COUNTY OF SANTA CRUZ

HEALTH SERVICES AGENCY ADMINISTRATION

HEALTH SERVICES AGENCY

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January 6, 1999

AGENDA: January 26, 1999

Board of Supervisors
County of Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

SUBJECT: Report on Mental Health and Substance Abuse Program Changes and Related Actions

Dear Members of the Board:

This letter is a report back on organizational changes within the Health Services Agency (HSA) in the areas of mental health and alcohol and drug services.

Background

In June, 1998, as part of the HSA budget hearings, your Board accepted a report on planned reorganization of the Alcohol and Drug and Mental Health divisions. The HSA reorganization had several important goals including increased services to clients, increased administrative efficiencies, better coordination of care for CalWORKs clients and dual diagnosis clients, and improved support for service providers. The proposed changes were to be studied with community, provider, and advisory board input. Specific recommendations were to be forwarded to your Board following this input from the community.

Since the June report, HSA has undertaken a variety of efforts to involve the community and the constituencies of both the Mental Health and the Alcohol and Drug programs to develop an organizational model with broad support which could achieve the reorganization goals. The Alcohol and Drug Abuse Commission formed a special subcommittee which worked extensively with County staff on the proposed model. The Local Mental Health Board identified one member who coordinated presentation of their concerns and issues with County staff. Individual and group meetings were held with alcohol and drug as well as mental health contractors. In addition, meetings were held with County staff in both programs to discuss different ways to organize services.

Many important program, clinical, and administrative issues were raised through the community process. In responding to these questions and concerns, HSA utilized a consultant from William M. Mercer, Inc., to assist in identifying the best approaches to meet the goals of the re-organization. The consultant report is attached for your Board's review (Attachment I). The report surveyed 6 counties which had completed similar reorganizations of mental health and substance abuse programs. The counties surveyed were Alameda, Monterey, Napa, Santa Barbara, Ventura, and Yolo. The survey questions were intended to address complex issues raised by the community and County staff. The goal of the survey was to learn from the successes and mistakes of other counties in doing these types of re-organizations and to craft a model which fit the unique needs of Santa Cruz County.

William M. Mercer, Inc. Recommendations:

The William M. Mercer, Inc., report is summarized as follows:

- Best clinical practices should influence the system of care and organizational design;
- Both treatment arenas have unique needs and programs which should be maintained and supported, even though the programs have similar (and often shared) administrative needs;
- Teamwork and trust are built only when care is taken to meet the needs of clients and families during the change process;
- Providers and stakeholders must receive up-to-date communication about the change process;
- Counties should take their time with structural changes to minimize problems and build trust between programs, staff, and community constituencies; and
- Commitment to collaboration must be present as changes in the system and programs develop.

In addition to these general recommendations, William Mercer provided a variety of organization charts and models for deployment and organization of services. These were used to draft the proposed organizational structure for HSA (Attachment 2). This is a functional organizational chart which identifies key positions and their primary responsibilities and duties. This organizational model was reviewed by the advisory boards for both mental health and alcohol and drugs. There was a general consensus that this model would work well for Santa Cruz County in meeting the overall goals of the reorganization, while preserving core services and their values, focus and integrity.

Key Elements of the Proposed Structure:

The proposed structure envisions a lead administrator to oversee all of the mental health and alcohol and drug services within HSA. The two divisions combined constitute 53% of the total HSA budget for the current year and include both contract providers and County staff. In recognition of the enhanced scope of this Division, the Mental Health Director is shown with a new working title on the attached organization chart. Additional changes in titles and job classification will be addressed as part of the HSA 1999/2000 budget presentation. Under this Administrative position are three main components: Substance Abuse Services, Mental Health Services, and Shared Administrative Support.

The direct core services for clients with psychiatric disabilities and those with alcohol and drug problems would continue to remain separate. Based on the recommendations of the consultants and the experience in other counties, this approach assures core program integrity and service delivery. However, this approach does not limit the ability of the programs to coordinate core services for joint clients. There are two existing programs currently providing extensive services for both mental health and substance abuse clients - CalWORKs and a State dual diagnosis demonstration grant.

To support the separate direct services components, it is recommended a shared administrative support program be created pooling staff from both programs. These staff will work together to develop and monitor contracts, process claims, develop cost reports, provide budget support, provide data supports to meet mental health and substance abuse reporting requirements, provide clerical support, and carry out utilization review responsibilities. This support element will serve both the County and contractor-operated programs.

This model preserves and promotes the best practices in care delivery in both programs and works toward administrative efficiencies and revenue enhancement strategies to support drug and alcohol treatment and mental health.

Given this model and other feedback from the community, there are other recommendations which would be incorporated into the program design and structure:

1. The Alcohol and Drug Abuse Commission and Local Mental Health Board would continue as separate advisory bodies to serve as a voice for the different constituencies of the two service delivery systems. Both advisory groups have endorsed this reorganization. The endorsement of the Alcohol and Drug Abuse Commission occurred at their January 11, 1999 meeting. Coordination between the two advisory boards will continue on shared concerns.
2. Maintain existing program names for direct services in mental health and alcohol and drugs. The term “behavioral health” is too unfamiliar and confusing for the public and could create access problems and a fear of stigma.
3. Maintain existing program sites for direct services unless the program is specifically serving dual diagnosis clients with both types of problems.
4. Maintain budget units which allow tracking of dollars spent on both of the programs and their support services.
5. Continue and expand efforts to provide cross training and collaboration between clinical staff from both programs to insure the best practices of care.
6. For Fiscal Year 1999-2000, the new administrative component will carry out many tasks important to the mission of the re-organization. These include studying the administrative support needs of contract agencies, implementing systems to streamline work of the contracting and claiming process, developing a plan for data support which meets Federal, State and grant requirements, reviewing Medi-Cal claiming opportunities within all the programs, and assisting indigent clients to obtain benefits.
7. Complete an annual report card on key goals of the re-organization. The proposed report card is Attachment 3 to this report. As other important indicators of success are identified, these could be added to the annual evaluation of the program as a whole.

Personnel Changes:

The following are recommended changes presented for approval by your Board.

The first position which has just become vacant on January 22, 1999, by resignation of the incumbent is the Deputy Administrator of the Alcohol & Drug Program, and is currently classified as a Sr. Departmental Administrative Analyst. Recent programmatic changes have resulted in restructured job duties being assigned to this position. Because of this, HSA will further review all job duties and discuss with Central Personnel to determine appropriate classification.

The second recommended change is also in the Alcohol & Drug program, in the area of jail discharge planning and social work. A vacant position of Health Program Specialist exists and is recommended for deletion and replacement with a Mental Health Client Specialist position. This latter classification is used for other jail discharge planning positions in Mental Health and the Drug Court. This change will allow all three of the positions to be in the same classification. There are savings in budgeted salaries to make these changes without requiring additional fund appropriations.

An evaluation of these two positions has been part of a process to coordinate personnel and classifications within Mental Health and Alcohol and Drugs. Both programs use many of the same classifications. These proposed changes insure they are being used in the same way for similar jobs and assignments, and provide opportunities for employees to move via transfer between the programs.

Additional job studies are anticipated as changes are made in duties and assignments. With assistance from Personnel, these will be reviewed and recommendations made to your Board later in the fiscal year or at the annual budget review.

Recommendations:

In summary, HSA has proceeded to complete the follow-up tasks identified in the June 1998 report to your Board regarding the reorganization of Mental Health and Alcohol and Drug divisions of HSA. These tasks included consultation and community input from stakeholders. The goal of this process is to develop a sound, organizational model for delivery of good services and efficient administrative support. Two personnel changes are recommended immediately to facilitate filling key positions. Other personnel changes will be studied with a report made to your Board.

It is, therefore, RECOMMENDED that your Board:

1. Accept and file this report on the HSA organizational model for mental health and alcohol and drug services;
2. Direct HSA to report back on April 6, 1999, after studying job changes related to the re-organization and make appropriate recommendations in concert with the County Personnel Department; and

3. Authorize the addition of one FTE position within HSA in the following classification, and direct the Personnel Department to take necessary actions to classify the position:

   a) 1 .O FTE Mental Health Client Specialist

4. Delete the following vacant HSA position:

   a) 1.0 FTE Health Program Specialist (NX5001AA)

5. Direct HSA to work with Central Personnel to review the existing vacant Sr. Departmental Administrative Analyst position, and review for appropriate classification.

Sincerely,

Charles M. Moody
Health Services Agency Administrator

RECOMMENDED:

for Susan A. Mauriello
County Administrative Officer

cc: County Administrative Officer
Auditor Controller
County Counsel
HSA Administration
Community Mental Health Administration
Alcohol and Drug Program Administration
SEIU
Alcohol and Drug Abuse Commission
Local Mental Health Board

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ATTACHMENT I

Santa Cruz Board of County Supervisors

Consolidation Approval

Alcohol + Drug Division 427

COUNTY OF SANTA CRUZ

HEALTH SERVICES AGENCY
ADMINISTRATION

APPROVED AND FILED
6/25/98
BOARD
DEPUTY

HEALTH SERVICES AGENCY
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SANTA CRUZ, **CA 95061-0962**
(408) 454-4066 **FAX:** (408) **454-4488**
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May 27, 1998 AGENDA: Last Day Report

BOARD OF SUPERVISORS
Santa Cruz County
701 Ocean Street
Santa Cruz, CA 95060

RE: CONSOLIDATION OF SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

Dear Members of the Board:

The purpose of this report is to advise your Board of an internal reorganization which is underway in the Health Services Agency. The Agency is administratively joining two programs, Community Mental Health Services and the Division of Alcohol and Drug Services, into a consolidated division of Community Mental Health and Substance Abuse Services.

The restructuring addresses a number of key issues:

- Administrative efficiency.
- Improved/streamlined service delivery.
- Improved coordination with HRA CalWORKs programs.
- Maximization of outside funding sources for increased services to clients.
- Improved communication and linkages with service providers.
- Opportunity for a refocused prevention and early intervention activity.

The consolidation which is summarized here is a conceptual plan. It is expected that in the coming four months HSA staff, under the guidance of Rama Khalsa, Ph.D. County Mental Health Director, working with the County's Alcohol and Drug Abuse Commission and Mental Health Advisory Board, will develop an elaborated structure which will serve as the basis for a consolidated approach to solving challenging problems in each of these areas of need. In the 1998/99 budget year the two programs will continue to operate with separate budgets. Though budgetary changes may be recommended in future years, the fiscal

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emphasis in the coming year will be on achieving efficiencies through administrative activities.

Background - County health services throughout California are dealing with increasing pressures created by managed care insurance programs, increasing numbers of uninsured citizens, and increasing demands on dwindling county resources. In response, many counties have re-organized their mental health and substance abuse functions into a single "behavioral health" program.

The Health Services Agency is committed to evaluating programs and identifying ways to increase administrative efficiencies, reduce costs and to maximize the availability of resources for direct client services. Combining administrative support functions in different health divisions assists in achieving this goal.

In Santa Cruz County, Community Mental Health and Alcohol and Drug Program services share many program goals related to clients with both substance abuse and mental health problems. For some clients these disorders are co-occurring. In such circumstances, research indicates that integrated treatment approaches for the "dual diagnosis" clients are most effective.

These two HSA divisions also provide services through many of the same service providers. Each division imposes stringent data reporting requirements on its contractors as required by their respective State oversight agencies. While some of these demands cannot be avoided even through administrative consolidation, there remain some administrative functions which are duplicative in both divisions.

Both of these divisions also face serious financial pressures in terms of Medi-Cal changes, the evolution of managed care, and increasingly limited access to federal and state grant funds for meeting existing and future community needs. A consolidation plan which takes advantage of mutual opportunities, while preserving the unique clinical and program activities in each division is both desirable and achievable.

The development of a detailed plan for the consolidation will include input of the County Commissions, community advisory groups, clients and families, service providers, staff from both effected HSA divisions and representatives from State and federal oversight and funding source agencies.

Goals of Consolidation:

- Increase the number of clients with alcohol and drug problems being served;
- Identify critical service gaps and develop plans for filling them;

- Improve care coordination and clinical outcomes for dual diagnosis clients;
- Develop a comprehensive, community based prevention plan targeted at children and teens (a copy of a staff draft prevention plan for 1998/99 is attached for reference; a final plan will be discussed with the Board in November, after consultation with appropriate County Commissions).
- Develop, in conjunction with HRA, a cost effective, coordinated response to Welfare Reform for clients with mental health and/or substance abuse treatment needs;
- Improve support provided to contractors working with each division; assist contractors in building their service and management capacity.

These basic goals will serve as the foundation for an effective consolidation of the Mental Health and Substance Abuse Programs. Acknowledging that each division has its unique revenue sources and administrative strengths, a thorough review of options and opportunities presented by the consolidation will be completed. This will be an inclusive process involving key "stakeholders" in both the mental health and alcohol and drug constituencies.

Principles of Consolidation - The following consolidation principles are presented for your Board's review:

- Organizational changes should be planned with advise and counsel from County advisory boards and commissions, the community, service providers, and HSA agency staff.
- Prevention, intervention and recovery from alcohol and drug problems will continue to be the primary mission of the Alcohol and Drug Program.
- Prevention and treatment of mental health disorders will continue to be the primary mission of Community Mental Health Services along with fulfilling its mandates related to Medi-Cal managed care services and disaster relief.
- Resources dedicated to alcohol and drug services should be maintained and, if possible, expanded.
- Day to day program management responsibility and implementation of related policies for substance abuse services will remain with the Alcohol and Drug Program. Administrative support components will work to fulfill program and policy goals of the alcohol and drug program within county and HSA policies.
- Administrative efficiencies in contracting, claims, data, purchasing and other areas should be explored and implemented when they support the achievement of program and service goals. These efficiencies might include automation of substance abuse data requirements which can be achieved using software already used by the Community Mental Health Services. Savings from efficiencies within the Alcohol and Drug division should be redirected to program and community goals of the Alcohol and Drug program services.

- Specialized programs exist in both mental health and alcohol and drug programs serving community and client needs where is a unique drug/ alcohol or mental health function or need exists. These programs will be preserved and remain under program staff with expertise in these areas. For Alcohol and Drug Programs, these include, but are not limited to, the Drinking Driver Program, Drug Court, Jail Referral and Placement, and some specialized prevention activities. For Community Mental Health Services these include, but are not limited to, psychiatric medication management, inpatient hospitalization, crisis management and related services.
- Changes in staffing as a result of consolidation will be achieved through attrition, reassignment, and other personnel options. Layoffs will not occur as a result of the consolidation.
- The two advisory boards/commissions shall continue to function in their respective roles while combining their efforts on joint funding issues, prevention efforts, and the needs of dual diagnosis clients.

These principles should provide reassurance to the constituencies of both Community Mental Health Services and Alcohol and Drug Programs that important specialized services directed to the populations they are concerned with will not be compromised.

The process for developing recommendations to present to your Board in November will include the following:

- Involvement of members of the Alcohol and Drug Commission and Local Mental Health Board members.
- Involvement of service providers and contractors.
- Involvement of key stakeholders in both systems.
- Technical Assistance from the State and federal funding and oversight agencies.
- Visits and consultation from other counties with consolidated programs.
- Consultation with other County departments, Criminal Justice Commission, SCCHO, and other stakeholders.

HSA believes that administrative consolidation of mental health and alcohol and drug programs will provide enhanced services to the community with increased efficiencies in the administration of these programs.

It is therefore RECOMMENDED that your Board:

1. Accept and file the report on consolidation of the Mental Health and Substance Abuse Divisions under the County Mental Health Director; and

2. Direct HSA to return on November 3, 1998, with a further report on the consolidation of the HSA divisions of Community Mental Health and Alcohol and Drug Abuse Services and associated programs and personnel to achieve the goals expressed in this report.

Sincerely,

Charles M. Moody, HSA Administrator
RECOMMENDED:

Susan A Mauriello
County Administrative Officer

attachment

cc. Auditor-Controller
Alcohol and Drug Abuse Commission
Mental Health Advisory Board
CAO
County Counsel
Community Mental Health
Alcohol & Drug Division
HSA Administration

Overview & Summary:

Addiction to and abuse of drugs and alcohol takes a great toll on the community as well as the individual.: This **cost** is very real. It affects the productivity of the addicted person and their family and costs real tax dollars in health, substance abuse treatment, all aspects of the criminal justice system, and child protective services. The goal of prevention is to stop substance use and abuse before it starts in both youth and adults.

This is a complex job which must be done with many community partners. Local government is just one partner working with schools, public health, law enforcement, the courts, the faith community, and a wide range of community groups and organizations. This coming year one of the most important goals is to *strengthen community partnerships* in prevention, treatment, and enforcement related to high risk drugs in our community particularly heroin, amphetamines, and crack.

Doing effective prevention means working on both supply and demand. HSA Drug and Alcohol services support and work with law enforcement and the community on supply issues. This means aggressive pursuit of dealers and persons who produce or transport drugs into the community. It also means insuring there are no illegal sales of alcohol to minors. Working on the **"supply"** means understanding how these drugs get to our young people and the methods used to get them addicted and abusing drugs. Together with the Criminal Justice Council, an effective plan to work on the supply of drugs into the community is being studied. Assistance from federal and state resources will need to be a part of this as well due to the complexity of addressing this side of the problem.

Most of the HSA Prevention efforts in the past and proposed for this next year work on the **"demand".** Educating young people about the dangers of drugs and the means used to get them drug involved is an important part of drug and alcohol prevention. Drug and alcohol involvement is *one* of 6 key risk factors for youth according the Federal Center for Disease Control. Working on the "desire" for drugs and alcohol involves health education in the school, mentoring with good role models, identification of "high risk" youth and getting them services and supports quickly, strengthening families, and providing healthy activities and outlets of self esteem other than drugs. Working on the "demand" will also be part of the CJC Drug Abuse Task Force this coming year. HSA will be reaching out to the schools, parks and recreation departments, and community groups to work on the "demand" issues with youth and adults. The proposed plan for this next year builds on these partnerships.

As part of the activity to integrate and streamline the efforts of community partners over the next year, the Countywide Prevention Council is considering merger with the Together for Youth interagency alcohol and drug prevention collaborative under the umbrella of the United Way. HSA will discontinue its staff support for the Council, and will only participate in Council activities that have been approved by the Together for Youth Executive Committee and are consistent with the objectives of this proposed prevention plan. If the Council decides to continue as an independent entity, HSA will discontinue its Council participation.

