MEMORANDUM

TO:	Adult Workgroup Members
FROM:	John Ott
DATE:	Tuesday, May 31, 2005
RE:	**Summary from May 25, 2005 Workgroup Meeting**

I. REASONS FOR MEETING

A. Assess convergence and divergence regarding investments in Full-Service Partnerships (formerly enrollee-based programs) and test for agreement

B. If time: begin discussion of system capacity investments

C. Develop agreement about timelines and next steps, including the possibility of an additional meeting the week of 6/6

II. CONTEXT FOR OUR WORK

A. Our process

1. One of 5 countywide workgroups
2. In the middle of a planning process for the Community Services and Supports plan
3. Timeline: June 10 for our recommendations to be finalized and sent to the delegates (though may need another week)

B. Approximate total to allocate over 3 years: $134 million

C. Twin foci for the Community Services and Supports Plan

1. Enrollee-based programs (Initial range: b/w $30-40 million/year)
2. System capacity investments (Initial range: b/w $0-10 million/year

D. Full-serve partnerships (formerly Enrollee-based programs).

1. The original language as I summarized it.
   a. Discrete individuals who meet certain population criteria enroll in a program
   b. Each enrolled individual participates in the development of a plan that is focused on recovery and wellness
   c. Each enrolled individual has a single point of responsibility (Personal Service Coordinators for adults)
   d. Each PSC or case manager has a low enough case load to insure 24/7 availability
   e. Services include linkage to, or provision of, all needed services or benefits as defined by the client and/or family in consultation with the PSC.
   f. A whatever-it-takes commitment
   g. Reporting quarterly on outcomes for the individuals enrolled

2. The new language (See pp. 21-22 of the May 18, 2005 guidelines)
   a. Each individual identified as part of the initial full service population must be offered a partnership with the county mental health program to develop an individualized services and supports plan.

   b. The services and supports plans must operationalize the five fundamental concepts identified at the beginning of this document.
      (1) They must reflect community collaboration;
      (2) They must be culturally competent;
      (3) They must be client/family driven

(4) With a wellness/recovery/resiliency focus; and
(5) They must provide an integrated service experience for the client/family.

3. Under full service partnerships:
   a. The county agrees to working with the individual and his/her family, as appropriate, to provide all necessary and desired appropriate services and supports in order to assist that person/family in achieving the goals identified in their plan

   b. Individuals will have an individualized service plan that is person/child-centered, and individuals and their families will be given sufficient information to allow them to make informed choices about the services in which they participate

   c. All fully served individuals will have a single point of responsibility—Personal Service Coordinators (PSCs) for adults—case managers for children and youth—with a caseload that is low enough so that their availability to the individual and family is appropriate to their service needs, they are able to provide intensive services and supports when needed and give the client/family considerable personal attention.

   d. Services should include the ability of PSCs or children's case managers **or team members known to the client/family** (emphasis added) to respond to clients, families, and collaborative partners, including landlords and law enforcement as well as individuals in the community defined by a child's family, 24 hours a day, 7 days a week.

   e. PSCs/case managers must be culturally competent, and know the community resources of the client's racial ethnic community.

   f. Services should also include linkage to, or provision of, all needed services or benefits as defined by the client and or family in consultation with the PSC/case manager. **This includes the capability of increasing or decreasing service intensity as needed. (emphasis added)**

   g. DMH will develop standardized outcome/performance measurement requirements and counties will be required to submit service, assessment and indicator/outcome information for each person/family who is fully served. Outcomes will address individual wellness/recovery and resiliency issues in addition to other outcomes.

E. Initial populations (formerly focal populations)
   1. State: first draft
      a. Adults with serious mental illness, including:
      b. Adults with a co-occurring disorder or health condition,
      c. Who are not currently served and are homeless, and/or
      d. Who are at imminent risk of homelessness, involvement in the criminal justice system, or institutionalization.

   2. State: recent draft
      a. Adults with serious mental illness—including adults with a co-occurring substance abuse disorder and/or health conditions
      b. Who are not currently being served **AND**
      c. Are homeless and/or involved in the criminal justice system (including adults involved due to child protection issues) **OR**
      d. Are frequent users of hospital and emergency room services.

e. Adults with serious mental illness who are individuals who are so underserved that they are at imminent risk of homelessness, criminal justice involvement or institutionalization **ARE ALSO INCLUDED.**

f. Transition age older adults between the ages of 50 and 59 who are aging out of the adult mental health system and at risk of any of the above conditions or situational characteristics **ARE ALSO INCLUDED.**

3. Our additions for consideration. Adults with serious mental illness who:
   a. Have a co-occurring disorder or health condition, including substance abuse
   b. Have a history of trauma
   c. Are not currently served
   d. Are isolated without peer or family support
   e. May be living with family members or other supportive individuals but are not receiving appropriate care
   f. Are living in institutional care, including State Hospital, IMDs, the jails or juvenile halls, urgent care facilities, acute beds, residential care, and sober living facilities.
   g. Are a conservatee and without a mental health services coordinator
   h. Are currently receiving outpatient services but the services are not sufficient.
   i. Note: We agreed that, for this first round of CSS funding, we did not want to privilege those adults with serious mental illness who are homeless above all other potential groups to be served. The group decided instead to examine the potential populations for enrollment-based programs based on a number of considerations, including need, the desire to reach different racial, ethnic, and cultural groups, the potential larger impact on the system, and other criteria.

