

# Community Mental Health Services Strategic Planning Focus Group Summary Overview For Discussion Only – January 19, 2005

## CONSUMERS, FAMILY MEMBERS AND ADVOCATES

### Parents of Adult Children with Mental Illness

#### Most pressing needs:

- supportive and affordable housing
- activities that reduce social isolation
- more case management, conservatorship and public guardian services;
- programs and services that better meet the needs of mentally ill clients who currently fall in medical or financial eligibility gaps
- support for the highest functioning possible, rather than waiting for clients to get sick enough to qualify;
- psychiatric and psychotherapeutic support for clients who refuse medication or are otherwise resistant.

#### Suggestions for improving services:

- greater awareness of “client culture”
- increased eligibility criteria
- meeting basic needs for food and shelter first
- utilizing more peer approaches to counseling
- seeking and reaching out the mentally ill where they are, rather than expecting them to manage the complexities of accessing and negotiating complex systems.

#### Effective programs that should be expanded:

- Joel Fay’s Restorative Policing program
- Family Advocates
- Medication Clinic
- Enterprise
- Public Guardian and Conservatorship programs
- Buckelew Housing.

#### Other frustrations expressed

- Kaiser’s lack of adequate care

### NAMI

#### Reduce obstacles to accessibility

- centralized information and referral
- Family Advocates
- more community education and awareness about mental illness and services by working with physicians, schools, organizations, events, health care facilities, twelve-step recovery programs

#### Suggestions for improving services:

- change eligibility requirements so clients get help before functioning is more impaired
- increase number of case managers
- build greater capacity through volunteers, interns, volunteer and faith-based organizations
- addressing basic client needs for supportive housing and physical health
- implement integrated system of care
- evaluate current practice against evidence-based practice standards
- provide more psychiatric services for clients who don’t meet current eligibility requirements
- use twelve-step programs as bridge to meeting needs of dually diagnosed

#### Effective programs that should be expanded:

- Enterprise Network
- Star Court
- Buckelew
- Shelter Plus
- Medication Clinic
- Caseworkers

### Other frustrations expressed

- lack of coordination between substance providers and the mental health system
- Kaiser not serving its patients with mental illness sufficiently

### **NAMI Board of Directors' Recommendations**

- Determine if Marin County should implement all or part of AB 1421 (Laura's Law)
- Re-establish the position of Family Advocate in Marin County
- Require that all Marin County contract service agencies use Evidence-Based treatment
- Insure that MGH maintains adequate Psychiatric Emergency Services at competitive rates
- Encourage contract service agencies in Marin to establish crisis residential facilities
- Outsource more tasks to contract service agencies that CMHS personnel presently perform
- Insure that those clients suffering from co-occurring disorders of mental illness and substance abuse are included in the plan

### **Clozapine Club**

Club members expressed appreciation for access to regular medication services

#### Suggestions for improvements

- basic needs for more people – housing, clothing, food and personal care items to activities that would provide greater opportunity for recreation and socialization
- use Prop 63 money for Section 8 housing
- out-county placement for hospitalization very disruptive and disorienting during a crisis

#### Supportive services that enhance independent living

- help with bills
- companionship
- opportunities to work

### **Parents of School-Aged Children**

- over emphasis on in-clinic services which are difficult to get to and don't address in-home and environmental issues sufficiently
- concern about becoming ineligible for services when children's behavior at school improves, even though help and support are still needed
- difficulty accessing supportive services as an adult in need, which would support parenting capacity.

### **Mental Health Board**

#### Increase awareness of services and mental illness through better public relations and marketing

- create greater media saturation for educational and service messages
- target primary care physicians, schools (via teachers, staff and psychoeducational curricula for students), media outlets (beyond the Marin IJ), and self-help groups (like AA, NA)
- create a centralized information and referral system
- develop user-friendly materials, like wallet cards, to identify available services
- reach more people resistant to treatment by first addressing basic needs for shelter, food, clothing, social/companionship opportunities

#### Address gaps in services

- vocational counseling and support for meaningful work
- transitional programs for 18-24 year olds
- services for unserved clients who don't meet current financial or medical necessity criteria
- services where people need them (satellite clinics)
- housing
- more diverse staff
- cultural competence training
- reduce structural barriers that impede treatment for dual diagnosis (agency turf issues, licensing and training)

#### Build capacity in order to serve more clients

- utilize alternative providers for medication and/or psychotherapy (psychiatry residents, psychiatric nurses) and case managers in medication clinics to reduce time drain during medication appointments
- develop satellite medication clinics with shorter medication follow-up appointments
- implement greater range of diagnostically-specific, evidence-based practices
- modify reimbursement fees to attract more/better quality providers

## **Enterprise**

### *Most pressing needs*

- accessibility of psychiatric services and limitations in choice due to insurance constraints
- meaningful work
- educational opportunities
- help negotiating benefit systems

### *Other frustrations expressed*

- complaints about specific providers or situations

## **PROVIDERS, CONTRACTORS AND REFERRERS**

### **Adult Referral Group**

#### *Most pressing needs for changes in CMHS*

- much more aggressive outreach in order to reach clients where they are, rather than expecting them to access services and navigate complex systems
- reduce the stringency of eligibility requirements that result in waiting until clients decompensate and enter the system much sicker than necessary
- co-locate and collaborate with other social service and health-related agencies

