed ISA will have a fleet of three vans to provide members with transportation to essential services, such as medical and dental appointments, vocational and educational services, and recreational opportunities for members who are unable to make use of public transportation.

Staff members will be compensated for using their own cars to

transport members when a van is not available.

10. **Daily living skills training.**

Service provided directly by the ISA and operating out of the ISA Village Center.

This service will be provided by Psychosocial Specialists serving on the teams and will consist of improving the skills of members in two distinct areas: independent living and self-advocacy. Independent living skills groups will provide instruction in activities such as money management, shopping skill, use of public transportation and other daily living skills. The self-advocacy service will provide instruction to members in such areas as communication skills, problem-solving skills, and assertiveness training. They will also receive training in understanding community resources and entitlement programs, understanding legal and consumer rights, understanding tenant rights and assistance programs, and peer counseling.

11. **Information, counseling, and other services for the parents, children, or other relatives of members.**

A consistent theme running throughout our methods of treatment is our incorporation of the family into the treatment of the disabled member. The service philosophy demonstrated throughout this proposal views the member as the central element of a family system which has special needs resulting from the member's disability. To meet these needs, the MHA ISA will actively provide information and counseling to the relatives of members. This information and counseling will not only include information about the member's disability and means of coping with it, but it will also encourage the family to participate in our proactive, enabling view of the member's potential for a satisfying and fulfilling life.

It is also important to point out that, while the ISA will not serve the children of members directly, the ISA service coordination teams will take an active role in assisting those members with children in locating and accessing appropriate services for them. For a more detailed description of the information and counseling services offered to the relatives of members, see sections C.1., 6. and 10.

12. **Respite for families and members.**

Service provided directly by the ISA through the use of student interns from a variety of helping and service

disciplines at California State University, Long Beach.

Due to the ongoing high level of care required for mentally ill individuals, family members sometimes feel that they reach a point of "burn out" where they require a respite from caring for their disabled family member. Similarly, a member may occasionally feel a need to distance him or herself from the interpersonal friction that may build up between him or herself and the other family members. To address this circumstance, it is necessary to create a system of respite care whereby the member and his or her family can achieve some distance from each other for a period of time in order to allow them to recover from the pressures of interacting with each other.

The MHA ISA will address this need by allowing members and their families to apply for respite care by a student intern from the Long Beach State School of Social Work or the Department of Psychology. The student intern would go into the home for up to three days at a time to provide support for the member while the parents or other family members are away, thus allowing member and family a chance to recover from what can often be a stressful situation. The frequency with which families and members are allowed to make use of respite care will have to be determined based on the proportion of members who are living with their families. The higher the proportion of members who are living with their families, the more time-limited and less frequent this service will be.

13. **Legal assistance and patients' rights services.**

Service provided directly by the ISA through the team social worker and indirectly through referral to the following agencies:

a) Patients' Rights Office of the County Department of Mental Health.

b) Legal Aid Foundation of Long Beach.

c) Mental Health Advocacy Services.

See section C. N., for a detailed description of the legal assistance and patients' rights services and the manner in which the ISA staff will assist the members in accessing these services.

14. **Money management, including substitute payee services.**

Service provided directly by the ISA through adult daily living skills training and by a representative payee

program administered by the ISA staff.

Members are often unable to effectively manage their resources. This issue must be addressed at two levels: (1) The member must be given instruction through daily living skills training in how to manage money. (See Section on Daily Living Skills Training); (2) It should be recognized that there will be a percentage of the members who will be unable to safely and effectively manage their own money. The reasons for this range from periodic decompensation, for example in bipolar disorder where one of the symptoms may be flagrant spending, to a secondary diagnosis of substance abuse, where the member is spending his/her income on alcohol and/or drugs.

Whatever the reason for the reduced ability to effectively manage their resources, it is clear that a proportion of the members will require a representative payee to assist them in money management. The ISA team will determine if a member needs a representative payee at the comprehensive assessment. Members will be able to select a family member as their payees, or may elect to designate a service coordination team member who on behalf of the ISA will serve as their payee. For these latter cases, the ISA will establish savings and/or checking accounts for the members either at a commercial bank of the member's choice or at the ISA Village Member "Bank". The ISA staff will be responsible for monitoring the accounts to ensure that the entitlement regulations (e.g., savings accounts cannot exceed $1500) are followed. The team will ensure that the member will "spend down" to meet entitlement regulations by instructing the member in making purchases that do not conflict with the regulations (e.g., prepaying rent and utilities).

15. **Consultation with landlords and employers.**

Consultation with landlords service provided directly by the ISA through the member's primary service coordinator.

As mentioned above, there are five levels in the continuum of residential care. The member's primary service coordinator will take an active "hands on" approach in working with skilled nursing facility operators, board and care operators, and family members to ensure a high quality of residential care for the member, including frequent visits to the member's residence. At the middle level of the continuum, members will be living in ISA administered apartments and will therefore be dealing directly with their primary service coordinators regarding housing issues. At the highest level of independence, members will be

encouraged to have their primary service coordinators act as a mediator in their dealings with their landlords so that they may receive direct assistance in working out problems with rent, noise, etc.

Consultation with employers service provided directly by the ISA through the Village Vocational Program job coaches.

The job coaches of the ISA Village Vocational Program will work directly with employers in both locating suitable vocational placements and in mediating between members and their employers when problems arise in the work place. When a member decompensates the staff will also be able to communicate with the employer and possibly be able to place another member in that position or retain the position until the member recompensates.

16. Hospitalization in community of state hospitals.

Service provided indirectly through the purchase of acute local and state hospital beds through the Los Angeles County Department of Mental Health.

17. Drug and alcohol rehabilitation.

Community-based outpatient drug and alcohol rehabilitation service provided directly by the ISA through the Substance Abuse Specialist.

The ISA Substance Abuse Specialist will be available for consultation with the ISA teams when they are designing personal service plans. When it is determined that a member has a drug or alcohol problem in addition to his severe mental illness, the PSP will include participation in a chemical dependency and abuse group led twice weekly by the substance abuse specialist, in addition to regularly scheduled individual counseling with the substance abuse specialist. The members will also be encouraged to attend outside twelve-step meetings.

If it is determined that a member's drug and/or alcohol rehabilitation needs cannot be met in an outpatient, non-residential setting, inpatient services will be purchased from the River Community, a community-based residential treatment facility specializing in individuals with a dual diagnosis of severe mental illness and substance abuse. As in all cases of purchase of services from outside agencies, the River Community will be required to provide a Program Specific Service Plan (PSSP) which will serve as the basis for monitoring service delivery.

18. **Formal education, including high school, college, or vocational training.**

Service provided indirectly through the purchase of services by the ISA from adult schools, colleges or programs providing vocational skills training beyond the capabilities of the Village.

During the preparation of the member's personal service plan, the member's educational and vocational goals will be assessed and it will be determined if further education or vocational training is appropriate and/or desired. Should the service coordination team determine that further education or training will be included in the service plan, the primary service coordinator will be responsible for assisting the member in acquiring these services, such as enrolling in adult school, receiving tuition for vocational services, such as trade schools, occupational centers, etc. helping the member to arrange appointments with the school counselor, etc.

19. **Motivational activities to encourage educational, vocational, and community participation.**

Service provided directly by the ISA through all service coordination team members and through peers.

It is MHA's belief that the system of integrated services outlined in this proposal will be inherently motivating to those members participating in them. MHA believes that the village metaphor conveys the spirit of a true "therapeutic milieu," with members and staff participating side-by-side to provide for the greatest possible amount of both individual and community enrichment. The experience that the MHA has had with the Project Return clubs suggests very strongly that the best way to motivate a member is to provide them with peer activity and encouragement and allow them as much self-direction and autonomy as possible. By providing the opportunity to engage in a diverse set of success experiences in the ISA Village, the member will become self-motivating as s/he becomes accustomed to being a successful autonomous agent.

20. **Physical, nutritional, and dental health care.**

Service provided indirectly through the purchase of medical, nutritional, or dental health care services as appropriate for the individual member.

As explained in method 2, each incoming member will be required to receive a physical exam upon intake into the ISA. This exam will serve as a baseline of the member's

physical, nutritional and dental health care needs during the preparation of the personal service plan. During the PSP meeting, the member and their family will have the opportunity to express their feelings about the needs of the member in these areas. The ISA team will develop an appropriate plan for meeting these needs and the primary service coordinator will be responsible for ensuring that the member is able to purchase services in these areas, according to the plan.

21. **Income maintenance.**

Service provided directly by the ISA through the member's service coordinator in consultation with the team social worker.

Many members require assistance in acquiring and maintaining their benefits and entitlements. The MHA ISA addresses this need by having a psychiatrist on each team who can evaluate the extent of the member's disability and, if necessary, certify them as unable to work due to their psychiatric disability. Because the defined target population will be primarily if not solely comprised of seriously mentally disordered individuals, it is anticipated that most members will be receiving some form of benefit and/or entitlement payments.

Each service coordination team will also include a licensed clinical social worker who will be familiar with benefit and entitlement regulations and able to consult directly with members and their primary service coordinators in assisting members who are applying for benefits/entitlements. The service coordinator and the social worker will also act as mediators between the member and the Social Security personnel in cases where a member's benefits are reduced or eliminated.

2 (b). GOALS OF SERVICE DELIVERY

Estimated Levels of Attainment of Goals

It is important to point out that accurate estimations of the levels of attainment of goals can only be made when reliable and accurate baseline data exist for the services to be provided. The most accurate data for this population is probably in the area of utilization of hospital services, and therefore it becomes a relatively simple matter to estimate how the proposed ISA will have an impact on hospitalization rates. This proposal uses data supplied by the State Department of Mental Health (SDMH) in arriving at these estimates (See appendix C).