Need To Prioritize Resources & Activities:

Limited resources make it critical to prioritize which prevention activities are supported with county resources. The total budget for prevention activities under HSA is $411,052. Most of these funds are federal or state and categorically linked to prevention activities. For 1997/98 there was $38,599 of prevention funds in excess of the minimum mandated amount.

Historically, prevention services have been provided primarily by non-profit substance abuse contractors along with 3.9 county staff. As part of the reorganization of services with Mental Health, the method of providing these services will be re-evaluated to make sure the maximum impacts are achieved with the resources available. This may include coordination with the elementary school primary prevention programs funded through mental health and the many services targeted to high risk youth with both substance abuse and mental health problems. Equally important is a collaborative approach with public health in its efforts to curtail HIV and other drug-linked diseases and risk behaviors. Finally, a strong link with schools in health education programs at all grade levels is critical.

Program Mission

The mission of the HSA Alcohol and Drug Prevention Program is to prevent or reduce alcohol and drug use among youth and adults by providing an array of age-appropriate, culturally competent services coordinated with existing prevention efforts in the community. Services address risk factors at the individual, family and community levels.

Core Values

Alcohol and drug problems result from factors operating at the individual, family and community levels. To be effective prevention services must:

- Be comprehensive
- Involve the entire community
- Provide sustained efforts overtime
- Address emerging drug trends in the community
- Target persons at highest risk
- Be culturally competent and age appropriate
- Be empirically based and include evaluation of services

HSA supports the nationally recognized Communities That Care Prevention Model. This model has 7 essential components. The goals of this plan are based on the priorities discussed related to emerging drugs and primary prevention using these service components. The components of prevention are:

- Increase knowledge and awareness of risks related to alcohol and drugs
- Build skills of individuals, families, and groups
- Increase community involvement in alcohol & drug free activities and recreation
- Provide early identification and intervention services
- Change social norms and policies
- Enforce laws and ordinances
- Increase a community's ability and commitment to respond to alcohol & drug problems

Goals and Objectives

Proposed prevention goals and objectives for the 1998-99 fiscal year are organized according to the seven prevention components. Alcohol and drug prevention services funded by the County are provided both directly by the HSA Alcohol and Drug Prevention Program, and under contract by schools and non-profit community-based organizations. The contractors are listed below in the section of this report titled “Expenses”. For each objective, services to be provided by the HSA Alcohol and Drug Prevention Program are denoted by “HSA", and contracted services by “CON”.

HSA is now renewing alcohol and drug prevention contracts for 1998-99, and final 1998-99 objectives for contracted programs will be available in August 1998. It is anticipated that 1998-99 contractor objectives will be similar to 1997-98 objectives, except to add efforts to address emerging needs and drug trends such as heroin and methamphetamines. The contractor objectives proposed below are taken from 1997-98 provider contracts, and may change for 1998-99.

Objective 1.: Increase knowledge and raise awareness about the effects of alcohol and drugs, the symptoms of alcohol and drug use, progression of alcoholism and drug addiction, consequences to society of alcohol and drug abuse, and roles that individuals and organizations can play in preventing alcohol and drug abuse.

1.1. Provide at least 340 prevention presentations to at least 2,600 individuals. Target audiences include students, teachers and school administrators, parents, health and social service professionals, civic and religious groups, grassroots organizations, labor camp residents, and others. (CON, HSA)

1.2. Conduct at least 6 events to increase awareness about alcohol and drugs. These events will focus on emerging drug trends and informational topics such as effects of alcohol and drugs, symptoms of use, and where to seek help. (CON, HSA)

1.3. Make at least 150 contacts with injection drug users to inform them about HIV risk reduction techniques and encourage them to enter treatment. (CON)

1.4. Maintain prevention libraries in north and south county, and respond to 600 requests for information and loans of materials. (CON, HSA)

1.5. Coordinate knowledge and awareness raising efforts with other stakeholders through Together for Youth, the Children’s Network, and the Criminal Justice Council.

1.6. Conduct **a** special public forum on health education standards related to drug and alcohol abuse and help strengthen existing school programs.

Objective 2.: Build skills of youth, parents, teachers, families, and concerned citizens that will reduce the likelihood of alcohol and drug use. Activities in this category include training parents in parenting skills and how to talk to their children about alcohol and drugs; training teachers and school administrators in implementation of alcohol and drug prevention classroom curriculum;

mentoring of youth; teaching youth communication, conflict resolution and drug refusal skills; and training youth and community members on leadership skills.

2.1. Provide training on alcohol and drug refusal skills to a minimum of 500 students. (CON)

2.2. Provide intensive, long-term, one-to-one mentoring services to 20 at-risk youth and group mentoring to 85 youth. (CON)

2.3. Provide training workshops to at least 135 teachers and school personnel on topics such as implementation of classroom prevention curricula, identification and referral of students with alcohol and drug problems, and building student resiliency. (CON)

2.4. Provide training to at least 550 parents on topics such as parenting skills, communicating with children about alcohol and drugs, identification and intervention with youth who are experimenting with alcohol and drugs, and leadership skills. (CON)

2.5. Coordinate skill building efforts with other stakeholders through Together for Youth, the Children's Network, and the Criminal Justice Council. (HSA, CON)

Objective 3.: Increase involvement by youth and adults in alcohol and drug-free social, recreational and cultural activities. Activities in this component weave education about alcohol and drugs, skill development such as leadership training and communication skills, and expanding community awareness about alcohol and drug issues, into the process of working with youth and adults to plan and implement alcohol and drug-free social, recreational, cultural, and community service events. Events typically involve substantial outside fundraising to reduce County costs and promote independence and leadership skill development among participants.

3.1. Provide daily after-school recreational and educational activities that focus on alcohol and drug education and risk reduction skill-building to at least 240 predominately latch-key elementary and middle-school children. (CON)

3.2. Coordinate the Friday Night Live/Club Live youth alcohol and drug prevention program at 13 middle and high school and community sites. The 13 club chapters will plan and implement at least 80 social, recreational, cultural or community service activities such as dances, teen leadership skills conferences, charity drives, graffiti clean-ups, informational events (e.g., the Great American Smokeout, Red Ribbon Week), outdoor adventure activities, mural projects, and cultural celebrations. (HSA)

3.3. In collaboration with the Volunteer Center, Santa Cruz City Parks and Recreation, Boys and Girls Club, and the Resource Center for Nonviolence, support the Youth Coalition Santa Cruz (YCSC). Support for YCSC will be accomplished through semi-weekly meetings and staff participation in specific projects to involve at least 100 teens in developing and implementing an annual plan to conduct at least four community service and awareness projects, and recreational and cultural events. Examples of YCSC projects in prior years include Youth Speak Out needs assessment forums, theater projects, and participation in planning and fundraising for a proposed youth drop-in center. These events will also be used to communicate critical information on high risk drugs. (HSA)

3.4. In collaboration with schools, community groups, youth and health and human service agencies, plan and implement at least five community and cultural celebrations such as Gym Jam, Sober Graduation, First Night, and Cinco de Mayo. (HSA)

3.5. As requested by event organizers, provide information to community events which currently provide alcoholic beverages or tobacco products, or are sponsored by the alcohol or tobacco industry, to become alcohol and tobacco-free and/or find alternative sponsorship. (HSA)

Objective 4.: Assist youth who are currently using alcohol and drugs by identifying their alcohol and drug problems, intervening to motivate them to seek help, and referring them to treatment or other appropriate services. Services typically involve between one and four individual and/or family counseling sessions, or short-term adolescent group counseling to address issues related to denial and motivation.

4.1. Provide early intervention services to at least 450 youth, including the parents or guardians of at least 100 of these youth. Special attention will be paid to youth experimenting with heroin, methamphetamines and "club" drugs. Early intervention services are typically provided through referrals from teachers and other school personnel who become aware of students who may have an alcohol and drug problem. (CON)

Objective 5.: Promote changes in policies, regulations, ordinances or laws of private or public organizations, or local, state or national governments related to alcohol and drug use. Prevention service providers can support this objective primarily by providing information and technical assistance as requested by policy-makers and concerned citizens.

5.1. As requested by local businesses and schools, provide information and technical assistance related to development of company and school policies related to alcohol and drug use, and promotion of responsible beverage service policies by alcoholic beverage retailers. (HSA)

Objective 6.: In conjunction with law enforcement, support enforcement of existing regulations, ordinances, and laws related to alcohol and drugs. (Enforcement activities are conducted primarily by law enforcement personnel). Prevention service providers can accomplish this objective by providing information and technical assistance to community groups concerned about illegal activities, and publicizing information about laws and enforcement activities to enhance the deterrent effect.

6.1. Working in close coordination with law enforcement, schools, community groups and businesses, conduct at least 10 information campaigns using targeted media (e.g., school newspapers) to publicize alcohol and drug law enforcement activities such as minor decoy "sting" operations, DUI checkpoints, and heroin sales enforcement operations. (HSA)

6.2. Provide technical assistance to at least three community groups concerned about law enforcement issues such as problem alcohol outlets selling to minors and landlords who permit their properties to be used for drug dealing. (HSA)

6.3. Conduct at least three focus groups in the community to discuss emerging drug problems with juvenile offenders, law enforcement and community leaders. These efforts will be coordinated through the Criminal Justice Council. (HSA)

Objective 7.: Increase the community's capacity and commitment to respond to alcohol and drug problems.

7.1. In collaboration with local schools, conduct a semi-annual survey of approximately 3,000 middle and high school students regarding alcohol, drug and tobacco use. (CON, HSA)

7.2. As requested by local law enforcement agencies, provide technical assistance to implement an automated system for routinely collecting data on alcohol and drug involvement in police calls for service. (HSA)

7.3. Provide at least six training events to a minimum of 300 parents, prevention professionals, and community members on topics such as recent research in alcohol and drug prevention, evaluating prevention programs, prevention needs assessment and program planning; involve the community in prevention issues, addressing emerging drug trends, techniques for implementing mentoring and resiliency-building programs, and involving the media in furthering prevention objectives. (HSA)

7.4. Support interagency collaborative prevention efforts through monthly or more frequent participation in the Together for Youth/Unidos Para Nuestros Jovenes Executive Committee and Roundtable, the Criminal Justice Council Drug and Alcohol Task Force, and the Children's Network, and provide staff support to implement prevention activities planned by these interagency collaboratives. (HSA, CON)

7.5. In cooperation with the interagency collaboratives described in Objective 7.4, work with law enforcement, schools, health and human service providers, youth, parents, and community groups to develop a coordinated information, early intervention and law enforcement campaign targeted toward reducing the use by youth of heroin and other emerging drugs. (HSA, CON)

7.6. Prepare at least three funding proposals to augment prevention services, targeting emerging drugs as a top priority (HSA)

7.7. Provide technical assistance on evaluation of prevention programs to at least four prevention service providers. (HSA)

7.8. Develop an organized approach with the Human Resources Agency to prevention of relapse for welfare/TANF participants using designated resources. (HSA)

Revenues

Budgeted revenues for prevention activities in 1998-99 total $411,052, and include $275,893 of Federal Alcohol and Drug Block Grant prevention set-aside funds, $88,879 of Safe and Drug-Free Schools and Communities funds, $33,280 of SB920 drinking driver fines, $10,000 of United Way funds, and $3,000 of prevention program participant fees.

Funding for prevention services is subject to State and Federal mandates, including the requirement that 20% of Federal Alcohol and Drug Block Grant funds be set-aside for prevention. Federal Safe and Drug-Free Schools and Communities funds are earmarked for

primary prevention. Many grants are for specific prevention programs, and SB920 drinking driver fines revenue must be dedicated to prevention. These earmarked prevention revenues may also be expended on allocated HSA administrative costs attributable to the HSA Prevention Program. For 1997198, $364,052 was allocated for primary prevention; $38,599 in excess of the minimum mandated amount. The miniinum mandated amount for prevention services for 1998-99 will be known once the State budget is adopted.

Expenses'

The proposed 1998199 budget for alcohol and drug prevention services totals $411,052, which includes $192,650 of contracted services and $218,402 of County-operated services. This is a $47,000 increase over 1997198 resulting from grants from the State for $34,000 for Big Brothers/Big Sisters mentorship services and $13,000 of United Way grants and client fees to permit establishment of three new Club Live chapters in junior high and middle schools.

HSA Alcohol and Drug Program prevention expenditures for 1997-98 and 1998-99 are listed below.

Agency	1997-98	Proposed 1998-99	Change
Big Brothers/Big Sisters	$0	$34,000	$34,000
County Office of Education	6,294	6,294	0
Fenix	100,374	100,374	0
Pajaro Valley Prev. & Student Asst.	18,015	18,015	0
Santa Cruz Community Couns. Ctr.	14,481	14,481	0
Santa Cruz City Schools	11,342	11,342	0
Women's Crisis Support	8,144	8,144	0
Subtotal Contracted Services	$158,650	$192,650	$34,000
HSA Prevention	$205,402	$218,402	$13,000
Total All Prevention Services	$364,052	$411,052	$47,000

The HSA Alcohol and Drug Prevention Program is recommended to receive $218,402, of which $171,494 is allocated to support a 1.0 FTE Prevention Coordinator, 2.0 FTE Health Program Specialists, and .9 FTE Typist Clerk II and III. The proposed allocation for services and supplies is $46,908, which primarily supports agreements with schools for Friday Night Live/Club Live advisor stipends and program materials; training for youth, parents and community members; and educational materials.

Santa Cruz County
Health Services Agency

Division of Alcohol and Drug Abuse and Community Mental Health Administrative Services Consolidation

Survey of Other California Counties
November 1998

BACKGROUND AND PURPOSE OF THE SURVEY

In June **1998,** the Santa Cruz Board of Supervisors approved the consolidation of substance abuse and mental health administrative services and directed the Health Services Agency to return to the Board with specifics of the new administrative structure (see Board letter, Attachment I). Rama Khalsa, PhD, Mental Health Director, was asked to be the lead administrator. Since then, Dr. Khalsa and William Manov, PhD, Alcohol and Drug Services Program Administrator, have been working closely to develop a coordinated approach to a smooth consolidation.

Dr. Khalsa and Dr. Manov have been meeting with staff from both programs to listen to staff concerns. In addition, they have had several meetings with the Alcohol and Drug Abuse Commission (ADAC) about the consolidation. The major concerns of staff and ADAC included:

- Fear of diversion of funding to mental health;
- Loss of full-time employees (FTE) for substance abuse services;
- Impact on client population related to stigma; and
- Loss of commitment to Alcohol and Drug Services.

Recognizing the concerns of staff and ADAC, Santa Cruz County commissioned William M. Mercer, Incorporated (Mercer) to survey other California counties which have consolidated behavioral health services. Information from the survey, along with input from staff and ADAC, was the first step in developing a coordinated approach for a smooth consolidation.

The purpose of the survey was to gather information on other California counties that have consolidated behavioral health services. This information would then be available to Santa Cruz County administrators and stakeholders as they begin the process of consolidating alcohol and drug abuse and mental health services.

SURVEY DEVELOPMENT AND IMPLEMENTATION

The survey tool developed by Mercer focused on the chief concerns expressed by Santa Cruz county staff and administrators and ADAC. An initial meeting was held with ADAC about the survey process and content. A draft was submitted to the county and revisions from Santa Cruz county staff and administrators and ADAC were incorporated. Once the survey tool was finalized, Mercer staff conducted a telephone survey with designated alcohol and drug abuse program administrators identified by the California Alcohol and Drug Program (ADP) in the six counties selected. Santa Cruz selected these counties because they have undergone a consolidation process.

The six counties surveyed were Alameda, Monterey, Napa, Santa Barbara, Ventura and Yolo. Individuals surveyed in each county are identified in Attachment II.

SURVEY INTERVIEWS: SUMMARY

Background of Counties Surveyed

All six counties surveyed have an integrated substance abuse and mental health administration. Napa has had integrated administrative services since 1980. Santa Barbara (August 1997) and Yolo (July 1998) only recently integrated their administrative services. Alameda, Monterey and Ventura have been operating with integrated administrative services for the past three to five years.

The counties report differences in the percentage of funding for direct provision of services versus provider provision of services. Santa Barbara contracts almost 100 percent of substance abuse services funding to providers. Conversely, only about 35 percent of mental health services are contracted to providers. Alameda contracts approximately 85 percent of their behavioral health funding. Ventura and Yolo retain about 70 percent of total behavioral health funding to provide direct services through the county. None of the programs identified consolidation as changing this mix of contract versus direct county operated services.

In most cases, the impetus for integration came from the governing county board. The rationale for integration varied from anticipated administrative savings to better coordination of client care. In one case, the county administrator suggested integration and the governing board approved the measure. In Napa, providers urged the change because they saw the county's escalating administrative costs and wanted the county to preserve and protect more service dollars.

Consolidation Concerns

Survey respondents were asked for their perceptions concerning provider and other stakeholder apprehension over the changes. In most counties, significant stakeholder apprehension was reported. Part of the apprehension stemmed from concerns over personnel losses, budget reductions, and negative impact on clients. In actuality, most of these negative consequences never materialized according to respondents.

Four of the six counties did not report any loss of FTE. Yolo indicated the role and function of some positions may have changed after consolidation but no positions were eliminated. Of the remaining two, one county (Alameda) reported the loss of one FTE – the substance abuse program administrator. However, the program administrator was not laid off; the position was eliminated through attrition. Monterey is the exception; Monterey reduced total FTE by **12** when consolidation occurred four years ago. This related mainly to "privatizing" some services, especially prevention services, previously operated directly by the county, In at least two counties (Napa and Ventura) the Alcohol and Drug Administrator was promoted to lead the behavioral health program after consolidation.

No county reported any budget reductions for either mental health or substance abuse services. Two counties reported increased Medical billing.

In all cases, respondents reported significant apprehension from stakeholders related to possible negative impacts on clients and families. Some stakeholders believed the clinical perspective would become more "medicalized," and social models would no longer be recognized and funded. Some were concerned that racial and ethnic minorities would not accept services provided in a jointly administered program. This did not appear to be the case in any documentable way. All counties reported maintaining the same basic service array and serving as many racial and ethnic minorities as prior to the integration. Santa Barbara specifically identified the disproportionate percentage of Latinos served. Most counties realized a significant enhancement to services when providers were better educated on both mental health and substance abuse issues.