#### *Most significant gaps in CMHS*

- the elderly
- transitional youth, 18-25
- Marin City youth
- clients in need of crisis residential and inpatient dual diagnosis treatment

#### *Effective programs that should be expanded*

- Joel Fay's community policing program
- STAR
- Enterprise Client Network
- AB2034
- adult case management
- public guardian program

#### *Build capacity in order to serve more clients*

- strengthen the peer programs, and provide a living wage for peer counselors and expanding their opportunities for training
- offer community agencies grants to devise means to address gaps
- developing a greater network of community-based volunteers to provide buddies and rep payee services

#### *Other concerns*

- expand range of opportunities for socialization and activities and approaches that help to reduce the isolation experienced by mental health clients

### **Children's Referral Group**

#### *Most significant gaps in CMHS*

- children who don't qualify for 3632, but have significant social/emotional needs
- children who are at risk at moving from the Children's Protective Service system into the Juvenile Justice system
- the children of undocumented workers and the uninsured working poor
- foster care kids and parents who need support so their placements are stabilized
- crisis residential services
- inpatient hospitalization for dual diagnosis
- affordable drug and alcohol treatment for children as well as their parents
- treatment for kids who won't go to drug court and can't afford treatment programs, including harm reduction options
- underserved minority populations

### Improvements to CMHS impact and efficacy

- locate services in the community and co-locate with existing child service agencies
- increase flexibility in billing and reimbursement to address the fact that alternative approaches, outside of the therapy office, are often more effective with many of the children and families served
- more integrated and wrap-around services to meet children and families in the community
- better collaboration with alcohol and drug treatment
- community outreach to cultivate more bicultural/bilingual staff members
- make the CMHS system easier to negotiate
- find ways to reduce the impact of categorical funding (because it exacerbates dysfunctional “either/or” approaches and thinking)
- focus less on gatekeeping and eligibility requirements and more on what is available or could, with innovative approaches, be available: “CMHS philosophy should be: ‘How do we screen people IN, rather than screen them OUT?’”

## **Mental Health Contractors**

### Most significant gaps in CMHS

- Asian-speaking therapists
- services in Marin City
- bicultural staff and consultation resources for issues related to cultural diversity
- crisis residential services
- services for transitional youth

### Most pressing needs for changes in CMHS

- much more community-based outreach (especially non-clinic based services and expanded hours and days)
- greater collaboration (more team development within CMHS, and more coordination between CMHS and contract agencies, as well as interdisciplinary approaches and communication with other community-based organizations, including police and other first responders)
- more emphasis on prevention and early intervention
- development of treatment approaches and linked services that address dual diagnosis
- assessment and information technology support with a coordinated approach to assessment that meets the needs of CMHS and contract agencies

### Efficacy assessment and treatment outcome issues

- great deal of variability from agency to agency regarding client outcome assessment, with many agencies doing little or no assessment
- there are no consistent procedures, expectations or tools for assessment
- very little, if any, communication or collaboration with CMHS regarding outcomes

## **AOD Providers**

### Range of obstacles to more effective treatment

- inadequate access to psychiatric consultation and medication evaluation and management
- need for mobile outreach to clients
- lack of services for adolescents, particularly in light of growing recognition of a significant increase in need for adolescent treatment
- inability to efficiently access CMHS services for clients when they need them
- CMHS eligibility requirements that are too limited
- the absence of structures that enable collaborations between mental health and AOD services
- lack of continuity of care because of lack of communication between treating agencies and the inability of AOD to access reimbursement for follow-up care
- attitudinal and structural barriers that undermine respect, trust and the ability to work together
- imbalance in funding streams which enable addicted clients to get treatment paid when they have committed crimes, but not before
- added challenges of physical health issues
- AOD population has very significant mental health needs across the spectrum
- Limitation in CMHS capacity to serve bilingual and non-English speaking clients, particularly those with AOD addiction issues

# CMHS STAFF

## **Senior Peer Counselors**

### *Most pressing issues*

- insufficient staffing levels
- lack of coordination of care within CMHS and between CMHS and medical providers, law enforcement, hospitals and residential settings
- absence of an older adult system of care with wrap-around services
- lack of services to reach home-bound seniors
- inadequate capacity to serve minority populations (other than Latino clients) or geographic locations outside of central Marin
- insufficient psychiatric and psychotherapy services
- need to recruit more peer counselors

## **Cultural Competence Task Force**

### *More outreach into community and to underserved populations*

- less conventional venues and methods of delivering and defining mental health services
- more community partnerships and collaboration
- greater flexibility in conducting outreach (using non-clinicians to do prevention and education and allowing compensation for non-billable non-clinical hours)
- address basic needs first -- housing, shelter, meaningful employment, help negotiating medical care system
- lack of services and case managers for Southeast Asian clients
- when there is appropriate staffing, the clients come (as evidenced by a ten-fold increase in clients with the presence of a Vietnamese case worker)
- address bicultural/bilingual staff recruitment difficulties
- recognize significant obstacles such as stigma and lack of education in some ethnic low income populations
- insufficient capacity in psychiatric care and medication management services
- significant unmet mental health needs of the uninsured working poor
- fragmentation of care and poor quality of inpatient hospitalization when CMHS patients need hospitalization, particularly for minority and non-English speaking clients