However, for many of the goals being addressed by the proposed ISA, very little data are available in regard to how clients have utilized these services in the past. This makes it extremely difficult to estimate the level of impact that the proposed ISA will have, since in many cases the services being provided by the ISA have no baseline with which to be compared. The services that fall under this category are primarily the community based services, for example, the rate at which clients have remained in the least restrictive, most "normal" housing consistent with their capabilities for at least one year.

In the case of services such as this where past utilization data are either unreliable or non-existent, it will be the responsibility of the ISA, through its research director, to begin to compile multiple baselines of past service utilization for each client when they apply for services through the ISA. This information will be compiled from the comprehensive assessment form and compared, on an ongoing basis, with the member's service utilization while participating in the ISA. In other words, the member's own service utilization history will serve as the baseline for comparison with his/her level of goal attainment in the ISA, in addition to comparisons with the state-mandated control group.

It must be recognized, however, that this approach makes it extremely difficult to make accurate estimations of the rates of increase or decrease of the utilization of particular services in advance of collecting these data. The proposed ISA takes a more pragmatic approach, and will use the members' own history of service utilization to make realistic estimates of improvements in service utilization.

Given the above assumptions and considerations, the ISA proposed here will make estimates of the attainment of goals in three broad areas as defined in AB 3777. These areas are labeled as Section A, B, and C below.

A. Client improvement/maintenance outcome goals that measure the benefit of services:

1. Reduction in the rate at which clients use state hospital bed days.

   In the Long Beach area during fiscal 1987-88, the 140 severely mentally disordered clients who were admitted during the year used a total of 6183 state hospital bed days for an average length of stay of 44.2 days (According to data provided by the SDMH -- See appendix C). These 140 clients represent 2.5 percent of the 5556 severely mentally ill clients receiving services in fiscal 1987-88. Therefore, if the ISA had no effect on the rate at which this service was used by its 200 members, it would be expected that approximately 5 ISA members (2.5 percent) would use approximately 44.2 state hospitalization bed days each.

   The proposed ISA aims to reduce the number of members requiring state hospitalization by 20 percent and to reduce the length of stay by those requiring hospitalization by 20 percent. Therefore, the proposed ISA will require 4 placements in state hospital beds at 35.4 bed days each, for a total of 142 state hospital bed days per year.

2. In the Long Beach area during fiscal 1987-88, 254 severely mentally disordered clients used a total of 2846 acute hospital bed days for an average length of stay of 11.2 days (According to data provided by the SDMH -- See appendix C). These 254 clients represent 4.8 percent of the 5556 severely mentally ill clients receiving services in fiscal 1987-88. Therefore if the ISA had no effect on the rate at which this service was used by its 200 members, it would be expected that approximately 10 ISA members (5 percent) would use approximately 11.2 acute hospitalization bed days each.

   The proposed ISA aims to reduce the number of members requiring acute hospitalization by 10 percent and to reduce the length of stay by those requiring hospitalization by 10 percent. Therefore, the proposed ISA will require 9 placements in acute hospital beds at 10 bed days each, for a total of 90 acute

hospital bed days per year.

3. Decrease in the rate at which clients are admitted to acute care facilities under the Lanterman-Petris-Short Act, Part 1 (commencing with Section 5000).

   In the Long Beach area during fiscal 1987-88, a total of 242 severely mentally ill clients were admitted to acute care facilities under the Lanterman-Petris-Short Act (According to data provided by the SDMH -- See appendix C). This represents 4.4 percent of the 5556 seriously mentally disordered clients receiving services during the year. Therefore, if the ISA had no effect on the rate at which this service was used by its 200 members, it would be expected that approximately 9 ISA members (4.5 percent) would be hospitalized under the act in a one year period.

   The proposed ISA aims to reduce the rate at which members are admitted to acute care under this act by 20 percent, to approximately 7 members per year.

4. Reduction in the rate at which clients spend time in the local jails.

   The amount of time that each member has spent in local jails will be determined at intake using the comprehensive assessment form. The member will be asked to sign a release of information allowing the ISA team to contact all correctional facilities in which the member has been incarcerated so that the member's statement can be confirmed. The amount of time spent in jail will be aggregated across members and will serve as the baseline for comparison with incarceration for members while participating in the ISA. While a reduction in the rate of incarceration while participating in the ISA is expected, it will not be possible to make an accurate estimate of the actual rate until these data are collected.

5. Increase in the rate at which clients receive income support entitlements.

   There are few data upon which to base an estimate of the rate at which members are receiving the income support to which they

are legally entitled. The proposed ISA will make an accurate determination of each member's entitlements at intake. This information will provide a baseline for comparison with the rate at which members receive entitlement benefits while participating in the ISA.

The proposed ISA anticipates at least a 5 percent improvement in the rate at which members receive income support entitlements.

6. Increase in the rate at which homeless persons accept services.

According to MHA data, there were approximately 550 homeless individuals served last year in its Long Beach Homeless Assistance Program, which served the homeless mentally ill in the target service area of the proposed ISA. Since the total number of individuals with a severe mental disorder who received treatment in fiscal 1987-88 was 5556, this suggests that the homeless mentally ill are receiving less than 10 percent of the mental health services offered in the Long Beach area.

The proposed ISA anticipates at least a 25 percent increase in this number, with at least 25 of the ISA members being drawn from the homeless mentally ill population.

7. Increase in the rate at which clients remain in the least restrictive, most normal housing consistent with their capabilities for at least one year.

There are few data upon which to base an estimate of the rate at which members are presently able to maintain normal housing. The proposed ISA will take an accurate account of each member's residential history at intake. This information will be quantified and aggregated across all members in order to provide a baseline for comparison with the rate of maintaining normal housing while participating in the ISA.

The proposed ISA anticipates at least a ten percent improvement in the rate at which members are able to maintain housing consistent with their ability for at least one year.

8. Increase in the rate at which clients are actively engaged in the community support network as measured by participation in peer support or self-help groups or socialization center programs, or other meaningful social support activities.

   According to MHA, there were approximately 375 seriously mentally disordered individuals involved last year in peer support, self-help, and socialization center programs in the proposed service area. Since the total number of individuals with a severe mental disorder who received treatment was 5556, this suggests that approximately 6.7 percent of this population presently participates in these programs.

   The proposed ISA anticipates at least a 400 percent increase in this number, with at least 50 of the ISA members participating in these programs.

9. Increase in the rate at which clients are participating in a rehabilitation program, as measured by membership in a psychiatric rehabilitation program, a supported employment program or a competitive employment program for at least one year.

   There are few data upon which to base an estimate of the rate at which the members in the target area is presently participating in rehabilitation programs, as defined above. The proposed ISA will take an accurate history at intake of each member's participation in rehabilitation programs. This information will be quantified and aggregated across all members in order to provide a baseline for comparison with the rate of participation in rehabilitation programs while participating in the ISA. The proposed ISA anticipates at least a 10 percent improvement in the rate at which members participate in rehabilitation programs.

10. Increase in the rate at which multi-problem clients, including those with a secondary diagnosis of substance abuse and seniors with special needs, are receiving a comprehensive program of treatment that addresses their dual-diagnosis needs.

Data indicate that within the Long Beach area during fiscal 1987-88, there were approximately 232 individuals with a primary diagnosis of severe mental illness and a secondary diagnosis of substance abuse. This number represents 4.2 percent of the 5556 patients with a diagnosis of severe mental illness.

Based on these figures, it is expected that of the 200 members served by the proposed ISA, approximately 8 (4 percent) will be dual diagnoses members. However, we believe that the dual diagnoses criterion underestimates the extent of this problem and we intend to serve 15 individuals with a dual diagnosis of serious mental disorder and substance abuse.

Of the 8299 individuals receiving mental health services in fiscal 1987-88, only 257 (3 percent) were 65 and older.

The proposed ISA will attempt to double the number of seniors served which translates to 12 of the proposed 200 members being seniors.

11. Minimize the rate at which clients are more dependent and living in more restrictive environments.

There are few data upon which to base an estimate of the rate at which the members "are more dependent and living in more restrictive environments." The proposed ISA will take an accurate account of each member's residential history at intake. This information will be quantified and aggregated across all members in order to provide a baseline for comparison with the rate at which members move to more restrictive environments while participating in the ISA.

The proposed ISA anticipates at least a 10 percent decrease in the rate at which members use the most restrictive housing, operationalized as skilled nursing facilities and board and care facilities.

12. Decrease the rate at which clients with a secondary diagnosis of substance abuse are abusing dangerous drugs.

As stated in 10 above, data indicate that within the Long Beach area during fiscal

1987-88, there were approximately 232 individuals with a primary diagnosis of severe mental illness and a secondary diagnosis of substance abuse. This number represents 4.2 percent of the 5556 patients with a diagnosis of severe mental illness.

The Proposed ISA intends to reduce the abuse of dangerous drugs by this population by at least 20 percent.

B. Cost savings, cost avoidance and cost effectiveness outcomes shall measure any short-term or long-term cost savings and cost avoidance achieved:

1. All major public costs for clients, including mental health, housing, social services, vocational rehabilitation, health services (including Medi-Cal), and adult protective services and public guardianship.

   It is extremely difficult to make an accurate estimate of the cost effectiveness and cost savings in each of these areas because few data exist to serve as a baselines for comparisons. However, since all of these services will be provided by the ISA, they will be significantly less utilized by members. We anticipate a 10 to 15 percent decrease in the use of these services by ISA members and therefore a comparable drop in the funds required to provide these services. It should be noted that the proposed ISA will be conducting a study to compare the utilization of these services by members of the ISA with a matched control group.