In accordance with state law, all of the counties supported a mental health commission. Four of the six counties had retained separate substance abuse commissions after administrative integration. Most of these reported regular meetings between the substance abuse and mental health advisory boards. Of the remaining two, one commission was converted to a task force after implementation of the consolidated structure. The other never had an advisory board for alcohol and drugs.

Components of Successful Consolidation

Elements of a successful consolidation were solicited from the six counties surveyed. Their responses have been grouped into the areas identified below,

Open Communication

The most frequently cited component of successful implementation was open communication with stakeholders and adequate time to prepare for the change. Two counties utilized extensive consensus building processes. Alameda hired a consultant to facilitate their system redesign initiative. The county's efforts focused on a clinical perspective to best meet the needs of clients and began with the core values stakeholders wanted for the service delivery system. This included a complete continuum of care. Through the redesign meetings, stakeholders began to take ownership for the way services should be changed. Trust was also built during this process. Alameda made a special effort to be inclusive of all providers

in their behavioral health system. Alameda had signs printed for provider offices inscribed with, "We are a member of the Alameda County behavioral health system of care."

Yolo engaged in a similar redesign process. A Quality Committee was developed, comprised of county substance abuse and mental health professionals, consumers. clients, providers, a representative from the county administrator's office, and advisory board members. The Quality Committee engaged in benchmarking current baseline information, developing other tools to measure system effectiveness, holding public forums, and developing recommendations to the county board. A copy of their recommendations is included in this report as Attachment III.

Santa Barbara's impetus for change involved less communication and planning. In August 1997, the Board of Supervisors voted to consolidate substance abuse and mental health by a controversial 3 to 2 vote. By January 1998, the consolidation was complete. This move was seen as "an unfriendly takeover" by some people. The Mental Health Director subsequently resigned.

Innovative Programming

Counties with consolidated substance abuse and mental health administrative functions under a single authority varied on how the administrative structure is organized. Most have single units for budget, personnel, contract management and MIS. Because of specific requirements associated with separate mental health and substance abuse funding sources, most counties have some staff in their budget units and MIS units with particular expertise in substance abuse, and others in mental health, while some administrative staff are generalists.

Service provision did not change dramatically when administrative functions were combined. Counties appeared to be making incremental changes to the system structure to better serve clients with single and dual diagnoses. Many of the counties have developed innovative programming. Ventura and Napa specifically identified training opportunities available to professionals from both fields. Ventura added professionals with expertise in dual diagnosis as a resource to their regional consulting teams. Ventura also developed a position for a substance abuse professional on staff at their mental health psychiatric unit and a part-time substance abuse professional on staff for the older adult unit.

Yolo placed a mental health clinician in their social detox unit to supervise paraprofessionals and train them about mental illness. Yolo branch offices are serving both mental health and substance abuse clients.

Most county clinical services supervisions, and in most cases some direct service delivery, continues to be divided into substance abuse and mental health units. Napa is an exception where services are managed or delivered through children, adult, and older adult units. Ventura's organizational chart is typical of this with shared administration but distinct services. Copies of all organizational charts received from surveyed counties are included as Attachment IV.

Without exception, counties identified a consolidated administrative structure as a plus for new service funding from welfare reform initiatives and Medical. Integrated structure and services could more easily access the funds and distribute them into services more readily.

The future trend appears to be toward further integration. Some counties had already undergone changes, from being part of the health system to being part of the human services system. The impetus for this consolidation appears to be in mental health and drug and alcohol's link with social services, child welfare, and criminal justice, Currently 34 of 58 counties have combined administrative structures based on the welfare reform survey completed by CSAC.

The chart on page 7 summarizes survey responses.

SURVEY INTERVIEWS: CONCLUSIONS

If other California counties are any indication, Santa Cruz's effort at a coordinated approach to consolidation appears to be the right first step. Gathering as much information from stakeholders and other information sources seemed to lead to better success and a smoother transition for other counties. Other counties have successfully integrated several administrative functions. However, most retain some substance abuse-specific expertise in budgeting and managing information systems due largely to the state and federal requirements associated with both disciplines.

Other specific findings included:

- Stakeholder apprehension over the consolidation process is lessened when there is stability in funding and personnel as the change is implemented.
- Trust is built only when care is taken to meet the needs of the clients and families.
- Only best clinical practice should influence the system of care redesign.
- Providers and other stakeholders must receive up-to-date communication about the change process.
- Frustration is lessened when training is made available, the budget and re-design process are inclusive of stakeholder input, and values from both disciplines are respected and retained. Any reductions in staffing should be done through attrition.

Valuable recommendations came from those counties who have participated in consolidation. The responses to the survey question, "What would you consider the most important issue to consider for a county contemplating integrating their service delivery system?" may provide the best guidance to Santa Cruz. Their responses included:

- Be respectful of one another, i.e., substance abuse and mental health stakeholders. There is value in both disciplines. Don't be judgmental about your perspective being "right."
- Don't rush to make structural changes. It takes time to build trust.
- Consider the similarities and not the differences in the disciplines as both are long-term, chronic, relapsing conditions
- A successful consolidation requires leadership and vision.
- Don't be afraid to be innovative.
- Much can be borrowed from the way the other discipline provides services. A full array is needed to meet peoples' needs.
- Share the power and ownership of moving the system forward.
- Let clinical appropriateness drive system change. "Start where the client is at."
- Have staff share physical space so they can learn from each other.
- Have advisory boards meet together periodically to strengthen mutual understanding and respect.
- Commit to continuity of services and budget neutrality during implementation.
- Commit to collaboration in every way possible. Merely putting people together won't fix problems.
- Communicate realistic expectations to stakeholders. Not every problem is going to go away because of consolidation.
- Communicate "hold harmless" statements to reassure people that jobs will not be lost and services will not be cut.
- Always take a clinical perspective, not a financial one.
- Engage in open communication and continually seek input.
- Provide leadership to create a team approach. Develop a shared vision with staff and stakeholders.

California County Survey:
Substance Abuse/Mental Health Consolidation

	Alameda	Monterey	Napa	Santa Barbara	Ventura	Yolo
Integration date	1994	1994	**1980**	August 1997	1995	July 1998
Separate ADAC from LMHB	No	No	Yes	Yes	Yes	Yes
Funds for direct county services compared to funds for contracted services	15:85	AD=0:100	AD=most are county MH=divided county and provider	AD=0:100 MH=65:35	70:30	70:30
Number of FTE reduced in both programs	1	12	0	0	0	0 (However, role and function may **change)**
Changes in alcohol and drug services budget	Increased Medicaid billing for SA	Increased	Maintained	Maintained	Maintained	Maintained
Change in minority clients served	No	No	No	No	No	No

Source: Telephone survey, November 1998.

c:tsgoens/santacurz/surveysummary/113098

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ATTACHMENT II

County Contacts Interviewed

Marye Thomas, MD, PhD
Director of Behavioral Healthcare
Behavioral Healthcare Services
Alameda County

Shirley Castillo
Program Manager for Alcohol and Drug Abuse
Department of Health
Monterey County

Al Rodriguez
Alcohol and Drug Program Manager
Alcohol, Drug and Mental Health Services
Santa Barbara County

Joan Parna, MS, MFCC
Deputy Director
Alcohol, Drug and Mental Health Services
Yolo County

Bob Egnew, MSW, MPH
Behavioral Health Director
Department of Health
Monterey County

Jim Featherstone, LCSW
Assistant Director,
Alcohol and Drug Administrator
Napa County Health and Human Services Agency

Steve Kaplan
Director
Behavioral Health Department
County of Ventura

ATTACHMENT III

Yolo County Quality Committee

Recommendations for Consolidation

Mental Health Alcohol and Drug Consolidation (MAC) Team

Arlene Amaral
Bonnie Beffa
Deborah Brown (Coach)
Debbie Carrion
Esther Castillo
Dan Frank
Laura Hogan
Beverly Howard (Facilitator)
Joan Parnas
Wanda M. Park
Tom Pavao
Eva Schepeler
Arun Seeley
Karen Serna
Sandra Serrano
Vic Singh (CAO Representative)
Tammy Smith
Mike Tucker (Coach)
Joanne Welty

Final Report to the Yolo County Quality Council

January 26, 1998

MENTAL HEALTH/ALCOHOL AND DRUG CONSOLIDATION (MAC) TEAM FINAL REPORT

TABLE OF CONTENTS

MENTAL HEALTH/ALCOHOL AND DRUG CONSOLIDATION (MAC) TEAM FINAL REPORT

A. PROJECT PURPOSE

In early 1997, the County Administrative Office recommended that a Quality Improvement Team be chartered by the Quality Council to gather data and information and make recommendations on the best options for consolidating the departments of Alcohol and Drug and Mental Health. As a result the Mental Health/Alcohol and Drug Consolidation (MAC) Team was formed. The charter given to the MAC Team stated that there would be one department head for the consolidated department who would be selected through an open recruitment. Otherwise, the team would have the opportunity to make recommendations on the extent and type of consolidation.

B. PROBLEM STATEMENT

The County Administrative Office determined that consolidation of Mental Health and Alcohol and Drug services should be considered due to the following:

- Too many departments and department heads within the County structure exist to create an effective leadership team.
- Managed Care for Mental Health services was about to be instituted with full financial responsibility falling on the County.
- The private sector has found various levels of integration of Menal Health and Alcohol and Drug Servicers are cost-effectrive and provide better service to consumers.

C. TEAM OBJECTIVES

The MAC Team spotlighted the following objectives:

- Create a structure that is cost-effective and seamless in service delivery
- Flatten the county organizational structure
- Improve services to the consumer
- Utilize Quality Improvement Principles in the development of Recommendations

D. PROCESS

1. **TEAM** CREATION: The directors of Mental Health and Alcohol and Drug asked for 'volunteers to join a team to shape recommendations for the consolidation of Mental Health and Alcohol and Drug using quality improvement principles. The resulting team consisted of a cross section of staff from each department, representatives of Advisory Boards/Committees, the County Administrative Office, and consumers. After being chartered by the Quality Council, the team met for two hours biweekly for the first three months. As information was gathered, the team decided to meet weekly in order to complete its tasks. Members also had additional responsibilities for sharing, gathering, and analyzing data between each meeting.

2. **FAMILIARIZATION WITH EXISTING DEPARTMENTS:** The first step of the MAC Team was to familiarize themselves with the existing mission, functions and structures of both departments.

3. **PUBLIC FORUMS** & ALL-STAFF MEETINGS: A public forum was held on August 11, 1997 to obtain stakeholder input on consolidation. An invitation to attend was sent to advisory board members, other stakeholders, and a notice was sent to all local newspapers; however, attendance at the forum was low. All-staff meetings were also held within both departments to familiarize employees with the MAC Team charter and progress, and a joint staff meeting of both departments was held in December 1997. Another public forum is scheduled for January 14, at which time the MAC Team Final Report will be shared, and questions and comments will be addressed.

4. CREATING AND ADMINISTERING STAKEHOLDER SURVEYS: The second step of the process was to identify the various groups of stakeholders, develop surveys, and administer them. Surveys were created for the following groups and administered in person or by phone: Consumers Staff Advisory Boards/CommitteesProviders Survey questions and results are included as Appendix D of this report.

5. **RECOMMENDATIONS FOR CONSOLIDATED DEPARTMENT DIRECTOR QUALIFICATIONS:** The MAC Team surveyed stakeholders to determine the qualifications they found most important in a consolidated department director. Results were compiled and analyzed prior to any other survey data so that the team could submit recommendations to Human Resources. The Depanment of Human Resources worked cooperatively with the team to develop the MAC Team's proposed director qualifications recommendations included as Appendix F of this report. Overall, stakeholders felt that extensive management experience and excellent communication skills were vital as well as Mental Health and Alcohol and Drug experience.

6. ON-GOING PRESENTATIONS TO MENTAL HEALTH ADVISORY BOARD, DRUG ALCOHOL AND TOBACCO ADVISORY COUNCIL, AND THE HEALTH COUNCIL: As the work of the MAC Team progressed, periodic progress reports were made to these Advisory Committees.

7. SURVEYING OTHER COUNTIES: A list of criteria was developed by the MAC Team for selecting other counties to survey. The criteria included counties similar in size as much as possible and ones which recently combined their Mental Health and Alcohol and Drug services or ones who had always been combined. Counties meeting these criteria and selected for preliminary telephone interviews included: Tulare, Sutter-Yuba, Placer, Ventura, Butte, Stanislaus, and Nevada. The counties were then initially interviewed by telephone to obtain general information and were later on interviewed in more depth.

   Repeated attempts were made to survey Stanisiaus County and Merced; however, these counties did not respond to the requests for an in depth interview. Results from the in-depth surveys of the other counties selected are included in Appendix E of this report.

8. COMPILATION AND ANALYSTS OF DATA AND INFORMATION: The team compiled the information and data obtained from the various sources, calculated statistics, and created lists of general themes, good ideas, concerns, and ideas for quick fixes and future quality improvement projects.

9. FORMULATION OF RECOMMENDATIONS AND PRODUCTION OF PROPOSED ORGANIZATIONAL CHARTS: Recommendations were formulated and reviewed several times. Organizational charts were then finalized to depict the team recommendations.

E. CHALLENGES

The MAC Team faced many challenges along the way

One challenge faced was the strongly held feeiings of some stakeholders who opposed consolidation, in general, and objected to the MAC team recommendations for qualifications for the consolidated Department Director. Although, the concerns raised by these stakeholders were carefully considered, the MAC Team used stakeholder survey results specific to the qualifications of a consolidated department director to make its final recommendations. The MAC Team's recommendations for the new consolidated Director qualifications are included as Appendix F of this report.

The process, itself, was very demanding and time-consuming. Members attended bi-weekly two-hour team meetings during the first three months, weekly two hour meetings during the last five months and performed several hours of outside work between meetings with no release from normal duties. Volunteers representing consumers and advisory boards/committees donated many hours without pay.

At times, the strongly held feelings of stakeholders impacted team members; but, the team worked out their own differences and strived to keep their work professional, to base conclusions and recommendations on information obtained, and to follow quality improvement principles.

All recommendations contained in this final report receive the full commitment and support of all team members.

F. SUMMARY OF STAKEHOLDER SURVEY RESULTS

MAC Team recommendations are based on data/information obtained from stakeholder survey results and department data. The surveys utilized and result summaries are included as Appendices D and E of this report. Highlights of the most significant survey results are as follows:

- 21% of Yolo County consumers are receiving both Mental Health and Alcohol and Drug Services. Overall in looking at all diagnoses for all consumers in both services, 40%, of both Mental Health Services consumers and Alcohol and Drug Services clients have both a mental health diagnosis and alcohol and drug related diagnosis.
- Consumers, providers, and staff repotted cross training of staffwould be beneficial to increasing the quality of treatment services (as long as specialization was still available).
- Consumers, Advisory Boards, providers, and staff reported the County needs to increase services to children, teens, and pre-adults.
- Consumers, Advisory Boards, providers, and staff reported the consolidation would hopefully lead to increased quality and efficiency in dual diagnosis services.
- 43% of consumers were not familiar with the services available within both departments. This indicates a strong need for consumer education.
- 34% of consumers, and 30% of staff are concerned that consolidation will have a negative impact on them personally.
- Consumers expressed concern that uniqueness of Mental Health and Alcohol and Drug services would be lost, and all consumers would be provided services as if dually-diagnosed clients.
- Consumers expressed concern about sharing space and resources with others with different diagnoses, both of which have stigmas attached. The stigma of mental illness or addiction is bad enough, but being confused with someone with another stigmatized diagnosis seemed doubly negative.
- Staff expressed concern about:
  a. Losing their identities
  b. Losing the frame of reference of their discipline
  c. Losing their jobs
  d. Losing a sense of belonging
- Advisory Boards/Committees expressed concern about:
  a. Each discipline losing its identity
  b. Fear the other discipline might swallow it up and drain its resources
  c. The increasing size of the organization could cause problems in communication and diminish a sense of common goals

G. SUMMARY OF OTHER COUNTY SURVEY RESULTS

MAC Team recommendations are also based on data/information obtained from other county survey results. The surveys utilized and result summaries are included as Appendix E of this report. Highlights of the most significant **good** ideas and pitfalls to avoid obtained From these county interviews include:

GOOD IDEAS

1. All clients on medications are subject to mandatory drug testing. (Tulare)
2. A 12 bed dual diagnosis unit with a drug/alcohol residential treatment facility license (Tuiare)
3. A Juvenile Drug Court and other programs for youth (Tulare)
4. Improved telephone listings for services (Tulare)
5. Follow up confidentiality procedures (Tulare)
6. Maintaining two separate advisory committees to keep visibility of issues high (Placer)
7. Working closely with other departments - good collaboration (Placer)
8. Creating a centralized generic access team for services (Placer)
9. Creating some shared M.H./A & D positions (Nevada)
10. Creating joint M.H./ A & D Teams (Nevada)
11. Creating structure to insure comprehensive M.H. &AD. continuity of care (Nevada)
12. Good dual diagnosis program **(Nevada)**
13. Proactive tear-n planning for Welfare Reform services (Sutter - Yuba)
14. Hire a grant writer.
15. Blended buildings (Butte)
16. Filled in cracks between M.H. and A & D services (Butte)
17. Reduced administrative costs (Butte)
18. Cross training of staff (Tulare)
19. Combined purchasing, billing, fiscal unit (Tulare)
20. Cross discipline teams are well received. (Butte)

POTENTIAL PITFALLS

1. Some staff may leave because they do not like the cross training and resulting changes.
2. Separate funding sources and budget requirements make consolidation difficult.
3. Substance abuse clients may feel they are not getting attention if they are not dually diagnosed.

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POTENTIAL PITFALLS

I. Some staff may leave because they do not like the cross training and resulting changes.
2. Separate funding sources and budget requirements make consolidation difficult.
3. Substance abuse clients may feel they are not getting attention if they are not dually diagnosed.

