COUNTY OF MENDOCINO

MENTAL HEALTH SERVICES ACT

COMMUNITY SERVICES AND SUPPORTS

THREE-YEAR PROGRAM AND EXPENDITURE PLAN

FOR

FISCAL YEARS 2005-2006, 2006-2007, AND 2007-2008

DRAFT FOR PUBLIC REVIEW

RELEASED ON DECEMBER 15, 2005

Administration
860 N Bush St.
Ukiah, CA 95482
Phone (707) 463-4480
FAX (707) 463-5443

Medical Records
Phone (707) 463-4996
FAX (707) 467-6395

Willits Mental Health Center
221-B South Lenore Avenue
Willits, CA 95490
Adult Services (707) 456-3850
Children's Services (707) 456-3852
FAX (707) 456-3808

COUNTY OF MENDOCINO
MENTAL HEALTH DEPARTMENT
Beth M. Robey, M.P.A.
Director

Ukiah Mental Health Center
860 N Bush St.
Ukiah, CA 95482
Phone (707) 463-4303
FAX (707) 463-5443

Coast Mental Health Center
790-B South Franklin St.
Ft. Bragg, CA 95437
Phone (707) 964-4747
FAX (707) 961-2698

MENTAL HEALTH SERVICES ACT (MHSA)
COMMUNITY SERVICES & SUPPORTS PLAN

The Draft Mendocino County MHSA Community Services and Supports Plan is herewith presented for a 30-day public comment period beginning December 15, 2005.

The Mendocino County Mental Health Department has developed this Plan in response to the Mental Health Services Act (Proposition 63) that became law in January 2005. Mendocino County's Draft Plan proposes how MHSA funding will be allocated to transform Mendocino County's mental health system. Through a planned process that incorporated community input blended with demographic data, the Plan was developed to address the needs of underserved and unserved mentally ill people in Mendocino County.

The 30-day public comment period will be followed by a Public Hearing conducted by the Mendocino County Mental Health Board and final review by the MHSA Steering Committee to consider issues raised during the public comment period. The Plan will then be reviewed by the Mendocino County Board of Supervisors, and upon their approval will be submitted to the California Department of Mental Health for final approval. Your written comments are encouraged during this 30-day comment period. All comments must be in writing and received no later than January 18, 2006. Please submit your written comments to one of the following:

By Mail: **MHSA Planning**
860 North Bush Street
Ukiah, CA 95482

By E-Mail: **mentalhealth@co.mendocino.ca.us**

By Fax: **(707) 463-4043**

On January 18, 2006 from 3:00 pm to 6:00 pm, the Mendocino County Mental Health Board will hold a Public Hearing regarding the Mental Health Services Act Plan. The hearing will be held in the Board of Supervisors Chambers located at 501 Low Gap Road. The public is invited to attend and will be given opportunity to comment on the Plan. If you have questions, need transportation to the public hearing, or would like more information, please contact:

Jennie Vinyard, MHSA Coordinator
Phone: (707) 468-3368
vinyard@pacific.net

Beth Robey, Mental Health Department Director
Phone (707) 463-4331
robeyb@co.mendocino.ca.us

EXHIBIT 1: PROGRAM AND EXPENDITURE PLAN FACE SHEET

MENTAL HEALTH SERVICES ACT (MHSA)
THREE-YEAR PROGRAM and EXPENDITURE PLAN
COMMUNITY SERVICES AND SUPPORTS
Fiscal Years 2005-06, 2006-07, and 2007-08

County: MENDOCINO Date: _____

County Mental Health Director:

BETH ROBEY
Printed Name

_____
Signature

Date: _____

Mailing Address: 860 North Bush Street
UKIAH, CA 95482

Phone Number: (707) 463-4331 Fax: (707) 463-4043

E-mail: robeyb@co.mendocino.ca.us

Contact Person: BETH ROBEY
Phone: (707) 463-4331
Fax: (707) 463-4043
E-mail: robeyb@co.mendocino.ca.us

TABLE OF CONTENTS

ACRONYMS, TABLES, AND FIGURES

Acronyms

ACRONYM	DEFINITION
ASOC	Adult System of Care
CARE	Community Action for Recovery and Education Program
CBO	Community-Based Organization
CHDP	Children's Health and Disability Prevention
CIMH	California Institute for Mental Health
CSOC	Children's System of Care
CSS	Client Services Specialist
CTHP	Consolidated Tribal Health Project, Inc.
FSP	Full Service Partnership
FTE	Full time equivalent
HIPAA	Health Insurance Portability and Accountability Act
LGBT	Lesbian, Gay, Bi-Sexual, Transgender
MCHC	Mendocino Community Health Clinics
MCMHD	Mendocino County Mental Health Department
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NAMI	National Alliance on Mental Illness
OASOC	Older Adult System of Care
O&E	Outreach and Engagement
PSA	Public Service Announcement
PSC	Personal Services Coordinator
SED	Seriously Emotional Disturbance
TAY	Transition Age Youth
TSOC	Transition Age Youth System of Care
UPD	Ukiah Police Department

Tables

Figures

MENDOCINO COUNTY MHSA
COMMUNITY SERVICES AND SUPPORTS PLAN

INTRODUCTION

Proposition 63, the Mental Health Services Act (MHSA) was passed by California voters in November 2004. By placing a 1% tax on Californians with incomes of one million dollars or more, the MHSA provides funds to counties to expand mental health services to individuals and families who have mental health needs and who are unserved or underserved. The MHSA includes six components:

- Community Program Planning
- Community Services and Supports
- Capital Facilities and Information Technology
- Education and Training Programs
- Prevention and Early Intervention Programs
- Innovative Programs

In all six components, funds must be directed toward local mental health jurisdictions for the purposes of expanding services to those in need of mental health services. The MHSA requires that funding will be directed toward children, transition age youth (ages 16-24), adults, and older adults who have a serious mental illness or serious emotional disturbance. Funds are not to be used to supplant existing expenditures, and are intended to expand successful, innovative service programs, including culturally and linguistically competent approaches for underserved populations. Evaluation and accountability are key components in implementation of the Act. The State is still developing guidelines for the remaining components of the MHSA, and local planning for these components has not begun.