2. Costs for crisis residential, local acute, and state hospital care.

   As explained above (Sections A1 and A2), the proposed ISA intends to reduce the admission to acute hospital beds by 10 percent and reduce the length of stay in acute hospital beds by 10 percent. Without participation in the ISA, the 200 members would be expected to require 10 acute hospitalizations at 11.2 days each for a total of 112 acute hospital bed days. The system proposed here estimates that utilization will be reduced to 9 acute hospitalizations at 10.1 days each for a total of 91 acute hospital bed days. Thus,

the ISA will result in a reduction of 21 acute hospital bed days. At an estimated cost of $401.00 per hospital bed day, this will result in a savings of $8,421.00.

As explained above, the proposed ISA intends to reduce the admission to state hospital beds by 25 percent and reduce the length of stay in acute hospital beds by 25 percent. Without participation in the ISA, the 200 members would be expected to require 5 state hospitalizations at 44.2 days each for a total of 221 state hospital bed days. The system proposed here estimates that utilization will be reduced to 4 state hospitalizations at 35.4 days each for a total of 142 state hospital bed days. Thus, the ISA will result in a reduction of 79 state hospital bed days. At an estimated cost of $263.00 per hospital bed day, this will result in a savings of $20,777.00.

3. Costs for criminal recidivism.

It is extremely difficult to make estimates regarding the cost savings of reduced criminal recidivism because very few data on the rate of criminal recidivism exist for the members. If it is assumed that the criminal recidivism rate of the members does not differ significantly from that of the non-disabled criminal population (It may, in fact, be lower, according to a study by Ribner, S.A. and Steadman, H.J., 1979), and it is further assumed that the costs of incarceration are approximately the same as those of hospitalization, then approximately $263.00 per day in direct costs can be saved for every day that a member is not incarcerated, not to mention the savings in indirect costs of criminal recidivism to the community. As stated earlier, it is the aim of the proposed ISA to reduce the amount of incarceration of its members by at least 10 percent over their previous history. What this will translate into in terms of actual dollars will depend on the history of the members, which will be assessed on intake.

4. Other short-term or long-term costs related to client outcome goals.

The ISA will encourage members to work to the

greatest degree possible and reduce their SSI benefits through the use of sections 1619 (a) and 1619 (b) under the Social Security Act. This program reduces a member's SSI benefits by one dollar for every two dollars earned after his/her first $85 per month. Thus, a member who earns $201 per month through the ISA Village Vocational Program will have his/her SSI benefits reduced by $58 (1/2 of the $116 they earn after the initially protected $85). Although it is impossible to estimate how many members will work and the total wages they would earn, if it is assumed that the average member will work 10 hours per week at minimum wage ($4.25 per hour), s/he will earn approximately $178.50 per month ($42.50 per week for 4.2 weeks per month). This would result in a $46.75 savings in SSI benefits per member per month. For 200 members, this would total $9350 in savings per month or $112,200 per year. Although 10 hours per week may be an optimistic goal, it gives a rough idea of the potential savings involved.

C. System of care effectiveness outcome goals shall measure the extent to which the target population is being served.

1. The percentage of clients who meet the target population definition.

   The goals stated here have been based on the assumption that membership in the proposed ISA will be limited to individuals with severe mental disorders (i.e., schizophrenia, major depression, bipolar disorder, etc.). and that no less than 95% of the membership will meet this criterion. Should the target population definition include a proportion of less seriously disordered individuals, MHA will be able to revise and improve its estimates of goal attainment.

2. The percentage of non-categorical local assistance funds that are spent on nontarget populations.

   As stated above, the proposed ISA will serve only members with a severe mental disorder, unless the target population definition is changed. There will be few if any members who belong to "nontarget populations" on whom

non-categorical local assistance funds will be spent.

3. The extent to which the joint responsibilities specified in the interagency agreements have been fulfilled.

   The proposed ISA will closely monitor the fulfillment of responsibilities by the agencies with which it contracts for services.

4. The extent to which ethnic minorities are served in proportion to their numbers in the general population.

   Of the 8299 individuals receiving mental health services in the proposed target area in fiscal 1987-88, the following ethnic distribution was obtained:

	Fiscal 1987-88		Proposed ISA
Other Hispanic:	22	0.3%	1
White:	4769	57.5%	115
Black:	1750	21.1%	42
Mexican Hispanic:	1023	12.3%	25
American Indian:	41	0.5%	1
Chinese:	31	0.4%	1
Japanese:	50	0.6%	1
Filipino:	72	0.9%	2
Other Asian:	99	1.2%	3
Other Non-White:	38	0.5%	1
Korean:	9	0.1%	1
Indochinese:	287	3.5%	7
Unknown:	108	1.3%	0

   The proposed ISA will make every effort to ensure that the membership in the ISA matches as closely as possible the ethnic distribution of the target area. Unless more recent figures indicate a change in the distribution of ethnic minorities receiving services, the third column in the table above will serve as target goal for each ethnic minority (See section C. 8. for a full statement of our intended services for ethnic minorities).

3. STYLE OF WORK

The ISA proposal process gives prospective bidders a unique opportunity to design an integrated, capitated system of service delivery for seriously mentally ill adults which corrects identified shortcomings in the existing "units of service", program driven system. In general, MHA is proposing an eclectic model of service delivery, representing a creative amalgam of medical and psychosocial programs, described in detail throughout this proposal.

In writing this proposal, MHA recognizes that no matter how precisely it draws its blueprints of service delivery, its ability to deliver viable structures from these blueprints will depend on how well they are grounded in solid philosophical foundations.

MHA feels that its style of work is the heart and soul of its service delivery plan. Service delivery is a staff intensive business. No matter how staff are organized on charts or how their jobs are defined, if they remain outsiders to the agency's decision making process and if they do not respect the individuals they have been hired to serve, then system reform is nothing more than an ineffective paper exercise.

As a private, nonprofit agency, MHA has had the freedom to establish a style of work that differs significantly from the more traditional models associated with government and other public service. In developing this style of work, MHA looked toward the for profit world for customer driven service delivery systems and for organizational structures offering staff high motivation and job satisfaction. The result has been the creation of services rooted in the old fashioned motto that "the customer (member) always comes first". Concurrently, the result has been cost effective programs, high staff productivity and low staff turn over. MHA will bring its existing style of work to the ISA, its members and its employees.

At the center of MHA's style of work are the values shared by its Board of Directors, its staff and its members. MHA is an organization with a mission to educate the public, advocate on behalf of and serve seriously mentally ill persons. MHA's strategic planning centers around this mission and is based on the following shared values: 1) Members and their expressed needs come first 2) Staff and member relationships are grounded in mutual respect and equality 3) Members can play a productive role in the community when their abilities are encouraged and their disabilities are lessened 4) Members have more in common with the general population than they have differences 5) Members should be given the same opportunities for treatment for their mental illnesses that victims of cancer, diabetes and other physical illnesses are given 6) Members should play an active role in any service delivery system designed to help them cope with their illness and to readjust to community life. These same shared

values will be at the core of MHA's ISA.

Structure

MHA's organizational structure is as flat as possible; there are no rigidly followed chains of command. No one sits behind a desk shuffling paper and telling others what to do. MHA requires that every staff member, with the possible exception of its accounting and clerical staff, has hands-on responsibilities for accomplishing goals directly related to its mission statements. Operationally, the vast majority of decisions are made by agency round-table groups of staff members responsible for implementing program objectives.

The ISA organizational structure would be equally flat. The ISA director will oversee the five ISA Service Coordination Teams, one Resource Team and the administrative staff. Each Service Coordination Team will have five mental health professional staff, two peer counselors and 38 other members who will, collectively, have the autonomy to make 95% of the programmatic and financial decisions relating to the team's activities and the implementation of Personal Service Plans for the members on that team. The ISA Director will become involved in the team decision making process only if there is dissension among team members or if a member's Personal Service Plan calls for the purchase of services that are extraordinary and expensive.

The Resource Team, made up of a research director, a research assistant, a substance abuse specialist, and a housing developer. The Resource Team will serve all 200 ISA members by working with the service coordination staff and by relating to members and their families in groups and one-to-one whenever needed.

The Village Social/Vocation Team is led by a social/vocational director. Two activity specialists will be responsible for the coordination of social and recreational activities at the ISA Village Center and for outside activities (camping, beach outings, excursions etc.) Interns, volunteers and service coordination staff members will augment this team as appropriate and desirable. The vocational component will include four worksite/work adjustment supervisors and two job developers/coaches. This component will also be augmented by volunteers, interns and the psychosocial specialists from the service coordination team.

Each ISA staff person will have hands-on responsibilities for accomplishing the goals detailed in the ISA legislation. Each service coordination staff team will choose an administrative liaison who will represent the team at ISA Administrative Round-table meetings and who will oversee the team's record keeping responsibilities. Team may choose this liaison on a permanent or rotating basis. Each ISA staff person will have a job description detailing their primary responsibilities, but, all staff members will be expected to do whatever is required to meet the needs of ISA members and to keep the ISA running smoothly.

Systems

For a system to be integrated, all of its parts must be linked together into a cohesive whole by effective communication. A study of profitable corporations shows that an informal, open system of communication works best. At MHA, staff talk to each other rather than write memos. For the ISA, written communications will be limited to announcements affecting staff and members, responsible clinical record keeping, statistical data required by funding sources and the research effort and documentation needed for a tight accounting system. Minutes will be taken at most staff round-tables and at all policy committee meetings so that staff and members will know about decisions made and new directions agreed upon.