H. RECOMMENDATIONS FOR IMPROVED SERVICES/QUICK FIXES

MAC Team recommendations for Improved Services/Quick Fixes are:

1. Clinical supervision for clinicians in both Mental Health and Alcohol and Drug be assigned to one position. This is a more cost-effective use of staff. Expertise can be sought as needed from other staff. This presents many opportunities for cross-training and for staff becoming comfortable working with each other, two issues mentioned frequently by staff in the survey.

2. The Access Team become available to both Mental Health and Alcohol and Drug services. Presently, the Access Team provides assessment and referral primarily for Mental Health services. This will eliminate duplication of work. In response to survey results, care must be taken to assure that another layer of barriers to access is not added, but a more efficient consumer friendly access system is developed.

3. Quality Assurance staff report directly to the consolidated Director. This function includes overall quality assurance, utilization review, safety oversight, staff training, consumer satisfaction surveys, consumer grievance procedures, and support of department quality improvement efforts. This reporting structure will provide for objectivity when investigating and assessing problems and grievances, which may involve any area of the department.

4. Work out a supervision plan for the Beamer Street Program which provides expertise in Mental Health issues as well as alcohol and drug issues to facilitate serving more mentally ill persons in Detox and Introduction to Recovery Residential Services.

5. Along with the Human Services Leadership Team (HSLT), the County enter into partnerships to staff the Multi-Disciplinary Assessment and Referral Team (M-DART) and HSLT. This will assist them in developing a data base, prioritizing needs, and performing support and follow-up work on a strategic planning process and will address the need identified in stakeholder survey results to increase and/or improve service delivery to high risk youth.

6. Utilize time clients are waiting for appointments for introducing newly developed resource lists, informational brochures, and information on other self-help groups available to assist consumers before, during, and after professional treatment. This was mentioned frequently by consumers in the survey.

I. RECOMMENDATIONS FOR ORGANIZATIONAL STRUCTURE

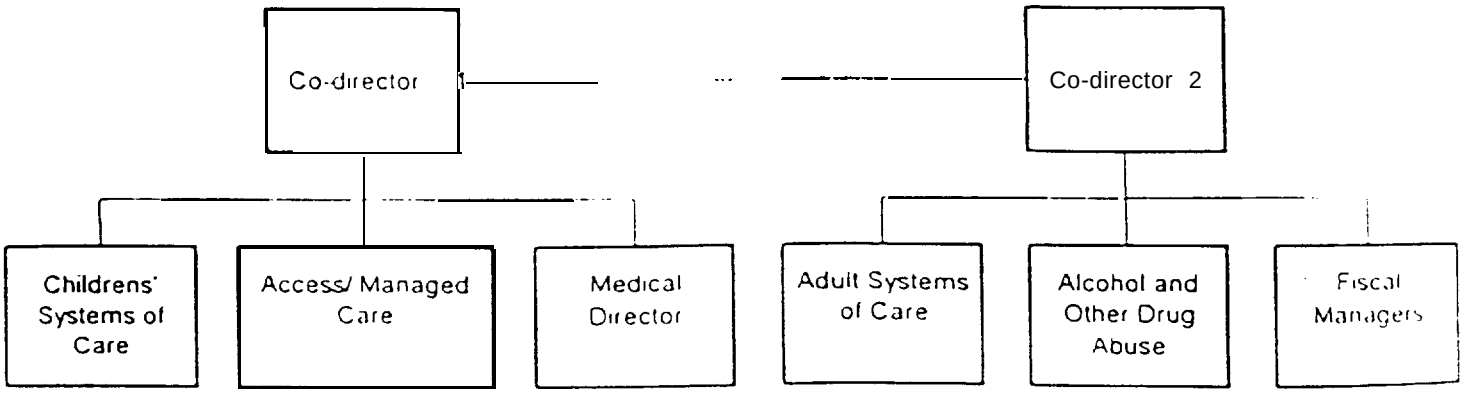
Final MAC Team recommendations to the Quality Council are

THE CONSOLIDATION OF THE DEPARTMENTS OF MENTAL HEALTH AND ALCOHOL AND DRUG TAKES PLACE IN PHASES

PHASE I:

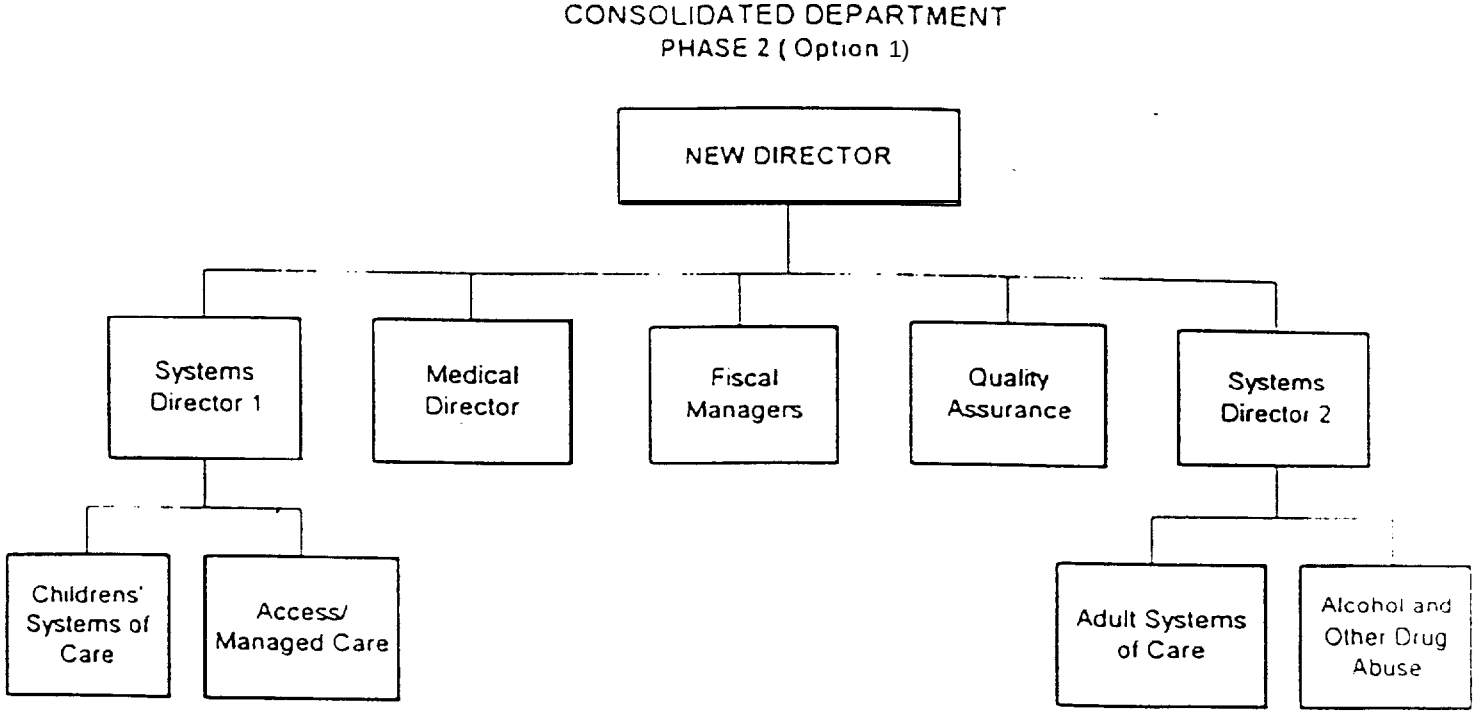
- Recruitment of a director for the consolidated department (MAC recommendations for qualifications are included as Appendix F of this report)
- Current department directors of Mental Health and Alcohol and Drug Programs serve as co-directors during the period of recruitment.
- QUEST Teams of both depanments merge and the Quality Assurance Coordinator becomes a member of the QUEST team.
- Quality Improvement Teams are chartered to gather data and make recommendations on specific projects resulting from analysis of survey data.
- The recommended immediate improvements/quick fixes are implemented.
- Implementation of Phase 1 take place immediately after approval of consolidation by the Board of Supervisors
- Develop a decision making process for choosing a new name for the consolidated depanment. Include staff and stakeholders suggestions for the new name. Call it the Department of Mental Health and Alcohol and Drug services until a new name is chosen.

CONSOLIDATEDDEPARTMENT
PHASE 1



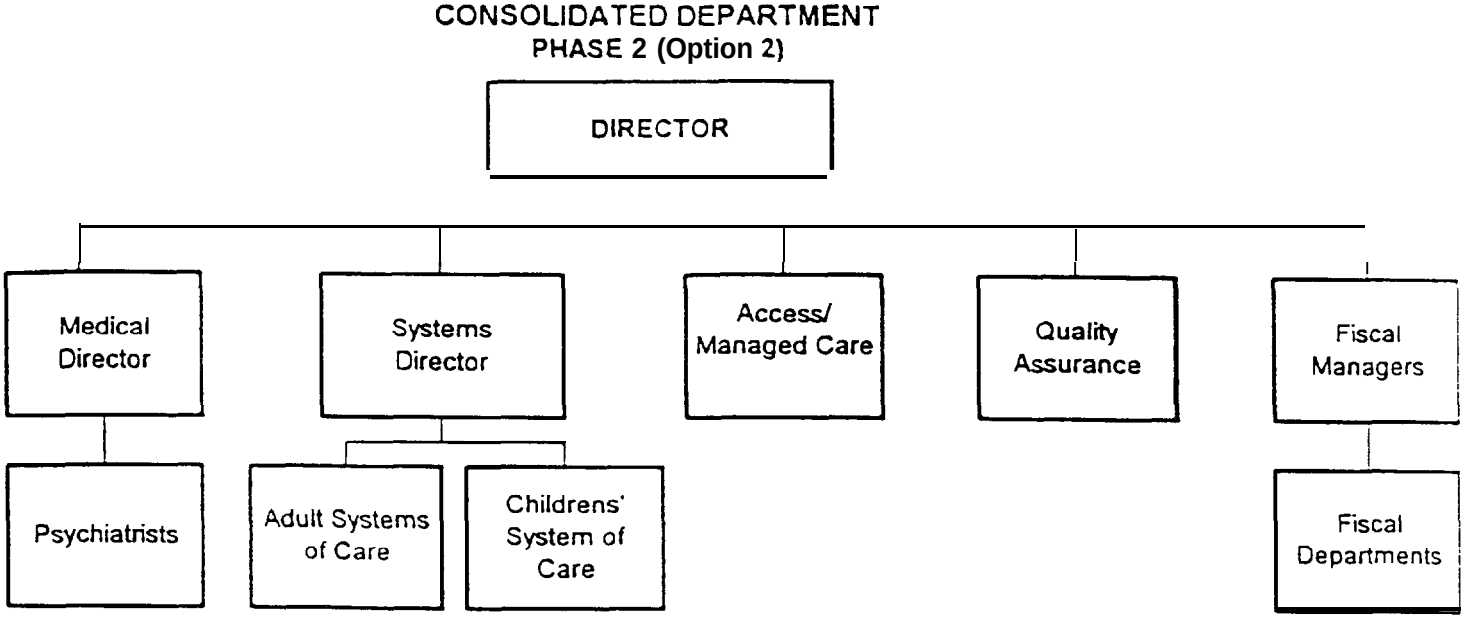
PHASE 2: Option 1

- Refer to Consolidated Department Chart Phase 2, Option 1.
- The consolidated department director is hired.
  If the new director is not one of the current depanment heads, then the current Director of Alcohol and Drug Programs is converted to a deputy director, and both deputies are renamed Systems Directors. One oversees the Childrens' System of Care and Access/Managed Care, and the other oversees the Adult System of Care and Alcohol and Drug Programs.



PHASE 2: **Option 2**

- Refer to Consolidated Department Chart Phase 2, Option 2.
- If one of the existing directors is hired as the Consolidated Director, **then** the remaining director becomes the Systems Director as seen in option 2, and the second position is eliminated.
- Alcohol and Drug integrates into both Adult and Childrens' Systems of Care and repons to the Systems Director.
- The Medical Director, Fiscal Managers, Access/Managed Care and Quality Assurance unit report directly to the director.



J. CONSIDERATIONS FOR PHASE 3

Future organizational developments will reflect the input from the stakeholders and staff surveys which addressed improved consumer service delivery. They will include:

- Regionalization of services
- Self-directed work teams
- Integration of Alcohol and Drug Services in all Systems of Care teams
- Integration of Access into all Systems of Care teams
- Integration of prevention/education services
- Development of dual diagnosis residential services

These developments will be studied and put in place within a two to three year process.

ATTACHMENT IV

Organizational Charts from Surveyed Counties

Alameda County Behavioral Health Care Services
ADMINISTRATION
1998

Mental Health, Drug and Alcohol Services are administered by:

Alameda County
Behavioral Health Care Services Department
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
(510) 567-8100

Board of Supervisors

MENTAL HEALTH BOARD

David Kears, LCSW
Director
Health Care Services Agency

Marye Thomas, MD
Director
Behavioral Health Care Services

Joan Steimer
Finance
Richard Conway
Contracts
Linda Billings
Provider Relations/ Billing

Marlene Gold
Director
Office of Financial Services

Jacqueline Jones
Director
Office of Personnel/Payroll Services

Stan Taubman, DSW
Director
Office of Management Services

Richard Singer, MD
Medical Director

Dennis Kennelly
Management Information Systems
Diana Cunningham
Management Specialist
Linda Goode, RN, MA
Quality Assurance
Nanacy Fernandez, MSW, MPH
Coordinator for Special Projects
Gary Spicer, MBA
Information Systems Specialist
Pat Vengarick, RN, MS
Authorization Services Administrator
Thomas Walker
Senior Program Specialist

Douglas Del Paggio, R.Ph., MPA
Pharmacy System

Barbara Majak, RN, MPH
Deputy Director

Brad Luz, PhD
Director
Children's Services

Barbara Majak, RN, MPH
Director, Adult Services
Peter Alevizos, Ph.D.
Associate Director, Adult Services

CHILDREN'S SERVICES

Children's Specialized Services
24 Hour & Day Treatment Mgmt
Special Education - MH Svcs
Acute Inpatient Services

MH Programs in Juvenile Justice & Social Services Depts.

MH Outpatient Services - County Operated & Contracted

AOD Contract Services for Children & Youth

S.T.A.R.S. Adolescent Sub Acute Program

ALCOHOL & OTHER DRUG PROGRAMS

AOD Rehab Programs

Med-Cal Certified Programs
Drinking Driver Programs
BASN Project
Methadone Programs
Residential Programs
Nonresidential Programs
Prevention Programs
Women's Programs

COMMUNITY SUPPORT SERVICE TEAMS

WEST OAKLAND
ASIAN CENTER
LA FAMILIA
CASA DEL SOL
OAKLAND
ALAMEDA
EDEN
TRI-CITY/VALLEY
BACS CM
BONITA CM

A.C.C.E.S.S.

Intake
Consultation
Community Crisis Response
Housing

STRIDES PROGRAM

STAGES SENIOR ASSESSMENT SERVICES

DAY TREATMENT

ACUTE INPATIENT SERVICES

CONSUMER SELF-HELP

SOCIALIZATION PROGRAMS

VOCATIONAL SVCS

WOODROE HOUSE CRISIS RESIDENTIAL

OTHER RESIDENTIAL SVCS

VIDA NEUVA DETOX PROGRAM

SUBACUTE & LONG TERM FACILITIES

CONSERVATORSHIP

CRIMINAL JUSTICE

ALAMEDA COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH CARE
Alcohol, Drug & Mental Health Services
MARYE L. THOMAS, M. D., DIRECTOR

464

'Administrative Offices
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
(510) 567-8100 FAX; (510) 567-8130
TTY (510) 533-5018

MENTAL HEALTH SERVICES

MISSION STATEMENT

To Provide a comprehensive network of integrated programs and services for all people with serious psychiatric disabilities, regardless of age, ethnicity, language or geographic location, in order to minimize hospitalization, stabilize and manage psychiatric symptoms, and help them achieve the highest possible level of successful functioning in their community of choice, and to provide mental health crisis and recovery services following major disasters.