## **Adult Team Staff**

### *Unmet Needs*

- transitional youth services
- crisis/acute residential care and case management
- geriatric services
- clients who don't meet financial or medical eligibility criteria
- insufficient subsidized housing
- vocational training
- cultural and linguistic diversity
- medication management services

### *Structural impediments to addressing client needs*

- conservatorship challenges
- resistance to acknowledging and treating dual diagnosis
- lack of collaboration across and within CMHS services
- funding should be client-based, and follow clients, rather than programs
- insufficient integration of CMHS into community-based organizations (e.g., Marin Community Clinic) and of non-CMHS psychiatrists into CMHS case management
- limited geographical locations
- arbitrary separation of alcohol/drug services and mental health services

### Staff/technology/infrastructure changes to build CMHS capacity

- livable wage for peer counselors
- hospital privileges for CMHS psychiatrists
- more efficient and cost-effective access to medication consults and monitoring
- resources to track client outcomes and promote evidence-based practices
- sufficient investment in information management systems to effectively track and treat clients
- standardized charting procedures
- contract with out-of-county agencies for more diverse part-time staff
- cross-training in alcohol and other drug abuse issues and certification of CMHS staff
- provide CMHS consultation to medical clinics to provide their in-house mental health services

### **Child Team Staff**

#### Get the "community" focus back into CMHS

- place services more strategically and conveniently to make them more accessible and visible (e.g., in schools, Special Day Classrooms, home visits to families, participation in community events)
- build effective community partnerships (police enforcement, school counselors and staff, parent leadership groups, participation drug courts and correctional facilities, better access to substance abuse treatment agencies and individuals);
- routinely place CMHS program staff in well-established settings (participation in school evaluations – Individualized Education Plans, suspension/expulsion hearings as well as criminal justice settings -- probation, drug court, juvenile detention)
- expand beyond traditional psychotherapeutic focus to address community health and sense of belongingness

#### Increase CMHS efficacy and its community impact

- greater emphasis on prevention to identify kids before they fail (including targeted media campaigns, parenting classes in high schools, teacher training to understand risk and refer early)
- serve more families by engaging parents early on and offering more family-based service
- serve more diverse populations more effectively through greater use of indigenous resources, hiring more people of color through non-traditional means)
- explore less traditional approaches, including art, theater, involvement in community celebrations, mentoring and peer counseling)
- address structural obstacles (i.e., undocumented parent fear, stringent diagnostic requirements) to accessing mental health services

### **West Marin Staff**

#### Need for basic supportive services

- supportive housing
- job skills training

#### Significant gaps in services

- CPS kids
- insufficient MD time
- PES follow-up
- transportation to Marin General, especially for older adults
- Spanish-speaking substance abuse treatment services

#### Options for increasing CMHS capacity

- peer counseling
- stipends to interns for parent education
- expanded use of interns and trainees with more supervision
- collaborative training for dual diagnosis treatment

#### Other suggestions

- reduce obstacles to treatment through anti-stigma education
- improve children's mental health by providing alcohol and drug abuse services for parents
- improve and expand Kaiser services to West Marin, generally, and older adults, in particular

## **CMHS Policy Group**

### Need for expanded children's services

- more wrap-around team services
- expanded school-based services
- probation mental health services
- youth transitional services
- intensive case management and stabilization following a crisis or hospitalization

### Need for expanded adult services

- subsidized and supportive housing
- jail mental health practitioner
- Enterprise
- peer support and recovery services
- STAR case managers
- transition aged youth services
- 24/7 capacity for AB 2034
- more psychiatric time and medication management
- supportive employment
- dual diagnosis services.

### Need for expanded older adult services

- case management
- senior peer counseling
- more nursing to address medical concerns
- adding a CMHS component to APS for in-home assessment and follow-up
- enabling PES to cover dementia.

### Strategies for bringing more services into the community

- a mobile crisis model
- more school-based services
- "one-stop shop" services co-located near social services in Terra Linda
- family partnerships and advocacy
- culturally/linguistically sensitive expansion of services to Marin City, West Marin and the Canal

### Strategies to make dual diagnosis more effective

- making the services fit the clients rather than making the clients fit CMHS resources
- implementing more integration across AOD and CMHS teams
- addressing the need for structural and systemic changes
- recognizing the different training, language and philosophy of treatment between mental health and addiction treatment.

### Ways to reduce obstacles to accessing services and negotiating the CMHS system

- making CMHS easier to find listing in 2005 phone book
- training for administrative staff
- reducing access points without a live person (reducing the use of voice mail systems)
- recognizing that strict eligibility guidelines will inevitably mean that many consumers will be told no
- the need for well-trained, clinically sensitive and dedicated staff to deal with phone center and to do follow-up, whether or not consumers are able to be served within system