Communication is at the center of any customer (member) driven system. Successful corporations build a strong, lasting relationship with their customers by 1) staying in close contact 2) listening to service users 3) tailoring services to meet client needs 4) going to the customer rather than asking the customer to come to them. These same ingredients will be at the center of MHA's ISA.

Staff and members will stay in close contact through a variety of interactions as individuals and in groups, in a variety of settings. Each member will have at least three "proactive" contacts with ISA service coordination staff each week in addition to any "reactive" contacts which may result from special circumstances or periods of crisis.

The entire service coordination team of five staff and 40 members will meet once a week to discuss issues affecting everyone involved with the ISA. Each of the four sub-teams-- the psychiatrist, two other service coordinators and 10 members-- will meet weekly. Each member will be visited by his primary service coordinator at his/her residence, place of work or at a program site at least weekly. Members and their families can telephone the service coordination staff team members whenever they want to talk. All non-emergency calls will be returned within four hours; all emergency calls will receive immediate attention.

Reactively, a member of each service coordination staff team will be on call 24 hours a day, 7 days a week to assist members and their families with emergency and crisis situations. This assures that the ISA staff person answering a member's call for help will have established a trust relationship with the member and his/her family and will be cognizant of the member's history and special needs.

Staff will work flexible hours that fit the ISA's program objectives. Staff hours will vary from day to day depending on planned evening and weekend activities as well as time spent responding to emergencies.

Everyone connected with the ISA will have access to financial information such as monthly balance sheets and expenditure reports. All ISA members and staff will have the right to look at information kept in their own treatment or employment file, except in cases where state or federal confidentiality laws forbid it.

Systematically, the ISA will be a paradox in action. The system will be loose in terms of inspiring informal, open communication and creative, experimental approaches to problem solving yet tight in terms of maintaining accurate record keeping and financial accountability.

Staff

Since the ISA represents a dramatic shift from the traditional clinician-patient service delivery system, it will fail if staff cling to old work habits and attitudes. MHA has found that some mental health professionals prefer a highly structured work environment that centers around appointments and meetings scheduled between 9 and 5. These professionals are usually frustrated by MHA's more flexible, less formal working style.

Perhaps the most challenging aspect about implementing this proposed ISA will be finding five psychiatrists, five licensed clinical social workers and five registered psychiatric nurses who are excited about working for a member driven rather than staff driven service delivery system and who are trained in community based programming rather than traditional clinic bound models.

Another characteristic of the ISA staffing pattern will be a emphasis on hiring staff members who have been clients in the mental health system. MHA has a history of hiring former clients as both direct-service and clerical employees. Any ISA job applicants who have been or are currently clients in the mental health system will be given at least equal consideration for any position s/he qualifies for.

Potential burn-out is another challenge to be faced with any collection of staff dealing day-in-day-out with people suffering with severe mental illnesses. With our current staff, with a very low turn-over rate, the key to avoiding burn-out has been flexible work schedules and high variability of task. From our agency experience we have found that staff who are able to utilize extra-curricular skills and interests on the job are less prone to the burn-out that can afflict people whose only relationship to the job is through their specific professional skills. Therefore, in addition to the professional skills needed in the various staff categories, we will be recruiting for a variety of life, recreational and hobby skills and interests. For example, we would want various staff members to have personal interests in a variety of sports, the culinary arts, dance, camping, etc. In this way outside interests can be brought to bear on the total experience of the ISA and its membership. We see this as being beneficial to members, as well as staff, in that it will provide

by instructive example, ways for members to fit together the various pieces of their lives.

4. CONSULTATION

The ISA Public Education Force

For the ISA to be a truly integrated system, it must be an integral part of the community at large and foster cooperation and involvement from other community service groups. Because of the stigma associated with mental illnesses, ISA members may experience discrimination when trying to use mainstream community services such as schools, libraries and recreational facilities. Because of their lack of accurate information about mental illnesses and mentally ill people, community service providers, like police officers, may treat ISA members inappropriately.

To educate the community at large and community service providers in particular, the ISA will establish a public education force. At least one staff member and one peer advocate from each of the five ISA teams will participate in a proactive public education force. Volunteers from the Mental Health Association, the Alliance for the Mentally Ill and other concerned citizens will also be asked to join the force.

MHA's public education department will train these staff-member-volunteer teams in public speaking and provide them with materials to educate the community groups about the ISA and about serious mental illnesses. Each public education team will make at least one presentation each month to groups such as community service clubs, church groups, professional staff groups, teacher inservice trainings, county and city employee groups, high school and college classes.

Consultations to the Police Force and Criminal Justice System

The ISA staff teams will need to develop a close working relationship with the Long Beach Police Department as well as judges probation officers and jail personnel who might interact with ISA members. The LCSW on each team will serve as the ISA liaison to the police and criminal justice system. First, these liaisons will need to educate police and criminal justice personnel about the ISA and its system of integrated support for its members and the role they need to play in order for the system to work. Second, the ISA staff team and the police will need to agree upon the procedures that will be followed if an ISA member is arrested or in police custody. For example, if an ISA member identifies himself or if the police suspect that someone may be an ISA member, then the police would call the ISA 24 hour hotline to locate the ISA staff person who is on call for that member's team. Ideally, an ISA team service coordinator would visit with the member within 2 hours of his arrest.

If a member is arrested and charged with a crime, then his service coordination team will support the member and his family through every phase of the criminal justice system. It is essential the team stand by the member and assure that he has adequate legal

representation no matter how serious a crime the member has allegedly committed.

If an ISA member is sentenced to a lengthy incarceration in some part of the penal system, the question of his/her continued membership in the ISA will need to be negotiated with the state Department of Mental Health liaison.

Consultations Related to Living Arrangements

Each member's Personal Service Plan will identify his current choice of a residence given the alternatives available. The ISA service coordination team will provide consultation and technical assistance to everyone connected with a member's living situation. The team will have an opportunity to provide this consultation when they visit members at their residence on a regular weekly basis and in times of crisis. Whenever possible, the ISA team will help members deal with crises by bringing services to them in their "home" environment rather than by removing the member and placing him in a unfamiliar, more restrictive setting.

If a member is living in his own apartment, the team will, with the member's permission, contact landlords and apartment managers giving them the 24 hour hotline number in case they need to contact the service coordination team on behalf of the member or because of a dispute with the member. The team will check in with landlords and managers at least monthly to make sure that the member's living arrangements are going smoothly.

If a member is living in a community care facility, the team will stay in close contact with its operator and staff to insure that the member is in an environment which supports the objectives in his Personal Service Plan and to monitor the treatment and care the member receives. The ISA team would encourage members to select community care facilities that 1) put member care above profits 2) allow members a voice in how the facility is run 3) offer a nurturing and supportive environment that does not inhibit the member's striving for independence. The team will monitor these facilities by listening closely to the members' comments and complaints and by visiting by the facility, unannounced and at differing hours. The LCSW's from each team will provide monthly workshops and individual consultation to community care operators for the purpose of improving the milieu in facilities where ISA members reside.

If a member is living with his parents, spouse, other family members or a significant other, a team service coordinator will be available to help family caregivers during regular weekly visits and function as a mediator when conflict threatens the stability and harmony of the living situation.

Consultation with Employers

Village vocational team staff will be available for consultation with outside employers who need clearer understanding of the individual capabilities of ISA members working in their establishments. The vocational team will also provide workshops for interested employers concerning people with serious mental illnesses as they relate to the world of work.

5. UTILIZATION OF SERVICES OWNED BY BIDDERS

At this time, the Mental Health Association in Los Angeles County neither owns nor operates any hospitals or residential facilities that will be utilized by the ISA. Therefore, this section is not applicable to our proposal.

6. INVOLVEMENT OF CLIENTS AND FAMILIES

Management of the ISA

Even though ISA members and their families will not sign the ISA employees' paychecks, they are the boss. After all, the ISA has no other purpose than to help members cope with the crippling effects of their illness and strive toward new levels of wellness. Because of the current service delivery system's inconsistencies and inadequacies, the burden of finding quality care and for handling members' crises has usually fallen on family members. It is the ISA's job to lessen the family's role as the primary service coordinator and caregiver so that members and their families can reestablish more normal parent-child, marital and sibling relationships.

Together, members and family members of seriously mentally ill persons will make up 2/3 of the ISA Policy Committee, which, along with the MHA Board of Directors, will act as the ISA's governing body. The Policy Committee will meet monthly and will have the responsibility of ensuring that the ISA meets all the mandated guidelines prescribed in Assembly Bill 3777. At least 1 client member and 1 family member from the ISA Policy Committee will be elected to the MHA Board of Directors to serve as communication links between these decision-making groups. As prescribed by the bill, members serving of the Policy Committee may also be ISA members. One of the above shall be MHA's board vice-president, Community Support Services and serve on the board's Executive Committee.

Preparation of the Personal Service Plan

Both the member (his/her legal guardian or conservator) and his/her family will be involved in the design and implementation of his/her Personal Service Plan. However, it is naive to anticipate that, in every case, the member and his/her family are going to easily and amicably come up with a plan for services that all agree upon.

While the ISA brings a "new day" in terms of its approach to service delivery, many of the members and their families will have a long and perhaps scarred history of struggling with the effects of the member's illness. The ISA team will need to recognize that members and their families may have differing opinions about the member's needs and capabilities based on the member's past behavior. For example, a member may choose unrealistic goals that deny his/her disability or he/she may be scared or unwilling to try new options. The family may feel "protective" of the member, especially if his/her past attempts at independence have failed, and as a result, exacerbated the symptoms of his/her illness. Or, they may have unrealistic expectation based on the member's pre-illness potential or accomplishments.