501

ALAMEDA COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH CARE
Alcohol, Drug 8 Mental Health Services
MARYE L. THOMAS, M.D., DIRECTOR

465

Administrative Offices
2000 Embarcadero Cove, Suite 400
Oakland, CA 94806
(510) 567-8100 FAX; (510) 567-8130
TTY (510) 533-5018

ALCOHOL AND DRUG ABUSE DIVISION

MISSION STATEMENT

TO IMPROVE-THE QUALITY AND AVAILABILITY OF PREVENTION TREATMENT, AND REHABILITATION SERVICES IN ORDER TO REDUCE ILLNESS, DEATH, DISABILITY AND COST TO SOCIETY RESULTING FROM SUBSTANCE ABUSE

50

Monterey County Board of Supervisors

- Health Department
  - Behavioral Health Division
    - Mental Health Commission
      - Administrative Support
        - Budgeting
        - Cost Reporting
        - Audits
        - Mgt. Information Systems
        - Claims Processing
        - Accounts Payable Accounts Receivable
        - Purchasing
        - CDS/CADDS Reporting
        - Clerical Support
      - Medical Services
        - Inpatient Services
          - IMC
          - CHOMP
          - CHARTER
        - Psychiatric Staff
          - Monterey Outpatient Meds
          - Salinas Outpatient Meds
          - SCCMHS Meds
        - Medical Review
        - Crisis Services
          - Salinas Crisis Team
      - Conservator/Public Guardian
        - UPS/Conservatorship
        - Public Guardian
        - Representative Payee
      - Children's Services
        - State Hospital
        - Day Treatment
          - Alisal
          - Chualar
          - Castroville
          - Monterey Peninsula
          - Palomares
          - Proyecto Unidad
        - Mental Health Services
        - Residential Treatment
          - Palomares STAT
        - School Consultation
        - Family Pres./Crisis Support Project
        - Juvenile Hall
        - Early MH Intervention
        - Delinquency Prevention Program
      - Adult Services
        - State Hospital
        - Institutions for Mental Disease
        - Mental Health Services
        - Supplemental Rate
        - Interim Inc. Residential
        - Short Term Crisis Residential
        - Transitional Residential
        - Co-op Housing
        - Independent Housing
        - Mental Health Services
        - Vocational Services
      - Alcohol & Drug Services
        - Drug Court
        - JADE
        - Community Human Services
          - Residential
          - Perinatal
          - Narcotic Treatment Program
        - Sun Street Centers
          - Residential
          - Community Recovery Centers
          - Perinatal Services
          - Drinking Driver Program
        - Door to Hope
          - Residential
        - Sunrise House
        - Prevention Intervention
        - Valley Health Associates
          - Narcotic Treatment Program
          - Drug Diversion Program
      - Behavioral Health Services
        - Behavioral Health Options
        - Provider Panel
      - Patient's Rights Advocate
      - Mental Health Reinvestment Welfare Reform
        - Quality Assurance
        - CHOMP
        - Family Services Of Pajaro Valley
        - Individual Service Providers

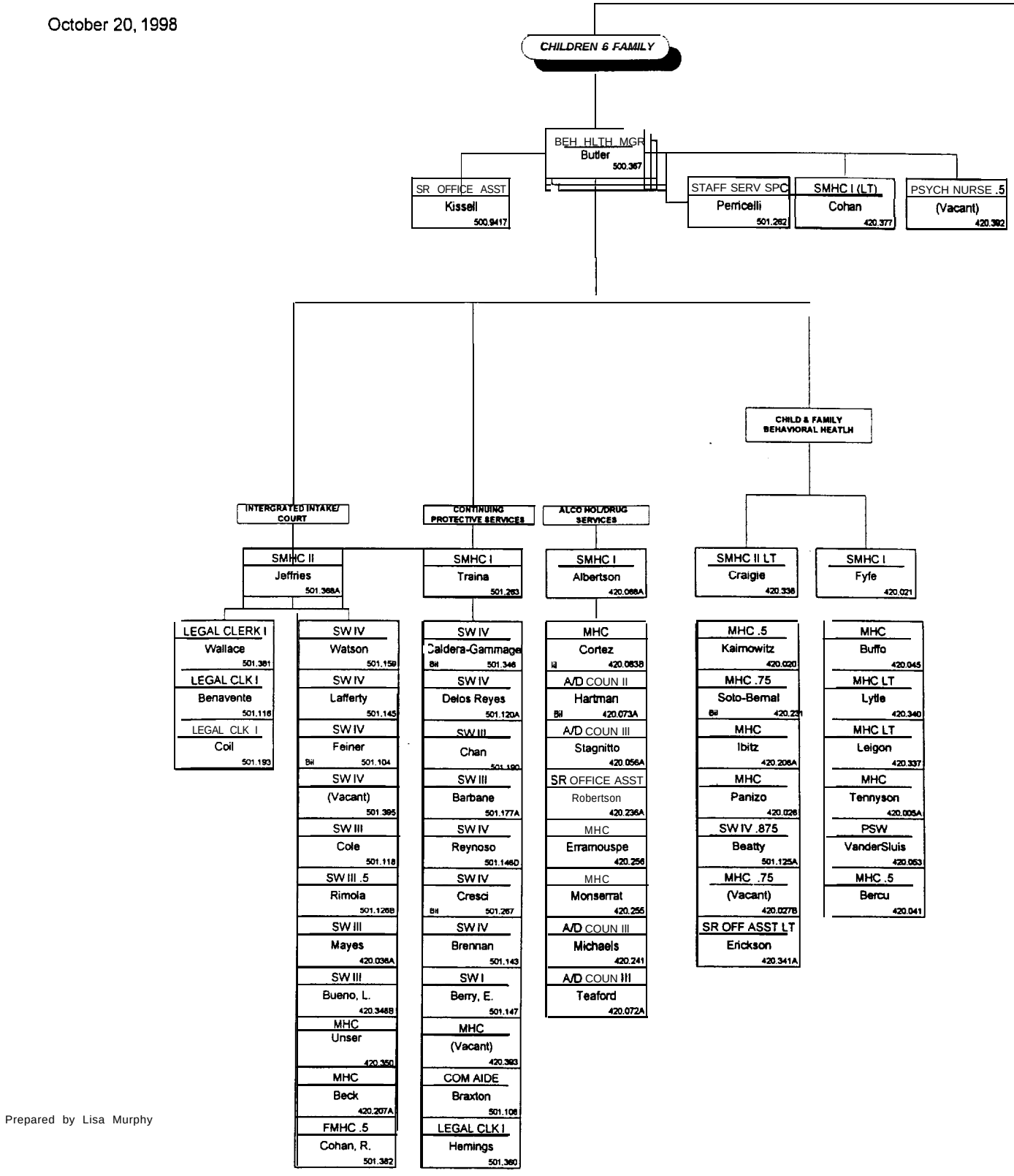
Behavioral Health Division
Program Organizational Chart

Chart Legend

- County Operated Programs
- County Contracted Programs

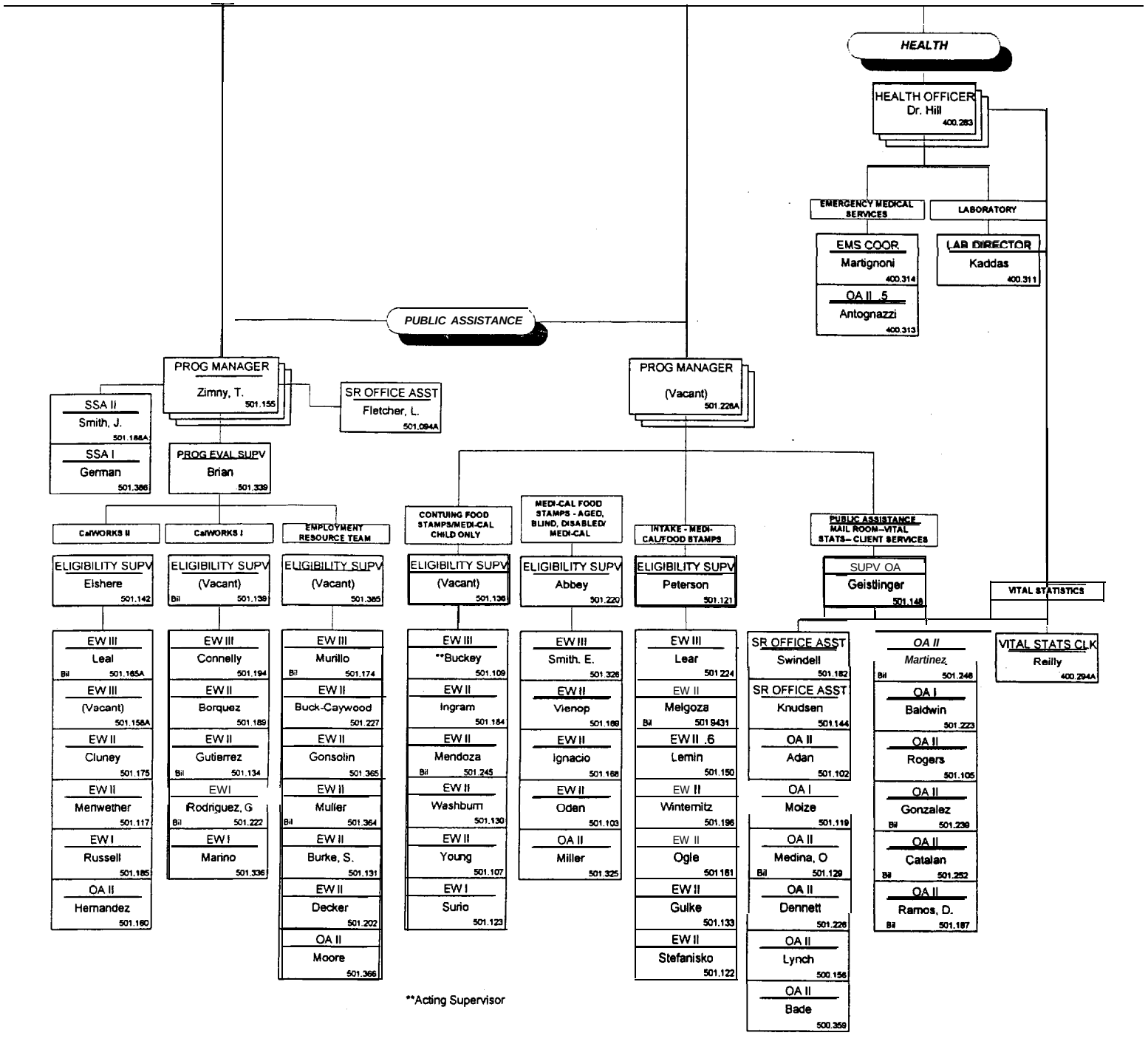
HEALTH & HUMAN

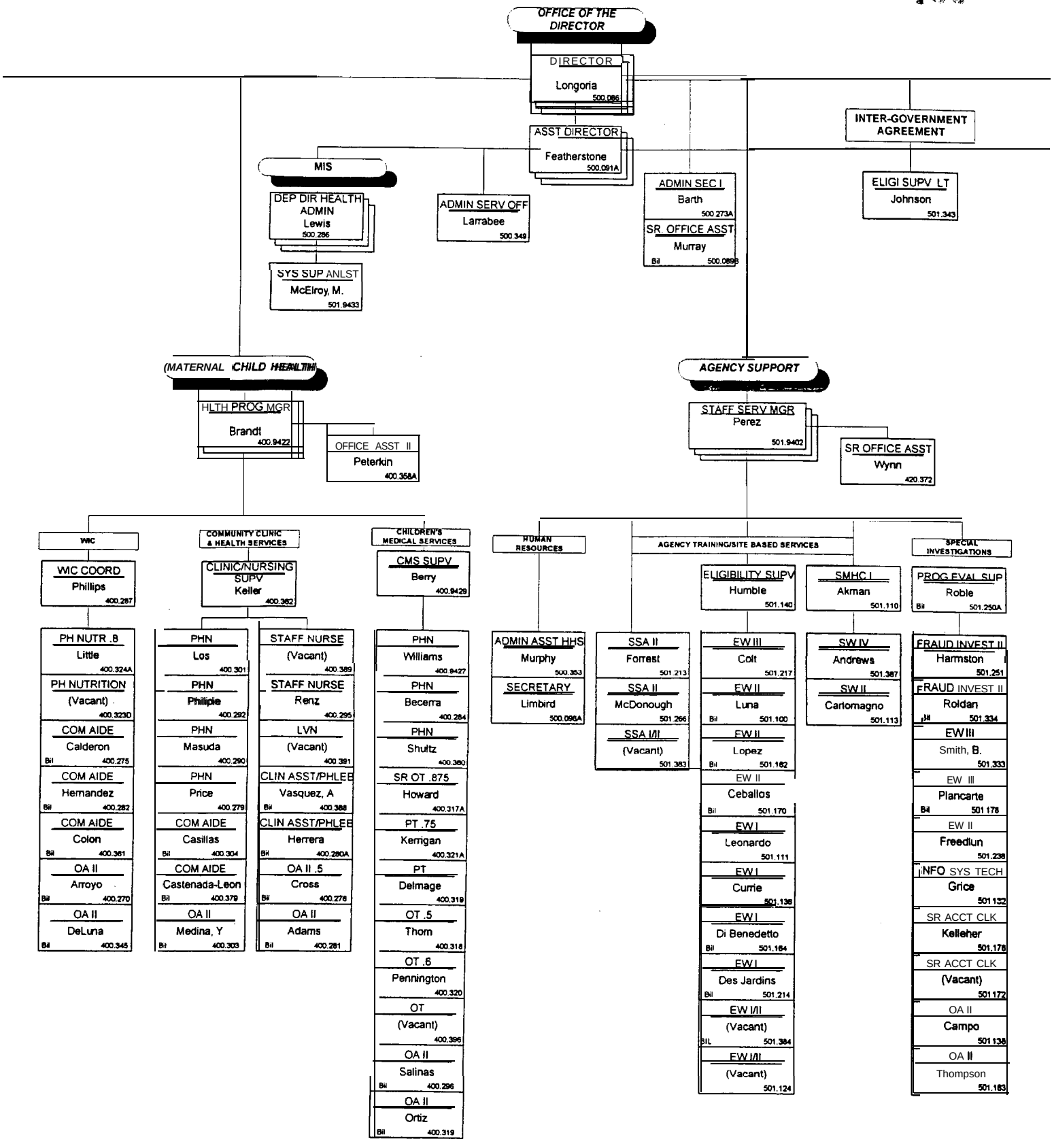
October 20, 1998

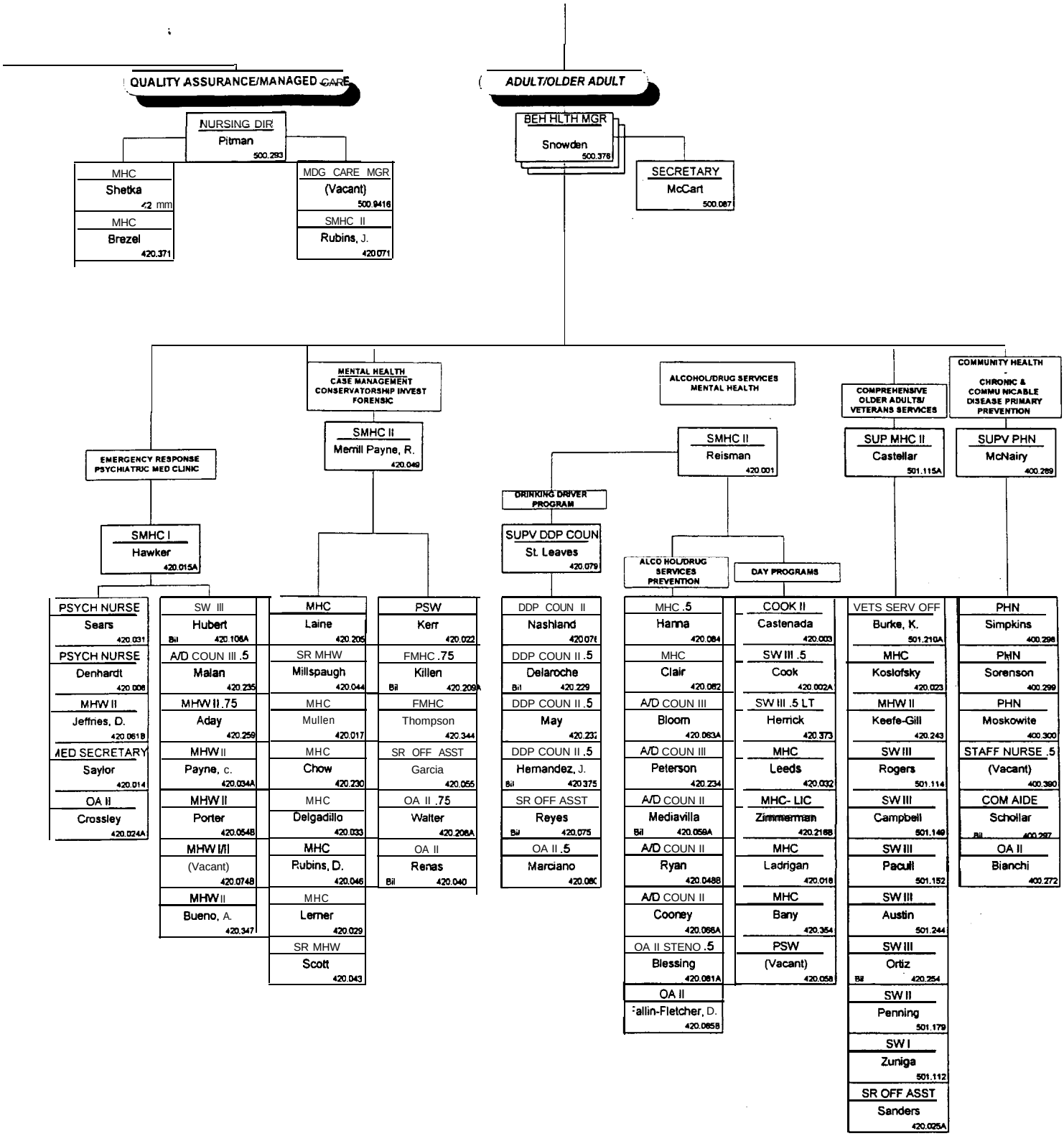


Prepared by Lisa Murphy

SERVICES AGENCY




OFFICE OF THE DIRECTOR
DIRECTOR
Longoria
500.086
ASST DIRECTOR
Featherstone
500.091A
INTER-GOVERNMENT AGREEMENT
ELIGI SUPV LT
Johnson
501.343
MIS
DEP DIR HEALTH ADMIN
Lewis
500.286
SYS SUP ANLST
McElroy, M.
501.9433
ADMIN SERV OFF
Larrabee
500.349
ADMIN SEC I
Barth
500.273A
SR OFFICE ASST
Murray
Bil
500.089B
(MATERNAL CHILD HEALTH)
HLTH PROG MGR
Brandt
400.9422
OFFICE ASST II
Peterkin
400.358A
AGENCY SUPPORT
STAFF SERV MGR
Perez
501.9402
SR OFFICE ASST
Wynn
420.372
WIC
WIC COORD
Phillips
400.287
PH NUTR .8
Little
400.324A
PH NUTRITION
(Vacant)
400.323D
COM AIDE
Calderon
Bil
400.275
COM AIDE
Hernandez
Bil
400.282
COM AIDE
Colon
Bil
400.361
OA II
Arroyo
Bil
400.270
OA II
DeLuna
Bil
400.345
COMMUNITY CLINIC & HEALTH SERVICES
CLINIC/NURSING SUPV
Keller
400.362
PHN
Los
400.301
PHN
Phillipie
400.292
PHN
Masuda
400.290
PHN
Price
400.279
COM AIDE
Casillas
Bil
400.304
COM AIDE
Castenada-Leon
Bil
400.379
OA II
Medina, Y
Bil
400.303
STAFF NURSE
(Vacant)
400.389
STAFF NURSE
Renz
400.295
LVN
(Vacant)
400.391
CLIN ASST/PHLEB
Vasquez, A
Bil
400.388
CLIN ASST/PHLEB
Herrera
Bil
400.280A
OA II .5
Cross
Bil
400.276
OA II
Adams
Bil
400.281
CHILDREN'S MEDICAL SERVICES
CMS SUPV
Berry
400.9429
PHN
Williams
400.9427
PHN
Becerra
400.284
PHN
Shultz
400.380
SR OT .875
Howard
400.317A
PT .75
Kerrigan
400.321A
PT
Delmage
400.319
OT .5
Thom
400.318
OT .6
Pennington
400.320
OT
(Vacant)
400.396
OA II
Salinas
Bil
400.296
OA II
Ortiz
Bil
400.319
HUMAN RESOURCES
ADMIN ASST HHS
Murphy
500.353
SECRETARY
Limbird
500.098A
AGENCY TRAINING/SITE BASED SERVICES
SSA II
Forrest
501.213
SSA II
McDonough
501.266
SSA I/II
(Vacant)
501.383
ELIGIBILITY SUPV
Humble
501.140
EW III
Colt
501.217
EW II
Luna
Bil
501.100
EW II
Lopez
Bil
501.162
EW II
Ceballos
Bil
501.170
EW I
Leonardo
501.111
EW I
Currie
501.136
EW I
Di Benedetto
Bil
501.164
EW I
Des Jardins
Bil
501.214
EW I/II
(Vacant)
BIL
501.384
EW I/II
(Vacant)
501.124
SMHC I
Akman
501.110
SW IV
Andrews
501.387
SW II
Carlomagno
501.113
SPECIAL INVESTIGATIONS
PROG EVAL SUP
Roble
Bil
501.250A
FRAUD INVEST II
Harmston
501.251
FRAUD INVEST II
Roldan
Bil
501.334
EW III
Smith, B.
501.333
EW III
Plancarte
Bil
501.178
EW II
Freedlun
501.238
INFO SYS TECH
Grice
501.132
SR ACCT CLK
Kelleher
501.176
SR ACCT CLK
(Vacant)
501.172
OA II
Campo
501.138
OA II
Thompson
501.183