III. COMMITMENTS TO ACTION

A. Emerging agreement from May 18, 2005 meeting about long-term vision and strategic opportunities

Through small and large group conversations, Workgroup members articulated several priority elements that should drive our thinking about initial investments in the CSS plan and throughout our planning and action in the coming years. These elements include:

1. **A foundational commitment to recovery and wellness.**
2. **A single point of fixed responsibility** for every individual in the system.
3. **A focus on supporting individuals flowing** through the system **toward wellness and recovery.**
4. **A focus on improving care in times of transition,** both from one part of the system to another, and from one level of care to another as life circumstances and needs change.
5. **A system navigator function** to facilitate people entering and flowing through the system, and in particular negotiating transitions in needs and care.
6. **An overarching commitment to housing** (in its multiple forms) **and employment** as essential cornerstones of any system commitment to recovery and wellness.

B. Emerging agreement from May 24, 2005 ad hoc subcommittee meeting on Full-Service partnerships

1. We want our investments in this phase of CSS to **serve people along a continuum of need.** Full service partnerships should be prepared to move folks to less intensives services and supports over time.
   a. We have agreement on this general concept. There are a variety of additional reflections associated with this overarching concept that also emerged from the May 24, 2005 agreement that have support from various members of the group but for which we do not yet have consensus. These include:

(1) Program models for those requiring highly intensive services should be based on the AB2034 and ACT like models. **But see refinement of this understanding below.**

(2) Caseloads within the most highly intensive services should be approximately 1:10. The range of costs have been estimated at $15,000 per client per year or higher.

(3) There should be another tier of services for those individuals requiring a lesser intensity of services such as those residing in Residential Care Facilities.

 (a) Some of us feel that caseloads for providing services to these individuals could be much higher (perhaps as high as 1:100). We do not have agreement yet on this program design issue.

 (b) The emphasis in this program strategy is to have a liaison to link the individual to services and to have a systems navigator to assist with access into appropriate care and other service needs.

(4) Another tier should be developed that provides support and linkage but much less intensive mental health services justifying an even higher case load ratio than the 1:100. Again this strategy incorporates the liaison and the navigator to ensure linkage to appropriate supports.

b. Most of these issues can be resolved in program design and implementation discussions that will follow this phase of our planning. Some of these issues will need to be explored in at least some detail to help establish appropriate cost/person estimates.

2. The full service partnership and related system development strategies should be developed in such a way as to be responsive to the particular needs of the individuals. There needs to be particular attention paid to the engagement and treatment strategies for different populations and individuals with different types of mental illness.

C. Commitments from the May 25, 2005 meeting

1. The workgroup reached consensus on the **inclusion of people with co-occurring disorders**, particularly substance abuse disorders, as an initial population for our CSS plan for adults. We also reached agreement that, as part of the design and implementation conversations that will follow the development of the budget for our CSS plan, we will explore in detail the data about effective treatment modalities for people who have serious mental illness and co-occurring disorders, particularly substance abuse disorders.

2. The workgroup reached consensus on the **inclusion of people who are seriously mentally ill as a result of trauma**, including childhood traumas, as an initial population for our CSS plan for adults. The workgroup believes that a significant majority of people who fall within the State's recommended list of initial populations are there in part because they have suffered various severe traumas, including traumas during childhood. We also reached agreement that, as part of the design and implementation conversations that will follow the development of the budget for our CSS plan, we will explore in detail the data about effective treatment modalities for people who have serious mental illness that results from severe traumas, including traumas during childhood.

3. The workgroup reached consensus to start with the State's new list of initial populations to build its recommendations for the initial CSS funding for adults, modified by the commitment to people with co-occurring disorders and trauma survivors outlined above. We had divergence about what relative weights to give the various sub-groups within the state's initial populations. We agreed to authorize an ad hoc sub-committee to develop options for numbers of people served in particular populations and to bring those options back to the workgroup at a newly scheduled June 8 meeting.

I. NEXT STEPS

A. The May 31, 2005 workgroup meeting is postponed until June 8. Instead, an ad hoc sub-committee will meet on May 31 from 1:00 until done. The focus of this sub-committee will be to develop concrete options for full service partnership investments, and if possible, related recommendations for systems development investments.

B. The Psychiatric Emergency Services sub-committee will continue to meet separately. The group will complete their draft recommendations ideally by Tuesday, May 31 for consideration at the June 8 meeting.

C. **The full workgroup will meet on Wednesday, June 8 from 2:00 until done. The place for the meeting is to be determined.**