When necessary, the ISA team will serve as a mediator between the

member and his/her family, carefully listening to everyone's feelings and opinions. The team may initially need to interview the member and his/her family separately as well as jointly. The challenge will be constructing a cooperative, balanced plan which emphasizes the member's abilities without threatening his/her stability. The Personal Service Plan must be integrated not only in terms of the services provided but also integrated in terms of being an amalgam of the opinions held by all interested parties. However, if there are major disagreements between a member and his/her family and mediating efforts do not yield a compromise, the team will need to develop a PSP with service elements that the member (or his/her legal guardian or conservator) are willing to sign off on even if it does not contain everything the family had hoped for.

Member Participation in Service Provision

ISA members will play an active role in providing ISA services. The ISA will offer 20 paid peer advocate positions, one for each sub-team of 10. These positions and the accompanying peer advocacy training program will be modeled after the Project Return peer advocacy program which has been operating for several years in Long Beach. The Peer Advocates will help other members cut through the red tape connected with entitlement programs, teach other members how to use the Long Beach bus system and help other members cope with problem situations associated with daily living. The Peer Advocates will lead weekly problem solving clubs modeled after the Project Return self-help clubs where members will brainstorm solutions to common daily living situations. A staff team member will attend these meeting to provide resource information when invited by the members. Each of these self-help clubs will elect a representative, who may or may not be the sub-team's Peer Advocate, to serve on the ISA Village Council. The Village Council will function like the Project Return Federation Council, offering feedback and advise to ISA staff. Representatives from the Members' Council will also serve on the ISA Policy Committee.

In addition to the problem-solving self-help clubs, members may participate in a variety of other special interest support groups. These groups will be started if 3 or more ISA members share a common need for support in dealing with their illness or other problems. Special interest groups would center around issues like substance abuse, medication, homosexuality, divorce, cultural identity, language needs and weight problems. Depending on the participants and their needs, these groups would be facilitated by an ISA member, a staff member or a trained volunteer.

The ISA will also offer members paid part-time positions as clerical trainees, receptionists, bookkeeping assistants and van drivers. These members will be taking part in the Village Center's vocational services and will be placed in positions at the ISA as part of their on-the-job training.

Family members will be encouraged, along with other citizens of Long Beach, to serve as volunteers in the ISA and its various parts. As with volunteers already involved with MHA, these will be screened and selected with an eye to the appropriateness to each situation. Care needs to be taken to make sure that the feelings and sensitivities of individual client members come first in the selection and placement of volunteers.

Participation in Service

The Personal Service Plan is, essentially, a good-will contract. The ISA is under a legal obligation to offer to each member the various services specified. It is under a moral obligation to encourage the member to accept these same services unless and until the member and/or his/her legal guardian negotiates an amendment to the PSP. At the same time, outside of the Section 5150 process, the member is on voluntary status with the ISA and any other parts of the mental health system. Therefore, it is crucial that the ISA team exercise sensitivity and tact in encouraging the members to comply with the plans outlined in the PSP. It is certainly of no value to get heavy handed to the point of irreparably damaging the relationship between the member and the ISA team.

Evaluation of the ISA

Members and their families will have extensive input into the evaluation of the ISA. First, members and family members will serve on the ISA Policy Committee as stated above. Second, the ISA research director will conduct periodic (every 6 months) surveys of representative sub-samples of members, their families and applicable others (guardians, conservators, significant others) to determine their level of satisfaction with the services being provided. The research director will conduct yearly surveys of the entire membership, their families and applicable others, again with the aim of determining their level of satisfaction with services. These survey results will be used to modify and improve the pilot program.

7. PSYCHIATRIC AND INVOLUNTARY SERVICES

Psychiatric Services

As described in the section on style of work, the treatment philosophy of the Mental Health Association is derived primarily from a psychosocial orientation. However, it is important to point out that the psychosocial model of rehabilitation is not being offered as a replacement for the medical disease model, but rather as an adjunct that must operate side by side with the more traditional model. Where the medical model focuses more on the disabling aspects of the disease, the psychosocial model focuses on promoting the growth of the individual and enabling him/her to live as full a life in the most independent setting that his/her disability will allow. What is important to acknowledge is that both models have something to offer, and that both must be included in any program that attempts to meet the needs of the psychiatrically disabled.

MHA recognizes the integral role that the medical component must play in the design of an ISA, and the team psychiatrists will play important roles in many aspects of the proposed ISA. These roles include but are not limited to:

1. Initial evaluation to assess the members' current mental state, take a clinical history, and determine an admitting diagnosis.

2. Participation in the comprehensive assessment process to provide input on the medical and psychiatric needs (including medication) of the prospective member.

3. Participation in the design of the Personal Service Plan to provide input on the best way to meet the member's medical and psychiatric needs.

4. Participation in the quarterly review of each member's Personal Service Plan.

5. Participation in weekly community meetings that will provide a context for the psychiatrist to evaluate the members' social functioning.

6. Leading a weekly medication group that will allow members to define their experience with their current medication and to provide a context where they can cooperate with the psychiatrist to maximize effectiveness and minimize side effects. The psychiatrist will be attempting to educate the members to recognize their medication needs and to use no

more and no less than they need.

7. Individual consultation with members and families on an as needed basis.

8. Continued treatment during hospitalization of the member in those cases where the member decompensates.

9. Emergency psychiatric coverage on a 24 hour per day basis.

It should be apparent from this description that the MHA ISA will provide extensive direct contact between the psychiatrists and the members and their families. The aim of this extensive contact is to enable the psychiatrists to identify the early signs of psychotic decompensation and to prescribe measures to prevent its progress. This can be accomplished through, for example, an increase in medication, an increase in social supports and outreach, or admission to a hospital or crisis bed.

Involuntary Services

Although MHA believes that the proposed ISA will drastically reduce the number of members who decompensate and need hospitalization, any program that serves the seriously mentally disordered population must make provisions for the periodic need for hospitalization. When ISA staff recognize that a member is beginning to decompensate, they will make every effort to arrest the decompensation without resorting to hospitalization. They will be able to consider a temporary increase in medication, provide for increased or decreased social contact, increase the amount of staff contact or temporarily increase the amount of structure in the member's life.

However, there will be incidents when the professional staff determine that hospitalization is necessary to treat the member's illness. When this occurs, the staff will attempt to communicate their concerns to the member and convince the member of the need and desirability of hospitalization. In many cases, the member will recognize the signs of his/her escalating illness and agree to voluntary hospitalization. In these cases, the member will be transported to the hospital by one of the ISA staff members. However, when the member refuses to accede to hospitalization and the team psychiatrist determines that the member is a danger either to himself or to others, involuntary hospitalization procedures must be implemented.

All ISA treatment staff will receive training from the County Department of Mental Health that will enable them to be certified as qualified to hospitalize members under section 5150 of the Welfare and Institutions Code. If a service coordination team member, in consultation with the team psychiatrist, determines that a member is a danger either to himself or to others, he/she

will attempt to transport the member to the hospital if he/she can do so safely. Should the staff determine that it is unsafe to transport the member, the police will be contacted and asked to transport the member. The ISA intends to use Harbor UCLA Medical Center as its involuntary hospitalization facility.

The psychiatrist and the rest of the professional staff will continue to have contact with the member while hospitalized and will work with the hospital staff to arrange for release of the member back into the community as soon as it is medically advisable.

8. SERVICES FOR MINORITY MEMBERS

The bilingual and bicultural needs of members will be met by considering ethnic issues in the areas of both staffing and cultural enrichment and resources.

Staffing

The proposed ISA will adhere to the following procedures in hiring and staffing patterns:

1. Cross cultural training and experience will be a primary consideration and advantage for all staff hired.

2. An aggressive personnel search will be conducted to hire at least two bilingual Hispanic, two bilingual Indochinese and two Black mental health professionals as service coordination team members.

3. Bilingual and bicultural student interns will be actively recruited from the following programs:

   a) The Professional Education Project sponsored by MHA. This project currently is providing summer work stipends and personal support to 60 bilingual and bicultural students from high school through doctoral training.

   b) California State University Long Beach departments of Nursing, Psychology, Social Work and Recreation Therapy. Over the past six years a field experience class has been offered at the university which has placed undergraduate and graduate students in community support service programs operated in the Long Beach by MHA. An interdisciplinary class may be negotiated or current field work and internship guidelines used to attract and train ethnic and other students. At least 10 ethnic students each semester are expected from this process.

   c) Other universities and colleges such as the University of California Irvine, which has a cross-cultural

studies program in its psychology department, and Long Beach Community College, which has a large Indochinese student enrollment, will be approached to provide students internship and field work training.

4. If there is greater need for bilingual staff than the program has available at any given time, interpreters will be hired to assist the members to interact with the teams and programs.

Cultural Enrichment and Resources

The following program elements will be implemented to meet the cultural needs of members in the ISA:

1. Cultural Resource Clubs will be organized for each ethnic group that is identified. These clubs will follow the Project Return self-help partnership model, but will focus upon meeting the cultural needs of the group. Clubs will also plan ethnic events in which all members may participate and gain exposure to another member's culture. A Chinese New Year parade, Cinco De Mayo celebration, and a Martin Luther King birthday picnic are examples of the type of events that will be planned. These Cultural Resource Clubs will be facilitated by a person who is a part of or identifies with the particular group.

2. Cultural educational activities will also be integrated into the Village Center calendar. Special topics, travelogues, guest lectures and history classes will be planned to focus on the different cultures of members. Field trips to cultural museums and historical sites will also be planned.