QUALITY ASSURANCE/MANAGED CARE
NURSING DIR
Pitman
500.293
MHC
Shetka
42 mm
MHC
Brezel
420.371
MDG CARE MGR
(Vacant)
500.9416
SMHC II
Rubins, J.
420.071
ADULT/OLDER ADULT
BEH HLTH MGR
Snowden
500.378
SECRETARY
McCart
500.087
EMERGENCY RESPONSE PSYCHIATRIC MED CLINIC
SMHC I
Hawker
420.015A
PSYCH NURSE
Sears
420.031
PSYCH NURSE
Denhardt
420.008
MHW II
Jeffries, D.
420.061B
MED SECRETARY
Saylor
420.014
OA II
Crossley
420.024A
MENTAL HEALTH CASE MANAGEMENT CONSERVATORSHIP INVEST FORENSIC
SMHC II
Merrill Payne, R.
420.049
SW III
Hubert
Bil 420.108A
A/D COUN III .5
Malan
420.235
MHW II .75
Aday
420.259
MHW II
Payne, C.
420.034A
MHW II
Porter
420.054B
MHW I/II
(Vacant)
420.074B
MHW II
Bueno, A.
420.347
MHC
Laine
420.205
SR MHW
Millspaugh
420.044
MHC
Mullen
420.017
MHC
Chow
420.230
MHC
Delgadillo
420.033
MHC
Rubins, D.
420.046
MHC
Lerner
420.029
SR MHW
Scott
420.043
PSW
Kerr
420.022
FMHC .75
Killen
Bil 420.209A
FMHC
Thompson
420.344
SR OFF ASST
Garcia
420.055
OA II .75
Walter
420.208A
OA II
Renas
Bil 420.040
ALCOHOL/DRUG SERVICES MENTAL HEALTH
SMHC II
Reisman
420.001
DRINKING DRIVER PROGRAM
SUPV DDP COUN
St. Leaves
420.079
DDP COUN II
Nashland
420.07
DDP COUN II .5
Delaroche
Bil 420.229
DDP COUN II .5
May
420.23
DDP COUN II .5
Hernandez, J.
Bil 420.375
SR OFF ASST
Reyes
Bil 420.075
OA II .5
Marciano
420.08
ALCO HOL/DRUG SERVICES PREVENTION
DAY PROGRAMS
MHC .5
Hanna
420.084
MHC
Clair
420.082
A/D COUN III
Bloom
420.063A
A/D COUN III
Peterson
420.234
A/D COUN II
Mediavilla
Bil 420.058A
A/D COUN II
Ryan
420.0488
A/D COUN II
Cooney
420.066A
OA II STENO .5
Blessing
420.081A
OA II
Fallin-Fletcher, D.
420.0658
COOK II
Castenada
420.003
SW III .5
Cook
420.002A
SW III .5 LT
Herrick
420.373
MHC
Leeds
420.032
MHC- LIC
Zimmerman
420.2188
MHC
Ladrigan
420.018
MHC
Bany
420.354
PSW
(Vacant)
420.058
COMPREHENSIVE OLDER ADULTS/ VETERANS SERVICES
SUP MHC II
Castellar
501.115A
VETS SERV OFF
Burke, K.
501.210A
MHC
Koslofsky
420.023
MHW II
Keefe-Gill
420.243
SW III
Rogers
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SW III
Campbell
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SW III
Paculi
501.152
SW III
Austin
501.244
SW III
Ortiz
Bil 420.254
SW II
Penning
501.179
SW I
Zuniga
501.112
SR OFF ASST
Sanders
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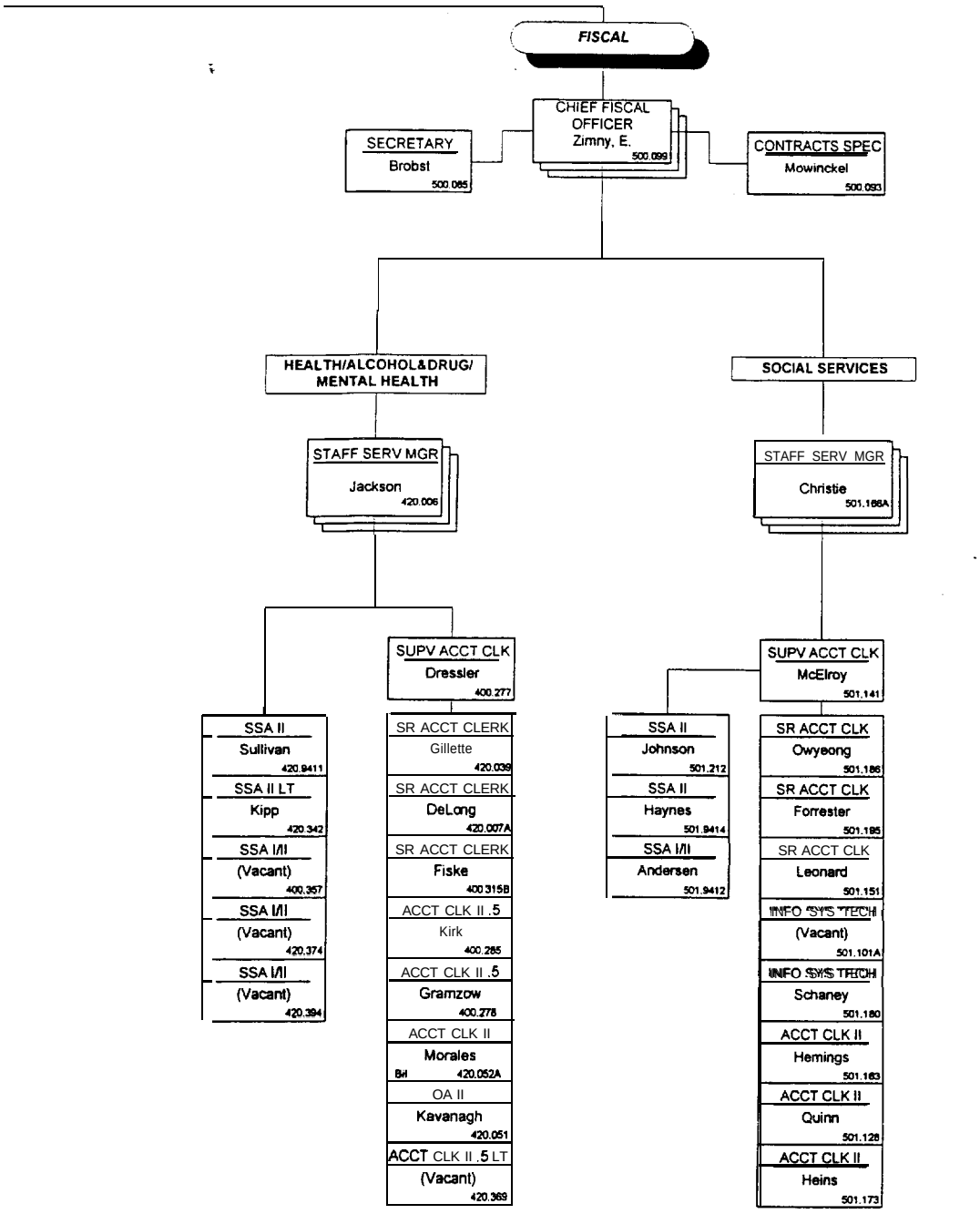
COMMUNITY HEALTH CHRONIC & COMMU NICABLE DISEASE PRIMARY PREVENTION
SUPV PHN
McNairy
400.289
PHN
Simpkins
400.298
PHN
Sorenson
400.299
PHN
Moskowite
400.300
STAFF NURSE .5
(Vacant)
400.390
COM AIDE
Schollar
Bil 400.287
OA II
Bianchi
400.272


FISCAL
CHIEF FISCAL OFFICER
Zimny, E.
500.099
SECRETARY
Brobst
500.085
CONTRACTS SPEC
Mowinckel
500.093
HEALTH/ALCOHOL&DRUG/ MENTAL HEALTH
SOCIAL SERVICES
STAFF SERV MGR
Jackson
420.006
STAFF SERV MGR
Christie
501.186A
SUPV ACCT CLK
Dressler
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SUPV ACCT CLK
McElroy
501.141
SSA II
Sullivan
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SSA II LT
Kipp
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SSA I/II
(Vacant)
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SSA I/II
(Vacant)
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SSA I/II
(Vacant)
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Gillette
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SR ACCT CLERK
DeLong
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SR ACCT CLERK
Fiske
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ACCT CLK II .5
Kirk
400.285
ACCT CLK II .5
Gramzow
400.278
ACCT CLK II
Morales
Bil 420.052A
OA II
Kavanagh
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ACCT CLK II .5 LT
(Vacant)
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SSA II
Johnson
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SSA II
Haynes
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SSA I/II
Andersen
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Owyeong
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SR ACCT CLK
Forrester
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SR ACCT CLK
Leonard
501.151
INFO SYS TECH I
(Vacant)
501.101A
INFO SYS TECH I
Schaney
501.180
ACCT CLK II
Hemings
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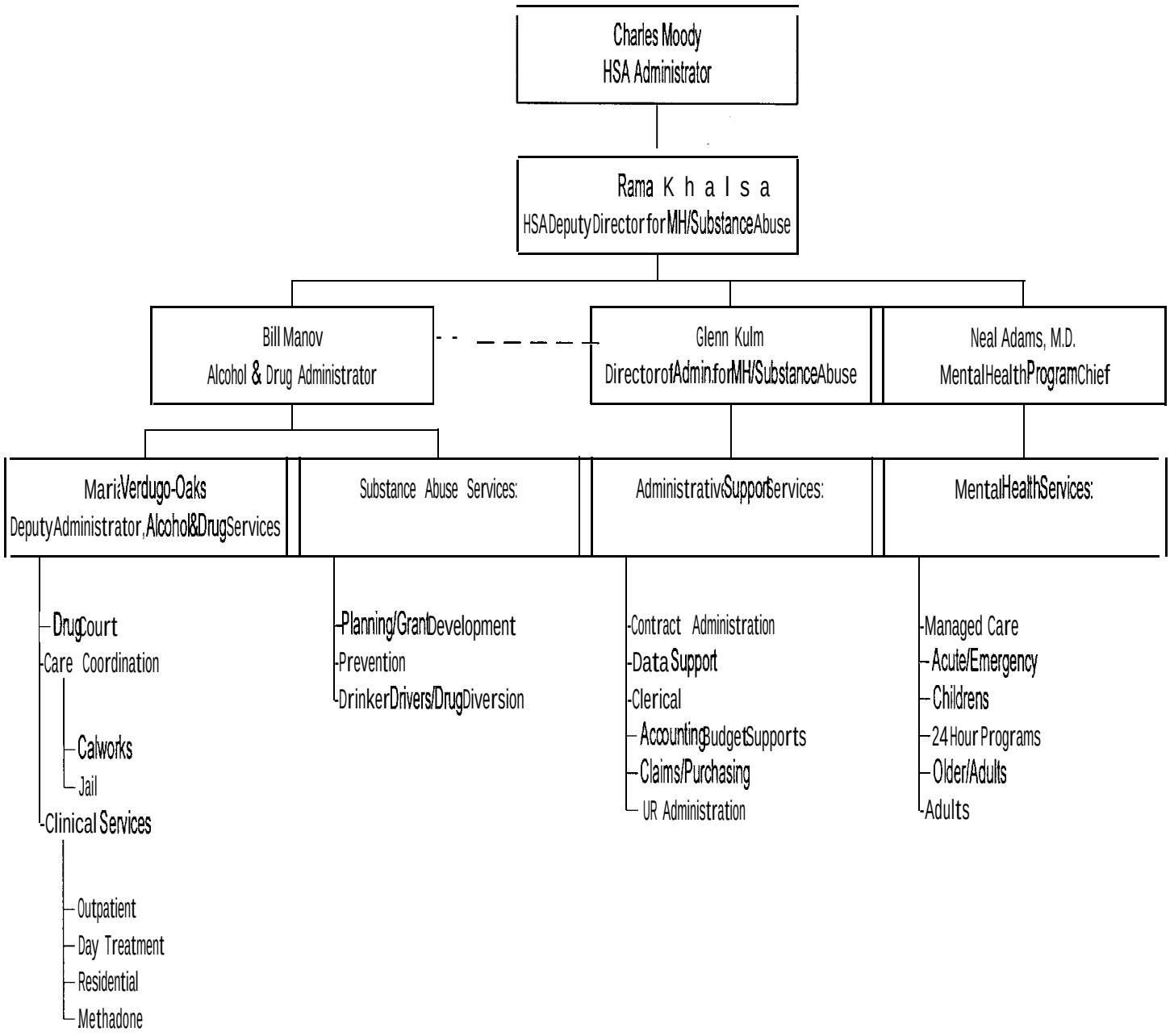
ACCT CLK II
Quinn
501.128
ACCT CLK II
Heins
501.173

Mental Health & Substance Abuse
Draft Concept
Organizational Structure



Goals of Consolidation
Evaluation Measures

Increase Number of Clients Served

- Compare current year number of admissions by program modality with prior year.
- Compare current year and prioi year number of admissions by race/ethnicity and age of clients.
- Compare current year and prior year program outcomes.
- Compare current budget allocation for services with prior year.

Identify Critical Gaps in Service and Develop Plans

- Service gaps and plans are reviewed annually by July 1st .

Improve Care Coordination and Outcomes for Dual Diagnosis Clients

- By July I" annually, compare current year FTE employees devoted to dual diagnosis care coordination to prior year.
- Review Dual Diagnosis Project' outcome results, numbers of clients served, and numbers of youth served in dual diagnosis programs.

Develop Teen Prevention Plan

- Completed.

Develop Services for CalWORKs Clients

- Develop provider contract amendments and referral procedures for alcohol and drug abusing CalWORKs clients.
- Report annually on number of CalWORKs clients served and program outcomes.

Improve to Support to Contractors

- Review annually with contractors by July 1st needs and improvements related to management information, fiscal and billing systems.

Substance Abuse Changes
Personnel

Index	Position	Start Date	Pay Periods	Fte	Hourly Rate	Regular Pay	Retire-ment 0.1423	OASDI 0.0765	Employee Insurance	Differ-ential	Cost
364012	HS Manager	3/8/99	8.30	1.00	29.17	19,369	2,756	1,482	1,016		24,623
364032	MHCS	3/8/99	8.30	1.00	19.56	12,988	1,848	994	1,016		16,845
	Subtotal Additions			2.00		32,357	4,604	2,475	2,032	0	41,468
364012	Sr Dept Admin Anyst	3/8/99	8.30	-1.00	26.78	-17,782	-2,530	-1,360	-1,016		-22,688
364032	Health Prog Spec	3/8/99	8.30	-1.00	16.94	-11,248	-1,601	-860	-1,016		-14,725
364012	Salary Savings	3/8/99				-1,587	-226	-121	0		-1,934
364032	Salary Savings	3/8/99				-1,740	-248	-133	0		-2,121
	Subtotal Deletions			-2.00		-32,357	-4,604	-2,475	-2,032	0	-41,468
	Total Personnel Cost			**0.00**		**0**	**0**	**0**	**0**	**0**	**0**

Napa County Health & Human Services Agency

May 11, 1998

Terry Longoria
Director

Dr. Robert Hill
Health Officer

- AIDS
- CDC
- EMS
- Inmate Nutrition
- Jail Health
- Lab
- Vital Stats

Administration

- *Civil Rights*
- Clerical Coordination
- Contract Coordination
- Legislation
- MIS
- Human Resources
- Public Information
- Quality Assurance
- Special Projects
  - Indigent Health Planning
- State & Federal Liaisons
- Managed Care
- Special Investigation Unit
- Training
- Facility Management
- Information Systems Support

Jim Featherstone
Assistant Director

Liaison to Boards & Commissions

- Commission on Aging
- Commission on Children, Youth & Families
- Commission on Emergency Medical Svcs
- Commission on Self-Esteem
- Commission on Status of Women
- Commission on Violence
- County Medical Svcs. Program Governing Board
- Drug/Alcohol Advisory Board
- Emergency Medical Care Committee
- Health Access Task Force
- HIV Consortium
- HIV Prevention Community Planning Workgroup
- Homeless Shelter Board
- Joint Commission
- Maternal / Child Health
- Mental Health Board
- Napa Co. Council for Economic Oppor.
- Tobacco Control Coalition

Eric Zimny
Fiscal Division

- Budgets
- Client Fees & Billing
- Contract Monitor
- Fiscal Monitoring Projections
- Food Stamp Issuance
- Public Assistance
  - Overpayment
  - Collections
- Revenue Collections/ Enhancements

Mary Butler
Behavioral Health Mgr., Children

Kristie Brandt
Health Program Mgr.