9. ISA RESIDENTIAL SERVICES

Seriously mentally disordered individuals differ markedly in the extent to which they are capable of living independently in the community. Their needs range from 24 hour support to being able to live completely on their own with a minimum of supervision. To serve this population adequately, an ISA must be able to provide a continuum of residential care.

It is important to point out that merely providing a roof over the member's head is not providing acceptable residential services. As demonstrated here, members require extensive outreach and support, depending on their particular level of need. Members with the lowest level of independent living skills require the most careful attention to ensure that they are receiving the comprehensive services they need. But even at the highest levels of independent living skills, members may require occasional residential assistance. The episodic nature of mental illness and psychotic decompensation means that any member, regardless of his/her usual level of functioning, is vulnerable to periodic loss of his/her place of residence.

The ISA proposed here will begin by making a comprehensive assessment of the residential needs of the member (See Comprehensive Assessment Form in appendix B). Upon determination of the member's desires and independent living skills, the ISA will assist the member in securing appropriate housing. This will mean one of the following:

1. Locating and arranging for placement in an Institution for Mental Disease.

   After acute hospital treatment, some members will require the most restrictive level of care in the community, which is the Institution for Mental Disease. This level of care is appropriate for members who are incapable of meeting their most fundamental needs, and will be purchased from a licensed Institution for Mental Disease as near the ISA Village Center as possible. These members require 24 hour supervision to ensure that their most fundamental safety and survival needs are met. In most cases, these members will be under LPS conservatorship.

2a. Locating and arranging for placement in a board and care facility.

   There is a group of members who, although they do not require 24 hour nursing care, are still incapable of performing most basic independent living skills, such as money management, negotiating public transportation, shopping, cooking, etc. This group cannot meet their

own needs for food and shelter without considerable assistance. However, these individuals can participate in community activities. The ISA would help these members locate board and care facilities that not only meet their basic survival and safety needs, but also provide services that enrich and enhance the lives of the members. The ISA will actively monitor any board and care facilities where members live. The ISA will provide transportation, when needed, from board and care facilities to the ISA Village and contracted facilities to allow them to participate in vocational, social, and recreational activities to the highest degree possible.

2b. Members living at home with their families.

There is a large group of members who live at home with parents and/or other family members. While these members undoubtedly have a wide range of independent living skills, in most cases these members do not have the skills necessary for independent living and, in this regard are roughly comparable to members residing in board and care facilities. While the ISA will not be directly providing a place of residence for these members, the service coordination team, with the member's permission, intends to engage in active outreach to the families of members living at home. This will include home visits and consultation with family and friends.

3. Placement in the ISA operated training house.

There are members who, while they are not yet capable of living in a supported apartment, have progressed beyond a need for the level of care provided by their family or a board and care facility. These individuals need a setting that will help to prepare them for independent living.

The ISA intends to meet this need by providing six beds in a house which will give members an opportunity to learn and practice independent living skills while at the same time having a staff person available for immediate consultation, when needed. A staff person will lead independent living skills groups from 3 p.m. to 9 p.m., Monday through Friday, and will give members the opportunity to participate in group meals, practice shopping skills, etc. There will also be a staff person sleeping in the house to be present for emergencies from 11 p.m. to 7 a.m., seven days per week.

Participation in the ISA Training House will be limited to 4 to 6 months, and the member will be able to earn a certificate for successful completion of the independent living skills training course. When the member and the

ISA staff determine that the member is ready for supported apartment living, they will be moved into a supported apartment with its lower requirements for staff support.

4. Placement of the member in an apartment leased and operated by the ISA.

   The primary residential option offered directly by the ISA will be placement in an apartment that is leased and administered by the ISA and sublet to the member. This level of residential service is appropriate for the member who is able to meet nearly all of their independent living needs themselves, but may still have difficulty in such issues as self-monitoring of medication, poor social interaction skills, a fear of interacting with the non-disabled population, etc. Members living in supported apartments will make monthly rent payments to the ISA and will be required to attend weekly residential meetings to be held at the members' apartments. Attendance at these meetings will allow team personnel to continually assess member needs, particularly in the early identification of when decompensation may be occurring.

   Participation in the ISA supported apartment program is not time-limited. A member is allowed to remain in their apartment as long as they choose.

5. Assisting the member in finding their own apartment and, if requested by the member, assisting the member in negotiating with the landlord.

   The member who is nearly totally self-reliant and able to acquire and maintain housing in the community may still occasionally require assistance in negotiating with a landlord and/or roommates. MHA intends to make this service available to all members, regardless of whether their apartment was obtained independently. In addition, members living in their own apartments will be encouraged to participate in the social, vocational, and recreational services of the ISA.

While the securing of housing and residential services is an important function of the ISA, possibly even more important is the maintaining of the member in their residential setting after it has been secured. During their psychotic episodes, members often engage in behavior (e.g., isolating themselves, substance abuse, lack of appropriate personal hygiene) which may cause them to be evicted from their place of residence. The episodic nature of the disability often results in a repeating cycle of psychotic decompensation > loss of residence > recompensation > acquiring a new residence > psychotic decompensation. The ISA will break this cycle through the following steps:

1. Active outreach and monitoring of the members through required residential team meetings held at the members' places of residence. Each member will be visited at their place of residence, a minimum of once per week, either individually or in a group.

2. Subject to receiving permission from the members, ISA treatment staff will have frequent communication and interaction with the owners of the members' residences (e.g., landlords, board and care operators) to identify decompensation in its earliest stages.

3. Twenty-four hour crisis response and emergency psychiatric intervention to arrest the decompensation at the earliest possible stage (See Section C. 2 (b). 3, Crisis Response).

4. The ISA staff will maintain the member's residence while he/she is hospitalized, unless the period of hospitalization exceeds 6 months. It should be pointed out, however, that with the level of staff involvement that the ISA entails, it is expected that this type of crisis situation will be a fairly rare event.

10. MEMBERS EXPERIENCING THEIR FIRST PSYCHOTIC EPISODE

Psychotic decompensation is always a difficult event with which to contend, but it is particularly difficult for both the member and the member's family and friends when he/she undergoes the first psychotic episode. Often in these cases, neither the individual nor his/her family understand the process taking place. The individual may recognize that there is something wrong and may experience a great deal of fear and feelings of loss of control. The individual's family and friends are often forced to witness a sudden deterioration in the individual's previously high level of vocational and/or social functioning. The feelings of helplessness that they experience are worsened by the fact that they have little if any knowledge of the resources that are available to help them to cope with the event. In some cases there may be a tendency for the member and the member's family to at first deny the seriousness of the individual's illness, hoping that the problem will somehow "go away."

Any comprehensive integrated service agency hoping to serve the seriously mentally disordered population must address the problem of how to provide services to members and the families of members experiencing their first psychotic episode. There are several issues that are germane to this subgroup. These include:

1. Helping the member and the member's family and friends cope with the sudden disruption of social, educational, and vocational activities.

2. Providing information and counseling to the member and the member's family on the nature of mental illness and its usual course and treatment.

3. Providing information, counseling, and referral to the resources that are available for the treatment of mental illness.

Active Outreach

The MHA ISA will initiate a comprehensive plan to provide services to the individual undergoing a first psychotic episode and his/her family. The first step of this plan is active outreach to the member, and, with the member's permission, to the member's family. When a referral for a first episode member is received while that member is in a psychiatric inpatient facility, a member of the ISA team will be assigned to visit the member in the hospital. That staff person will become the member's primary service coordinator, and will be responsible for initiating the comprehensive assessment and developing a personal service plan. Additionally, one of the peer advocates will be assigned to visit the member and will be responsible for providing information about the several Project Return Clubs that are located in the Long Beach area. After discussion with the member regarding his/her interests and desires, the peer advocate will make a referral to the Project

Return club most appropriate for that member.

Family Involvement

There is a great deal of research suggesting that the treatment of the seriously mentally disordered individual is most successful when the individual's family is actively involved in treatment. The earlier that the family of the member can be involved in the member's treatment, the more likely it is that the treatment will be successful. Therefore, it becomes crucial to involve the family of members experiencing their first psychotic episode to as great an extent as possible.

When a first episode member is referred to the ISA, the member will be requested to allow the ISA staff to contact his/her family. Should the member refuse to allow this, the staff will attempt to convince the member of the benefits of including friends and/or family in his/her treatment program. Should the member still refuse to allow family involvement, his,/her wishes will be respected. However, it is anticipated that in most cases the member experiencing their first psychotic episode will be willing and eager to include their family in their treatment.

After obtaining permission from the member, the family will be contacted and a meeting arranged with a staff person. The parents or significant family members that the member designates will be invited to share their concerns and issues regarding the member's illness and its treatment. They will be referred to their local chapter of the Alliance for the Mentally Ill. They will also be invited to attend the member's comprehensive assessment and participate in the development of the personal service plan.

The aim of this extensive family contact is to minimize the disruption of the member's functioning in all aspects of his life. The ISA staff will also serve as consultants to the member and his/her family regarding the way in which the member and the family should share information regarding the member's illness with employers, landlords, etc. All of these services are particularly crucial to the member and family experiencing the first psychotic episode because of their lack of knowledge and experience with this situation.

11. VOCATIONAL SERVICES

Estimates vary about the percentage of the seriously mentally disordered population that is capable of maintaining full time independent employment. Because this number is generally considered to be fairly low (Many estimates range from between ten and fifteen percent), many clinical and rehabilitation specialists have argued against funding programs that have as their main goal the vocational rehabilitation of the seriously mentally disordered population. From their perspective, employment is seen as a maintenance/survival function. That is, its sole (or at least primary) purpose is to allow the individual to meet his or her financial obligations.