Teresa Zimny
Program Manager

Vacant
Program Manager

Randy Snowden, Team Consultant
Behavioral Health Mgr., Adult

Behavioral Health

- Children's Protective Services
  - 24 Hour Access Emergency Response
  - Case Management
  - Foster Care Licensing
  - Independent Living Program
  - Foster Care Eligibility
- Drug & Alcohol Services
  - Counseling/Day Treatment
  - Perinatal
  - Prevention
- Mental Health Services
  - Case Management
  - Family Preservation
  - Juvenile Hall Outreach
  - LPS Conservatorship
  - Managed Care
  - Medication Services
  - SED Treatment
- System of Care/Mental Health Services

Maternal, Child & Adolescent Health

- Birth Data Analysis
- Breastfeeding Support
- Calif Childrens Svcs
- Child Health & Disability Prev.
- Childhood Injury Prevention
- Children's Treatment Program (CTP)
- Clinics
  - HIV Testing
  - Family Planning
  - Sexually Transmitted Disease
- CPSP Coordination
- Immunizations
- Maternal Child Health
- MTU Clinic
- Nutrition Consultation
- Prenatal Care Guidance
- Public Health Nursing
- SIDS Response
- Teen Outreach
- Touchpoints
- High School Outreach
- Women, Infants & Children (WIC) Nutrition Program

Contracts

- Child Abuse Prevention
- Day Treatment
- Independent Living Program
- Mental Health Counseling
- OB/Gyn Consultation
- Mental Health Crisis Residential
- Psychiatric Hospitals
- Psychiatric Medical Services
- Physical Rehabilitation
- Psychologist Services
- Substance Abuse Prevention
- Vocational Services

Public Assistance

- CalWorks
- Cal-Learn
- Food Stamps

Public Assistance

- County Medical Services Prog.
- General Assistance
- Indigent Health
- Long Term Care
- Medi-Cal
- Non-Assistance Food Stamps
- Outstation Eligibility Workers
- Vital Statistics

Comprehensive Services to Older Adults

- Adult Protective Services
- Alcohol/Drug Outreach
- Communicable Disease Control
- Gero-Psych/Case Management
- In Home Supportive Services
- LPS Conservatorship
- Public Health Nursing
- Representative Payee
- Veterans' Services

Contracts

- Board & Care Liason Supportive Housing
- Homeless Outreach
- Homeless Shelters
- Mental Health Crisis Resid.
- Mental Health Residential Care
- Patients Rights
- Psychiatric Hospitals
- Psychiatric Medication Services
- Satellite Housing
- State Rehabilitation
- Substance Abuse Prevention
- Substance Abuse Residential Treatment
- Tobacco Control
- Vocational Outreach

Behavioral Health

- Drug & Alcohol Services
  - Community Outreach
  - Counseling
  - Day Treatment
  - Drinking Driver Program
  - Drug Diversion Program
  - Jail Outreach
  - Prevention
  - Tobacco Control
- Mental Health Services
  - 24 HR Emergency Response
  - Case Management
  - Day Treatment
  - CONREP
  - Homeless Outreach
  - Jail Outreach
  - LPS/Conservatorship
  - Managed Care
  - Medications Clinic
  - Next Step Vocational
  - Representative Payee

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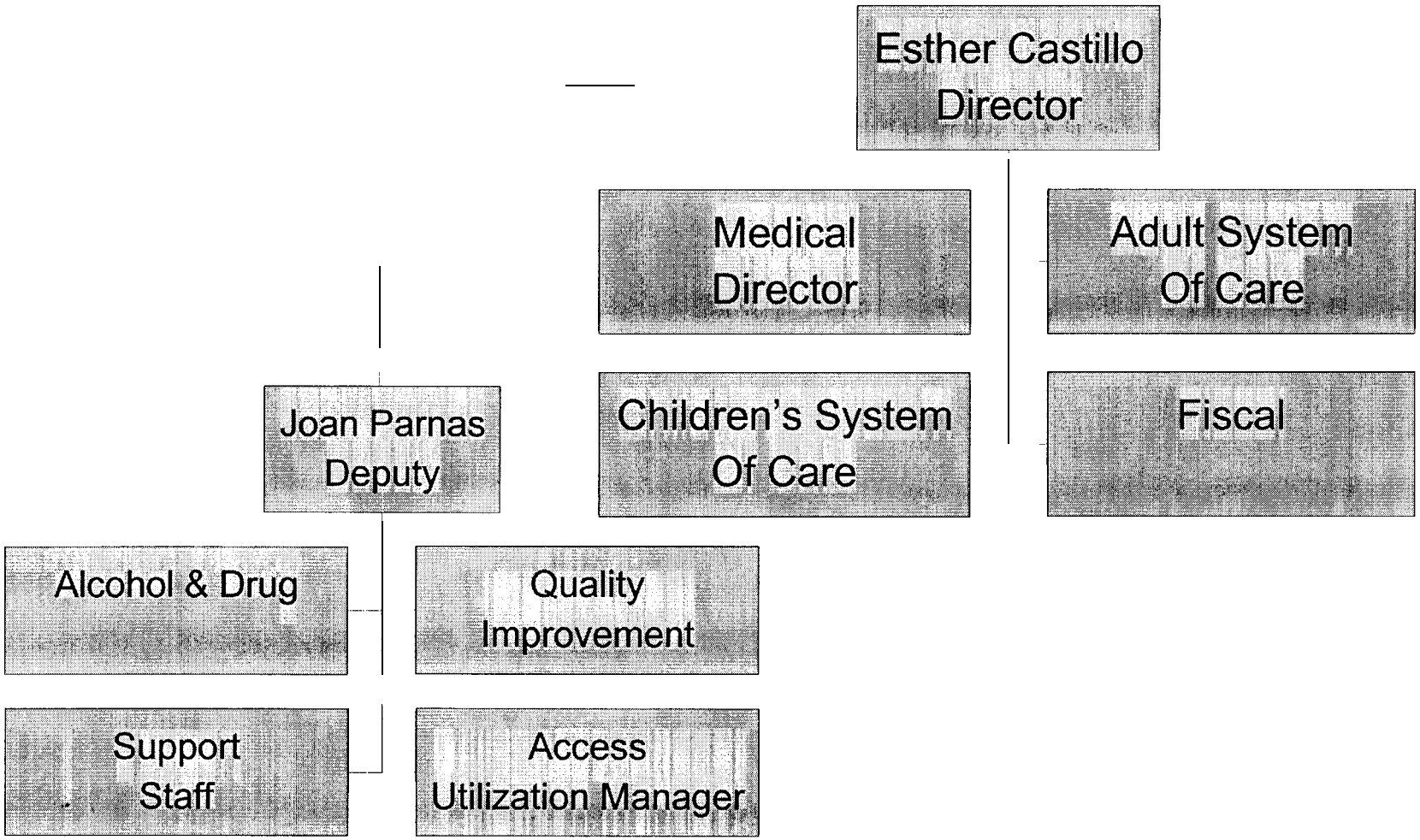
Yolo County Department of Alcohol, Drug and Mental Health Services

Organizational overview



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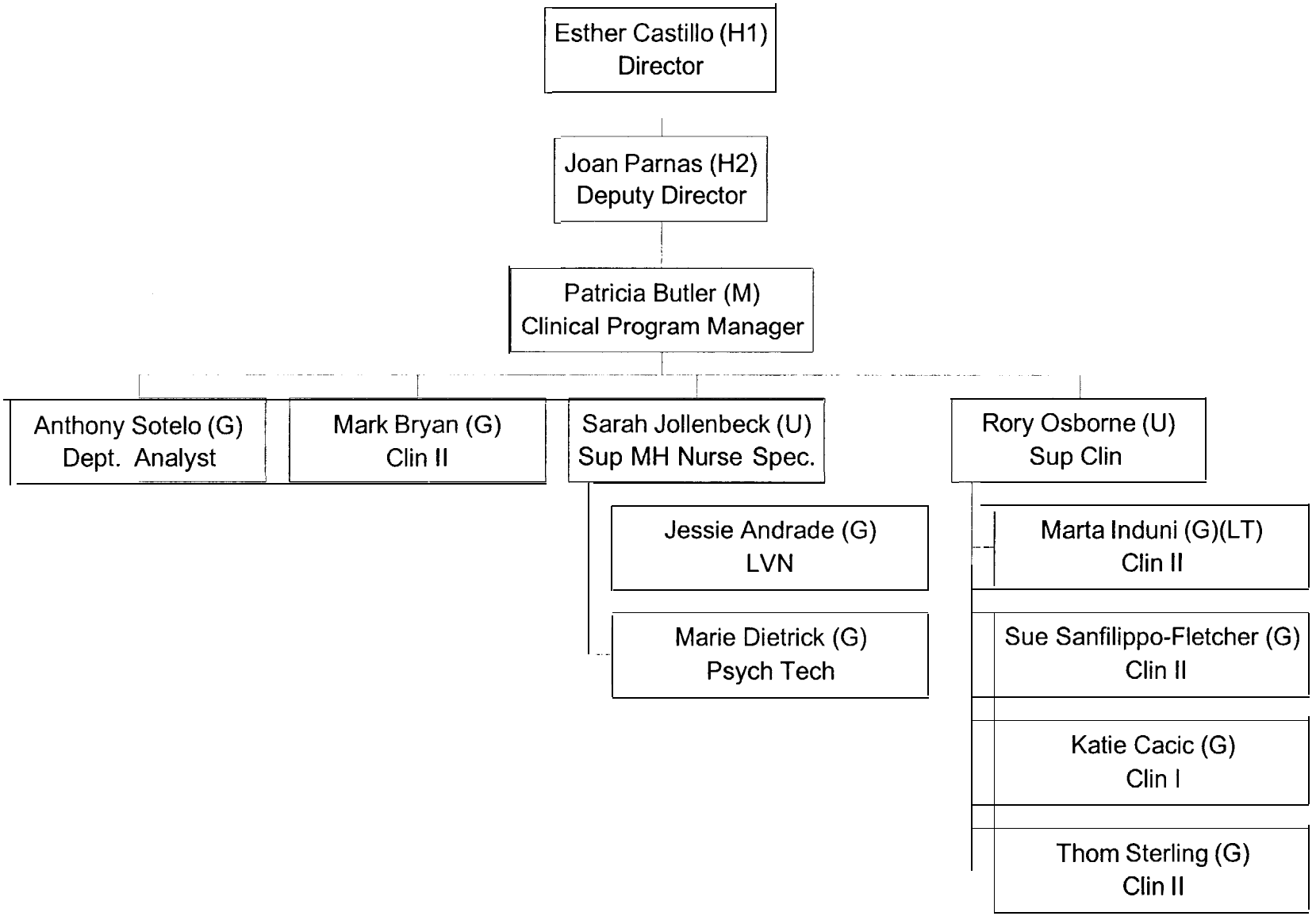

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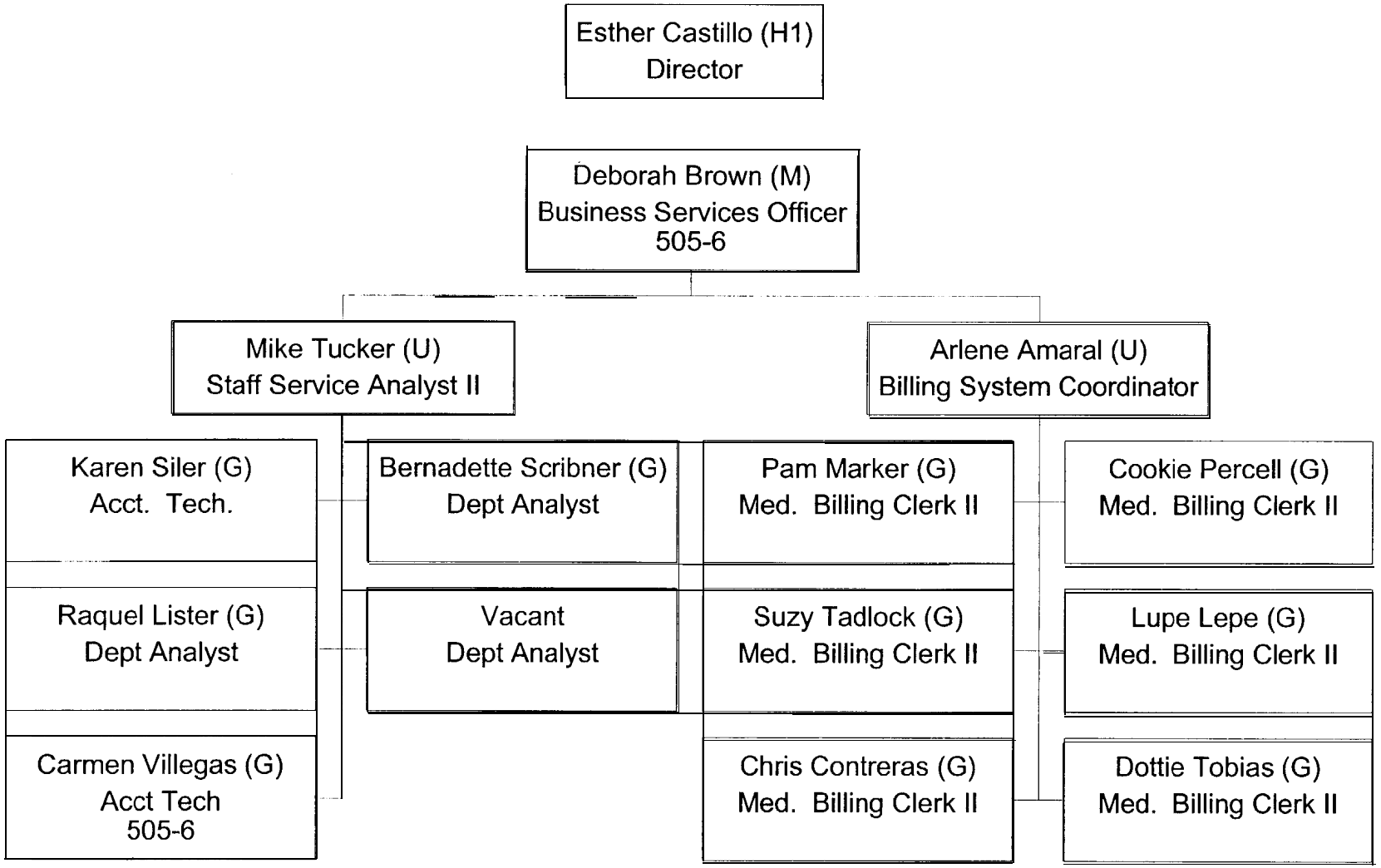

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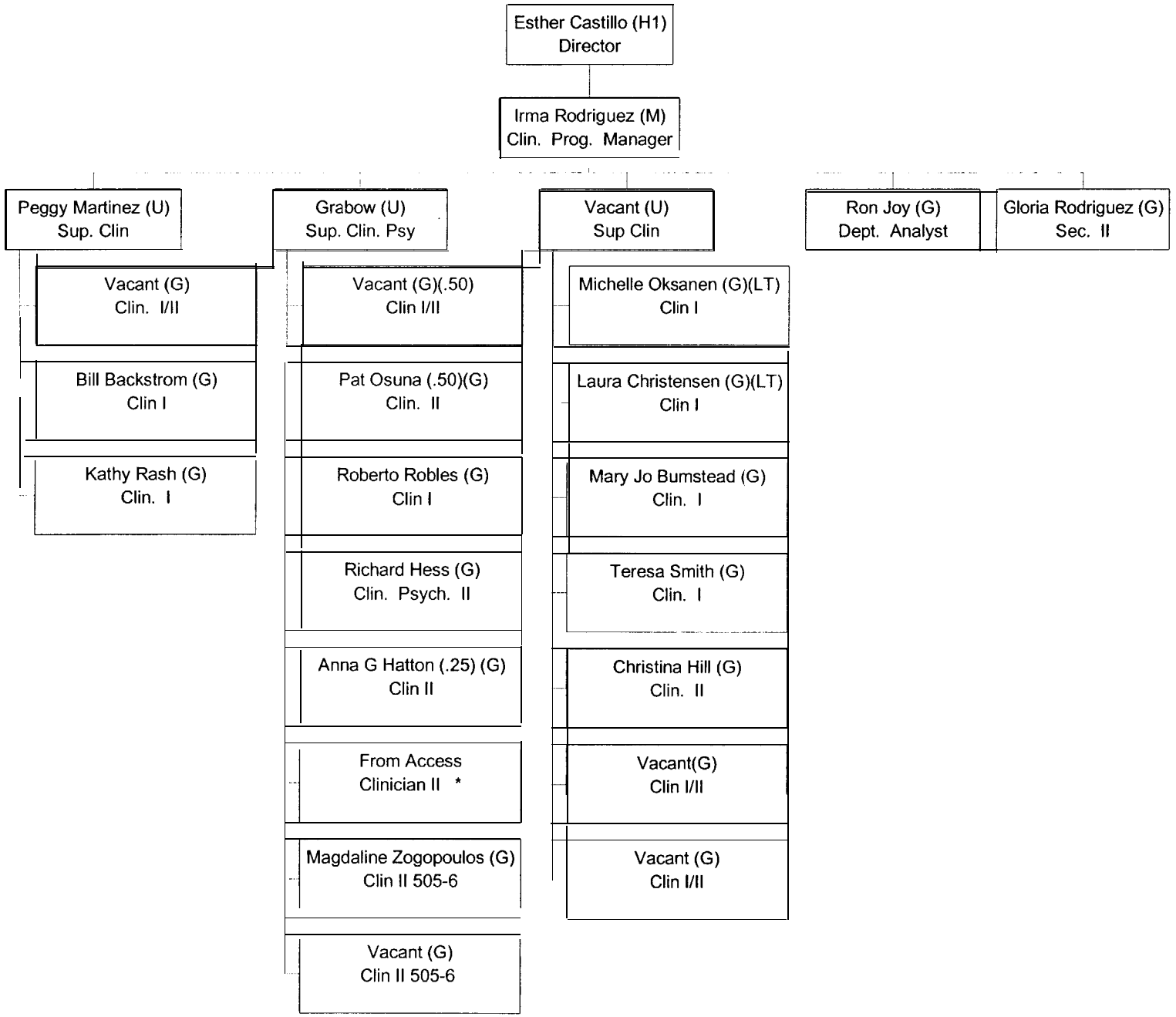

Yolo County Department of Alcohol, Drug and Mental Health Services

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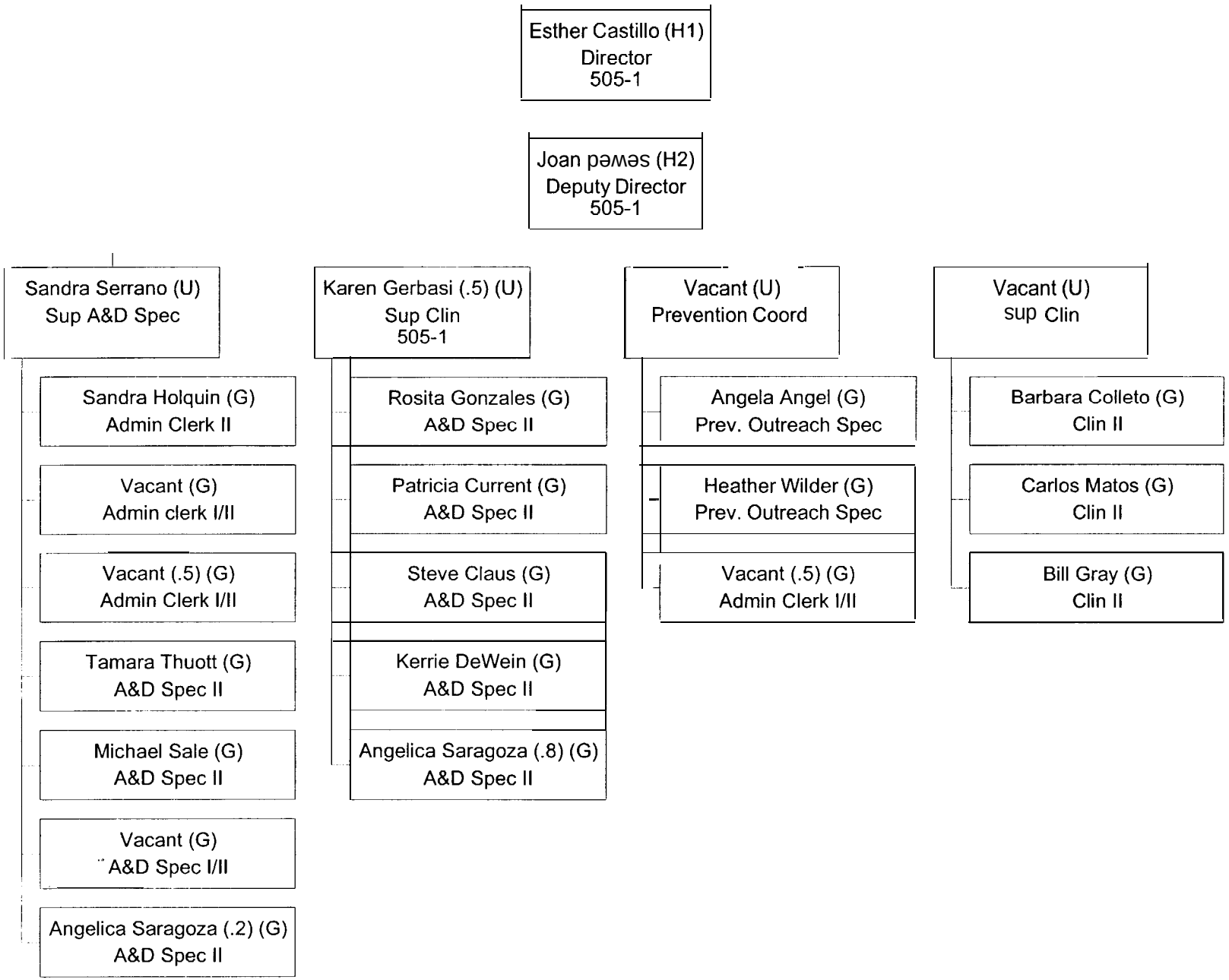

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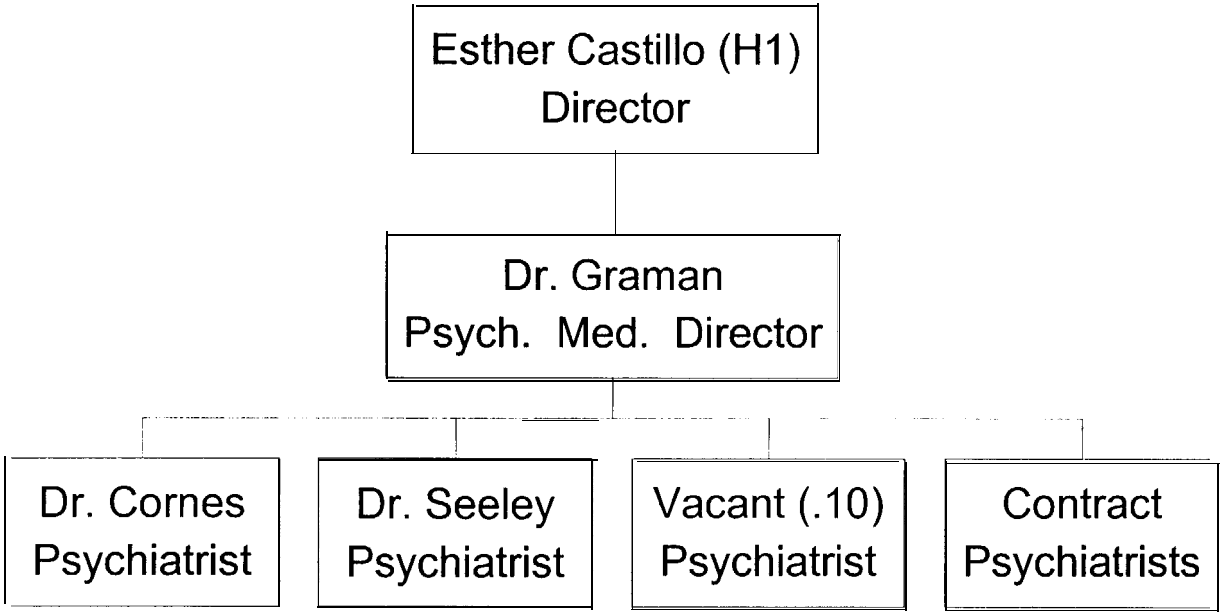
Yolo County Department of Alcohol, Drug and Mental Health Services



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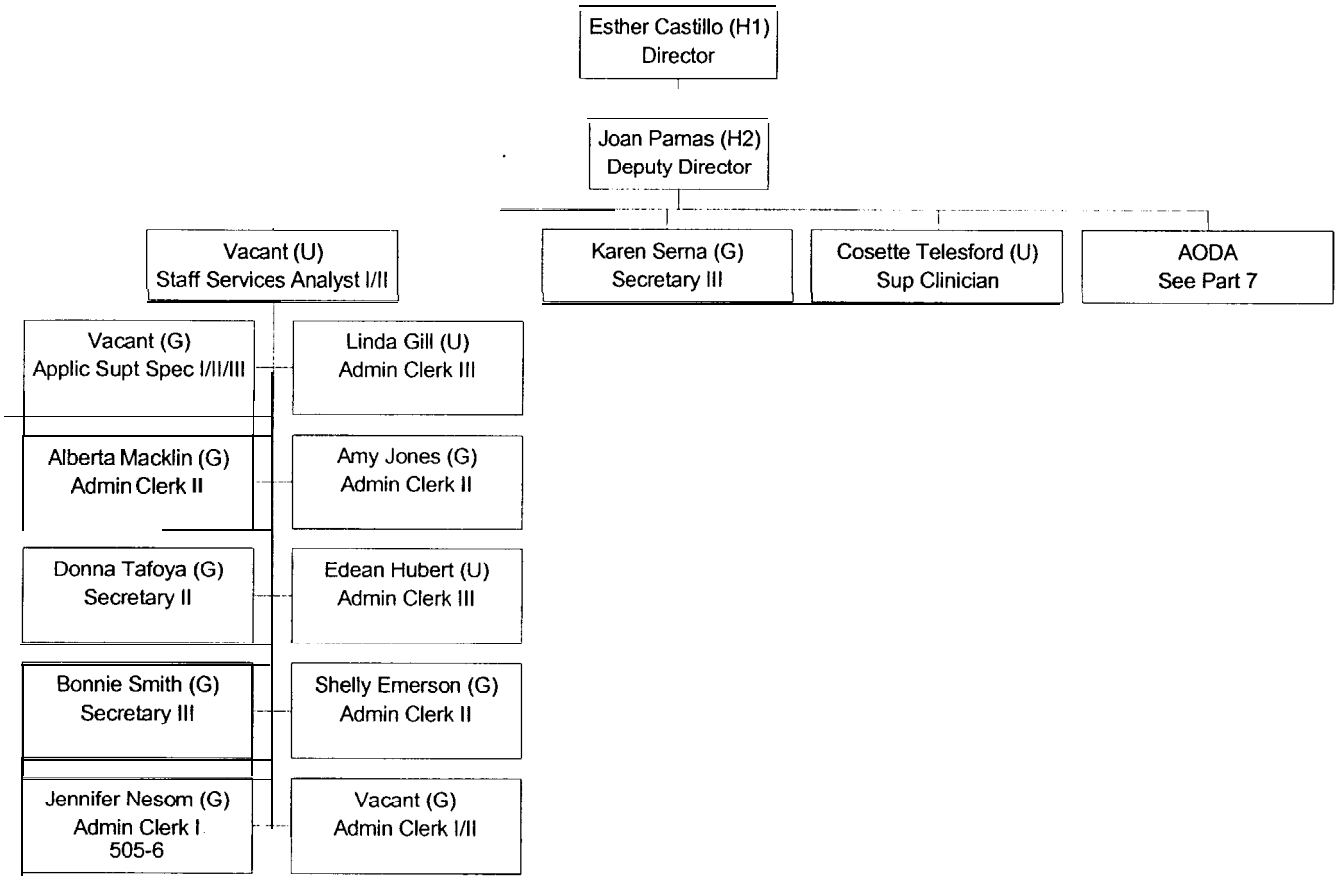

Yolo County Department of Alcohol, Drug and Mental Health Services

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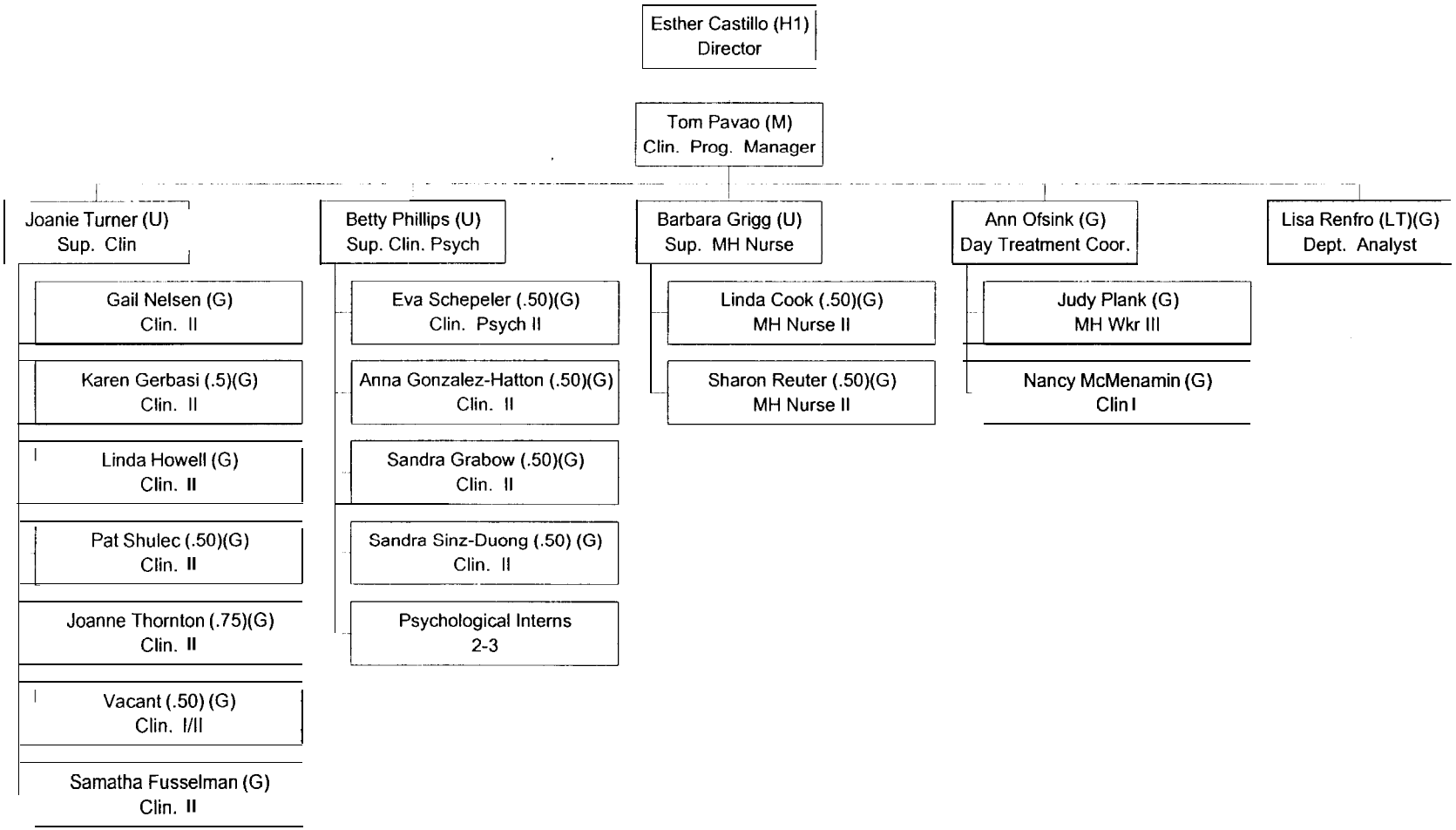

County of Ventura
Proposed Independent Behavioral Health Department

CHIEF ADMINISTRATIVE OFFICER

Mental Health Board

Alcohol & Drug Advisory Board

Stephen Kaplan, LCSW
Behavioral Health Director
2 FTE

J.R. Wilson, MA
Fiscal Services

Judi Balcerzak, LCSW
Deputy Dir I, Alcohol & Drug
8.6 FTE 0.15 FTE MD

- **Roberta Parker, LCSW**
  Adult Services
  - Simi Valley Center 7 FTE
  - Oxnard Center 5 FTE
  - Via Center 7 FTE
  - VCMC 2 FTE
  - Adult Ancillary 5.4 FTE
- **Cathy Puccetti, LCSW**
  Child, Youth & Family
  - New Start 9.8 FTE
  - Adolescent OP 3.8 FTE
  - Adolescent I/A Programs 4 FTE
- **Luis Tovar, MPA**
  Drinking Driver Program
  - Conejo 7 FTE
  - Ventura 23 FTE
  - Oxnard 12 FTE
  - Simi Valley 6 FTE
- **Kathy Staples, MS**
  Prevention
  3 FTE
- **Mark Summa, MPH**
  Prevention/Administration
  3 FTE

NOTE: FTE MD includes civil service and contract physicians.

Kevin DeWitt, PhD
Deputy Dir II, Mental Health
3 FTE

- **Elaine McKee, RN**
  Hillmont Psychiatric Center
  118 FTE (7.75 FTE MD)
- **Ellie Fritz, RN PhD**
  Crisis Services
  32.5 FTE
- **Dennis O'Connell, LCSW**
  Adult Residential Services
  12 FTE
- **Robert Benedetto, LCSW, DPA**
  Forensic Services
  - FACT Team 8 FTE (.5 FTE MD)
  - ConRep 4 FTE
- **Vikki Smith**
  Homeless Services
  9.5 FTE
- **Robin Briceno, SRT**
  Adult Employment Services
  8 FTE

Vacant
Clinical Chief, Adult MH Services
2.5 FTE

- **Dennis Cain, RN (Acting)**
  Adult Outpatient Services
  - Mid-Ventura 12 FTE (1 FTE MD)
  - Port Hueneme 20 FTE (1.25 FTE MD)
  - Santa Paula 10 FTE (0.9 FTE MD)
  - West Oxnard 15 FTE (1.2 FTE MD)
  - West Ventura 14 FTE (1.4 FTE)
  - Downtown Oxnard 17.5 FTE (1.53 FTE MD)
  - Conejo Valley 12 FTE (0.8 FTE MD)
  - East Ventura 11 FTE (0.8 FTE MD)
  - Simi Valley 11 FTE (1 FTE MD)

Nancy King, LCSW
Children & Youth Services
- Juvenile Justice 21 FTE (0.33 FTE MD)
- School-Based (32 FTE)
- Protective Services 23 FTE (0.18 FTE MD)
- Options OP Services 25 FTE (1.63 FTE MD)
- Contract Services 3 FTE (1.15 FTE MD)

- **Barbara Kurtz, RN**
  Senior Outreach Services
  - East County MH Clinic 4 FTE (.5 FTE MD)
  - West County MH Clinic 12.4 FTE (1 FTE MD)

- **Duane Essex, PhD**
  Managed Care/Admin Services
  - Managed Care 2 FTE
  - Quality Mngmt 14.4 FTE
  - Comm/Facilities 4.5 FTE

John Wong, MD
Medical Director
1 FTE
1.93 FTE Quality Management MD

- **Phil Malinas, MD**
  Child SOC Medical Director
  1 FTE
  5.49 FTE MD
- ***Vacant*, MD**
  Adult SOC Medical Director
  1 FTE
  10.88 FTE MD
- **David Guderman, MD**
  HPC Inpatient Medical Director
  1 FTE
  6.75 FTE MD
- **Barbara Adams, RN, BCQA**
  Quality Management Coordinator
  12.3 FTE
- **Renee Van Kalsbeek**
  Human Resources
  2 FTE
- **Michael Amey, JD**
  Patient Advocacy
  2 FTE

Rev. November, 1998