However, with some reflection it becomes apparent that viewing employment primarily as a maintenance/survival function, even for the non-disabled population, has certain limitations. Most people, when asked, could name many other things that they get or would like to get out of their jobs besides mere financial security. They would name such things as a sense of accomplishment, a sense of being challenged, and a feeling that they were making a contribution, just to name a few. It is these "ancillary" functions that give a job meaning and <u>enable</u> the individual to feel that he/she is a productive member of society.

This proposal views employment primarily as an <u>enabling</u> function rather than as a maintenance/survival function and in this view the question of what percentage of the population can maintain independent employment becomes irrelevant. The more important question becomes: what is the optimum level of employment that each member can attain? MHA recognizes that many, if not most, of the members will remain unable to support themselves entirely through independent employment. However, in treatment philosophy, it remains vitally important to continue to provide what are generally considered to be the secondary benefits of employment. While they are more difficult to quantify than an hourly wage, such factors as a sense of satisfaction from a job well done, the belief in one's ability to meet and overcome a challenge, and the sense of being a contributing member of society are every bit as important to an individual's mental health.

From this view of employment as primarily an enabling function, it becomes necessary to provide employment services to each seriously mentally disordered individual that are appropriate for his/her level of ability. This means providing a continuum of services ranging from the most supported employment settings, such as work adjustment activities, job clubs, and sheltered workshops, through work experience, enclaves, member-run businesses, to supported employment, job coaching, transitional employment, and assistance in searches for independent employment. The member is assisted in progressing through these levels of employment as his/her ability gradually increases until he/she reaches the level where he/she can no longer progress. As in all components of a member-driven system, the member is an instrumental part of determining which

services he/she will access and if and when he/she is ready to move on to the next level of employment.

The Village Continuum of Vocational Services

The following vocational services will be available to members through participation in the ISA Village.

1. Work Adjustment/Work Experience

   Work adjustment/experience will be the first option offered to members who desire to work but whose skills are not adequate for supported or independent employment. The work adjustment component will help members develop the appropriate attitudes, habits and social skills necessary for employees. It will increase members' general work stamina, psychomotor skills, level of productivity, knowledge of work practices (payroll deductions, insurance, safety practices, etc.) and time management.

   The vocational staff is responsible for developing a Work Experience Plan for each member that includes vocational goals, measurable objectives and target dates for achievement. Each member is evaluated monthly in terms of attendance, punctuality, appearance, ability to stay on task and other work related behaviors. The goal of work experience is to assist individuals to maintain or improve their work skills and to increase their endurance and speed in preparation for supported and regular employment. Monthly, the vocational staff meets to discuss each member's progress and possible referrals to supported employment programs, JTPA, or regular mainstream employment.

   In the ISA Village, work adjustment/experience activities and training will be offered daily through participation in one of four work settings. These settings include:

	Work Adjustment	Work Experience
1.	Clerical Support/Data Collection Unit	Assembly/Mailing Service
2.	Coffee Shop	Catering Service
3.	Facility Maintenance Unit	Apartment Cleaning Service
4.	Collection and Re-furbishment Unit	Retail Thrift Store

   The four work adjustment units consist of the clerical

support/data collection unit, the Coffee Shop, the facility maintenance unit, and the collection and refurbishment unit. Members in the clerical/data collection unit provide clerical support to the ISA staff, are trained in all forms of clerical tasks, and will assist in the collection of data for the evaluation of the ISA. Members in the coffee shop will be trained in food preparation, shopping, and cooking and will produce three low-cost meals per day for members who wish to have their meals at the Village Center. The facility maintenance unit will train members in maintenance and cleaning procedures and will be responsible for the upkeep and cleanliness of the facility. The collection and refurbishment unit will be responsible for the collection of voluntary donations and will be trained in the repair, refurbishment, and pricing for resale of the items collected.

For each work adjustment unit, there is a corresponding work experience setting in which the members receive jobs from and/or interact with the general public. For example, the clerical support/data collection unit has its corresponding assembly/mailing service. This service will secure contracts from businesses in the communities and the members will be employed to stuff and/or address envelopes, assemble pieces in kits, etc. The catering service will contract to provide meals to outside agencies and businesses and will prepare these meals out of the coffee shop. The apartment cleaning service will take a crew of up to eight members out to apartments and offices in the community and provide high quality cleaning and landscaping services with the skills learned in the facility maintenance unit. Finally, the Village intends to rent a store to provide a retail outlet and employ members to resell the items collected by the collection/ refurbishment unit.

Since many of the members who will be making use of the ISA Village vocational program are receiving SSI, the wages that they receive will have to be closely monitored by their service coordinators to ensure that the members comply with social security regulations. Recipients of SSI are presently allowed to earn up to $85 per month with no effect on their benefits. However, members will be encouraged to work to the limit of their ability and to apply, with their service coordinator's assistance, for the special work incentive program under section 1619(a) and 1619 (b) of the Social Security Act. Under this program, for every two dollars that they earn over $85, their monthly benefit check is reduced by one dollar, allowing them to achieve partial self-support. For example, a person earning $201 per month would have their benefit check reduced by $58 (1/2 of the $116 over the initially exempt $85) but they

would still have earned a total of $143 more than they would have received from their SSI check alone. Thus, the members working under this program can gain the self-esteem benefits of working, increase their income, retain their benefits should they decompensate at some future time, and at the same time save the government money in the form of reduced SSI payments.

The vocational continuum envisioned by the ISA Village is intended to maximize flexibility and increase responsiveness to the member's needs. The work adjustment and work experience settings are considered equivalent experiences. Members will be allowed to modify their participation as dictated by the condition of their illness without fear of losing their role or status.

2. Supported Employment (Transitional Employment and Individual Placement Services)

When the vocational staff assess that the member is ready to progress beyond work adjustment/experience, the member is evaluated for placement in a job in the community while being provided specialized support services.

The vocational staff, through its two job developers, will develop two types of positions with employers in the community. The first type of position, referred to as transitional employment, will be in a time limited setting with an employer who will reserve this position to rotate between members every three to six months. The second type of position, referred to as individual supported placement, will be the member's to keep as long as he/she is able to fulfill the employer's expectations. In both types of positions, at the beginning of the placement, the vocational staff will give daily on-the-job support to the newly placed member and will taper this support as the member becomes accustomed to the job. The vocational staff will hold weekly vocational support groups one evening per week for all members who have been placed in individual supported employment sites during the prior year so that any work related problems can be discussed and resolved.

3. Independent Employment

In those cases where a member is able to acquire a job without the assistance of the ISA team, he/she can still ask members of the team for assistance in maintaining his/her job. Members who have achieved independent employment may request help from staff in mediating with an employer, understanding employer work requests, and may attend the vocational support groups for those

engaged in supported employment.

In addition to the vocational services offered to members through the ISA Village, MHA intends to work closely with the Department of Rehabilitation and with local adult schools, colleges and vocational training facilities. Those members who can benefit from short term specialized training will be referred to the Dept. of Rehabilitation and it's wide access to training programs for the disabled. Members who have not finished high school will be assisted in enrolling in adult school in order to pass the high school equivalency exam. Members who desire it may also apply for college or vocational training programs. In these latter programs, the ISA staff will, with the member's permission, act as a mediator between the member and the college or training school counselor. In all cases, the ISA staff will take an active "hands on" approach in assisting members at all functional levels to reach their vocational goals.

12. SERVICE PROXIMITY

The ISA Village Center will be located within the Long Beach city limits. The City of Long Beach is approximately 50 square miles and has a population of approximately 400,000.

The city has one of the best public transit systems in California. The downtown area, which is the anticipated site for the ISA Village Center, is accessible from all other areas of the city (see appendix D for a Long Beach Transit map).

In Long Beach, the Project Return Peer Advocates have developed a public transportation training program which teaches members how to travel around Long Beach by bus. Peer Advocates serve as "bus buddies", accompanying members as they practice reading a bus schedule, selecting the right bus and transferring to a second bus en route to services and activities.

All ISA members will be urged to learn how to use the bus system because it is the key to their independence and autonomy. The ISA Peer Advocates will be responsible for teaching others how to travel by bus. All ISA members will be eligible for special Long Beach Transit bus passes for the disabled that cost only $6 a month.

The ISA will have three vans available to transport members to and from services if the member is unable to take the bus because of his/her illness. If the ISA purchases a service for one of its members that is outside of the Long Beach city limits, then that member will be transported in an ISA van.

13. Deployment of Personnel

This section will describe the major functions of each of the staff members (excluding support staff) and will describe what percentage of each staff person's time is estimated for each major function.

INTEGRATED SERVICE AGENCY DIRECTOR

Percentage of Time	Major Functions
30	Supervises all ISA staff.
20	Oversees the planning, coordination and implementation of all treatment, vocational, social and recreational programs.
10	Responsible for the assessment and documentation of all ISA programs to determine their effectiveness in meeting goals and objectives.
5	Convenes and facilitates a monthly staff meeting for the entire ISA staff.
5	Convene and facilitate the weekly ISA administrative round-table meetings.
5	Attend and participate in weekly MHA executive round-table meetings.
5	Participate in weekly member meetings.
20	In general, is responsible for the smooth and efficient delivery of all ISA treatment, vocational and social / recreational program services.

RESEARCH DIRECTOR

Percentage of Time	Major Functions
20	Oversee initial admission assessment and assignment of members to ISA or control group.
5	Establish procedures for the collection of baseline data on all members admitted to the ISA.
5	Establish procedures for the collection of data during member participation in the ISA.
20	Responsible for the statistical analyses of all data collected to determine ISA effectiveness in meeting stated goals and objectives.
15	Serve as liaison between the ISA and the State Department of Mental Health.
10	Conduct semi-annual and annual surveys to determine level of member and family satisfaction with ISA service delivery.
5	Participate in weekly member meetings.
5	Participate in weekly resource team meetings.
10	Supervise the Research Assistant.
5	Other duties, as assigned by the ISA Director.

RESEARCH ASSISTANT

Percentage of Time	Major Functions
10	Assist Research Director in the initial admission assessment and assignment of members to ISA or control group.
15	Assist Research Director in the collection of baseline data on all members admitted to the ISA and enter the data into the ISA compute system.
20	Assist Research Director in the collection of data during member participation in the ISA and enter the data into the ISA computer system.
20	Assist Research Director in statistical analyses of all data collected to determine ISA effectiveness in meeting stated goals and objectives.
10	Assist Research Director in conducting semi-annual and annual surveys to determine level of member and family satisfaction with ISA service delivery, and enter data into the ISA computer system.
5	Participate in weekly resource team meetings.
5	Participate in weekly member meetings.
15	Other duties, as assigned by the Research Director.

SUBSTANCE ABUSE SPECIALIST

Percentage of Time	Major Functions
10	Lead two weekly substance abuse groups.
10	Participate in the development of member personal service plans when a history of substance abuse is present.
10	Participate in quarterly comprehensive assessments of members who have histories of substance abuse.
25	Consult to members regarding substance abuse issues on an as needed basis.
20	Consult to staff regarding substance abuse issues on an as needed basis.
10	Serve as liaison between the ISA and River House for those members requiring inpatient treatment of their substance abuse/chemical dependency.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
5	Other duties as assigned by the ISA Director.

HOUSING DEVELOPER

Percentage of Time	Major Functions
20	Evaluate prospective supported apartment site in regard to their suitability for members.
70	Contact prospective landlords in the community and negotiate for master leases for supported apartment sites in a variety of settings.
10	Other duties as assigned by the ISA Director.

TEAM PSYCHIATRIST

Percentage of Time	Major Functions
15	Participate in quarterly comprehensive assessments.
5	Provide psychiatric and medical consultation to other professional staff.
10	Provide on call emergency psychiatric coverage.
40	Provide individual psychiatric and psychotropic medication consultation to members.
10	Participate in weekly staff meetings.
10	Participate in weekly member meetings.
10	Other duties as assigned by the ISA Director.

TEAM SOCIAL WORKER

Percentage of Time	Major Functions
25	Serve as primary case manager for ten psychiatrically disabled members.
10	Participate in quarterly comprehensive assessments of forty team members.
10	Provide benefits, entitlements, housing, and other social welfare resource consultation to other professional staff.
10	Provide on call 24 hr. emergency resource coverage.
25	Assist members in accessing and maintaining social welfare resources such as S.S.I, S.S.D.I., appropriate housing, etc.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
5	Other duties as assigned by the ISA Director.

TEAM REGISTERED NURSE

Percentage of Time	Major Functions
25	Serve as primary case manager for ten psychiatrically disabled members.
10	Participate in quarterly comprehensive assessments of forty team members.
10	Provide nursing and medical information and consultation to other professional staff.
15	Provide on call 24 hr. emergency nursing coverage.
25	Provide psychiatric and medical nursing care for forty psychiatrically disabled members.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
5	Other duties as assigned by the ISA Director.

PSYCHOSOCIAL SPECIALIST

Percentage of Time	Major Function
25	Serve as primary service coordinator for ten psychiatrically disabled members. Assist members in accessing and maintaining residential, vocational, social, recreational, legal, medical, transportation, and entitlement/benefits services, as needed.
35	Participate in ISA Village Vocational and Social/Recreational Programs, as assigned.
10	Participate in quarterly comprehensive assessments of forty team members.
10	Provide on call 24 hr. emergency coverage.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
10	Other duties as assigned by the ISA Director.

PEER ADVOCATES

Percentage of Time	Major Functions
50	Serves as assistant to the primary service coordinator for ten psychiatrically disabled members. Assists members in accessing and maintaining residential, vocational, social, recreational, legal, medical, transportation, and entitlement/benefits services, as requested by primary case managers.
10	Represents members in staff interactions.
35	Lead weekly sub-team member meetings.
5	Other duties as assigned by the primary case managers.

VOCATIONAL AND SOCIALIZATION PROGRAMS DIRECTOR

Percentage of Time	Major Functions
25	Participate in the planning, coordination, and implementation of all vocational program services.
25	Participate in the planning, coordination, and implementation of all social and recreational program services.
5	Weekly supervision of all Vocational Program staff, including the Job Developers and the worksite supervisors.
5	Weekly supervision of all Social and Recreational Program staff, including the Activities Leaders.
10	Participate in the development and the quarterly evaluations of the members' Program Specific Service Plan (PSSP) in both the Vocational Program and in the Social and Recreational Program.
5	Conduct weekly staff meetings.
5	Participate in weekly member meetings.
20	In general, is responsible for the smooth and efficient delivery of all vocational and social / recreational program services.

WORK SITE SUPERVISORS

Percentage of Time	Major Functions
5	Evaluate prospective work experience sites in the community in regard to their suitability for members.
25	Contact prospective employers in the community and develop work experience sites in business and industry.
25	Provide on the job training and support for members in a variety of work experience settings in the community.
5	Participate in the development of each member's Program Specific Service Plan (PSSP), which will detail the member's vocational goals and the specfic means that will be used to achieve those goals.
10	Lead members in weekly vocational readiness and vocational support groups.
10	Conduct on-site evaluation of the member's performance in a work experience position.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
10	Other duties as assigned by the Social/ Recreational Program Director.

JOB COACH / JOB DEVELOPER

Percentage of Time	Major Functions
10	Evaluate prospective supported employment sites in regard to their suitability for members.
25	Contact prospective employers in the community and develop supported employment sites in business and industry.
25	Provide on the job training and support for members in a variety of jobs in the community.
5	Participate in the development of each member's Program Specific Service Plan (PSSP), which will detail the member's vocational goals and the specfic means that will be used to achieve those goals.
10	Lead members in weekly vocational readiness and vocational support groups.
10	Conduct on-site evaluation of the member's performance in a supported employment position.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
5	Other duties as assigned by the Social/ Recreational Program Director.

ACTIVITIES SPECIALISTS

Percentage of Time	Major Functions
10	Participate in the planning, coordination and implementation of both ongoing social and recreational activities and special social and recreational events.
25	Lead members in a wide range of recreational activities, such as arts and crafts groups, dance groups, exercise groups, athletics groups, etc.
10	Educate members in the need for leisure time activities, different types of leisure activities, how to plan activities, and awareness of social and recreational resources in the community.
25	Participate in recreational community outings to the beach, museums, amusement parks, art museums, etc.
5	Participate in the development of each member's Program Specific Service Plan (PSSP), which will detail the member's social and recreational goals and the specfic means that will be used to achieve those goals.
10	Participate in the organization and implementation of special program fuctions, such as fundraisers, holiday festivities, Christmas fair, etc.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
5	Other duties as assigned by the Social/ Recreational Program Director.

HOUSE TRAINER

Percentage of Time	Major Functions
50	Provide independent living skills training in the areas of food preparation, nutrition, shopping, budgeting, managing money, and cleaning. This training may include group meals, group trips to the grocery store, etc.
25	Provide advocacy skills training in the areas of understanding and accessing community resources and entitlement programs, understanding legal and consumer rights, communication skills, problem-solving skills, assertiveness training, and political awareness.
5	Participate in quarterly comprehensive assessments of house members.
5	Document all member contact in daily contact log.
5	Participate in weekly staff meetings.
5	Participate in weekly member meetings.
5	Other duties as assigned by the ISA Director.

TRAINING HOUSE AIDE

Percentage of Time	Major Functions
85	Provide sleep over emergency coverage for six members of the training house between the hours of 11 p.m. and 7 a.m.
5	Administer CPR and first aid, if needed.
5	Document each shift in the daily contact log.
5	Other duties as assigned by the ISA Director.

14. MEMBER'S RIGHTS

Notification of Rights - At the beginning of the application process each applicant will be provided with written and verbal explanations of the nature of their rights as a member of the ISA pursuant to the Wright-Bronzan Act of 1988, the Lanterman-Petris-Short Act, the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (P.L.99-319), and any other state or federal statutes that may obtain at the time. In addition, they will be given specific information concerning the agencies that are specially equipped to assist them in securing their rights, including but not limited to, the Patients' Rights Office of the Los Angeles County Department of Mental Health, Protection and Advocacy, Inc., Mental Health Advocacy Services and Project BACUP (Benefits Assistance Clients Urban Project).

Internal Safeguards - 1) The Village Members' Council, consisting of a person elected from each sub-team, will meet monthly to discuss any issues that may arise, plan future social and recreational programs and be a consistent member voice in the operation of the ISA. 2) Each sub-team will meet weekly with the peer advocate (no other staff present) so that any issues members may wish to raise can be discussed in total freedom.

Grievance Procedure - Should a member have a conflict with his/her personal service plan or any element of the ISA, s/he may follow a simple, defined procedure with either peer-advocate or outside advocate assistance, as desired. Each step in the process should allow time for resolution of the conflict, but a member should be able to move through the process at no greater than two week intervals. The grievance steps are as follows: 1) the service team, 2) the ISA director, 3) the ISA Policy Committee, and 4) the MHA Executive Committee. The decision of the MHA executive committee is the final administrative step. If the dispute is still unresolved, it may be taken to a court of competent jurisdiction.