This Plan addresses only the Community Services and Supports funding component. In order to access MHSA funds, counties must prepare a three-year Community Services and Supports Plan specifying how the funds will be spent. State Guidelines provide for three funding categories, in addition to one-time funding that must be consistent with approved plans. These funding categories are:

- **Full Service Partnership Funds.** Full service partnerships are enrollee-based programs that provide “whatever it takes” to individuals with serious and persistent mental illness, such as assistance with housing, employment, food, clothing, social activities, or peer support. This approach is often described as wraparound services. Initial populations must be age-specific and services must target unserved populations and individuals. The State requires that at least half the funding available to small counties like Mendocino County be spent on Full Service Partnerships by 2007-2008.
- **System Development Funds.** Funding is available to provide programs, services and supports for all clients and families, including those enrolled in Full Service Partnerships and those currently receiving other services. System

development is intended to incrementally transform current system delivery so that individuals and communities are fairly served, whatever their geographic location, ethnic background, age, or gender, and so that all services provide "whatever it takes" to support recovery and resiliency for clients and families.

- **Outreach and Engagement Funds.** Funding may be used for activities needed to reach populations and communities that are currently unserved. Examples include underserved ethnic minorities, women and families reluctant to enter the mental health system, or gay and lesbian individuals who do not seek care.

The State Department of Mental Health has identified the following as Essential Elements for every Community Services and Supports Plan:

- **Community collaboration**. Sharing leadership, decisions, ownership, vision, and responsibility with clients and families, agencies, organizations, and businesses throughout the community creates comprehensive systems of care for adults and children with serious mental illness and serious emotional disturbance.
- **Cultural competence**. Behaviors, attitudes, and policies come together in a system that provides services effectively in cross-cultural situations.
- **Client/family driven mental health systems**. Adult clients, transition age youth, older adults, and families of all clients identify their needs and preferences, leading to the services and supports that will be most effective for them.
- **Wellness**. Recovery and resiliency are the goals of the treatment and supports provided to each client and family. The concept of recovery refers to a process in which people who are diagnosed with a serious mental illness are able to live, work, learn, and participate fully in their communities. The concept of resiliency refers to the personal qualities of optimism and hope and the good problem solving skills that lead individuals to live, work, and learn with a sense of mastery and competence.
- **Integrated service experiences for clients and their families**. Individualized, comprehensive service plans support these systems of care, and services are experienced as seamless by clients.

STRUCTURE OF THE PLAN

This draft Plan reflects the format and structure that is required by the State. The draft Plan is intended to be as reader-friendly as possible for the purposes of public comment, at the same time reflecting the state's requirements.

While the new MHSA funds will support significant improvements in Mendocino County's mental health services, it is important to remember that the additional $917,500 for mental health services that the county is eligible to receive represents only 6.5% of the County's current mental health services budget. This sets a very real limitation on the extent to which the system can be transformed by these new funds and the new services that can be developed.

As prescribed by the State, the Plan structure requires a substantial amount of repetition across sections, although each section has a different emphasis.

Part I describes the County's public planning process and includes a section describing the public review process of the draft version circulated for public comment. This discussion includes a description of how the draft plan was circulated, documentation of the public hearing by the Mental Health Board, and a summary of public comments and recommendations for revisions.

Part II provides an assessment of community need for mental health services and describes the County's Plan for addressing them in six sections:

- **Section I** begins with a discussion of the major community issues identified through the community planning process. It describes how the issues that will be the focus of the County's Plan were selected and includes racial, ethnic, and gender disparities that impact the issues for each age group.
- **Section II** provides an analysis of the mental health needs of unserved populations in Mendocino county by age group, including a discussion of ethnic disparities in the fully served, underserved, and unserved populations. Objectives for the provision of culturally and linguistically competent services are also articulated in this section.
- **Section III** identifies initial populations for Full Service Partnerships. The Full Service Partnership is a central concept of the Plan, and the State requires that more than half the MHSA funds be allocated to Full Service Partnerships by Year Three. The State also requires that initial populations for the Full Service Partnerships be identified within four age groups: children and youth between the ages of 0 and 18 (or Special Education pupils up to age 21), who have serious emotional disorders; transition age youth between the ages of 16 and 25 who have serious emotional disturbances; adults with serious mental illness; and older adults 60 years and older with serious mental illness.
- **Section IV** provides a Logic Model for Mendocino County's MHSA Plan and references the detailed program and strategy work plans included in Section VI.
- **Section V** assesses the capacity of service providers to meet the needs of racially and ethnically diverse populations in the county.
- **Section VI** provides full descriptions of the proposed programs, including details related to implementation, budgets, staffing plans, and progress goals.

Part III, the Appendix, provides supporting documents.

PART I. COUNTY PUBLIC PLANNING AND PLAN REVIEW PROCESS

PART I, SECTION I. PLANNING PROCESS

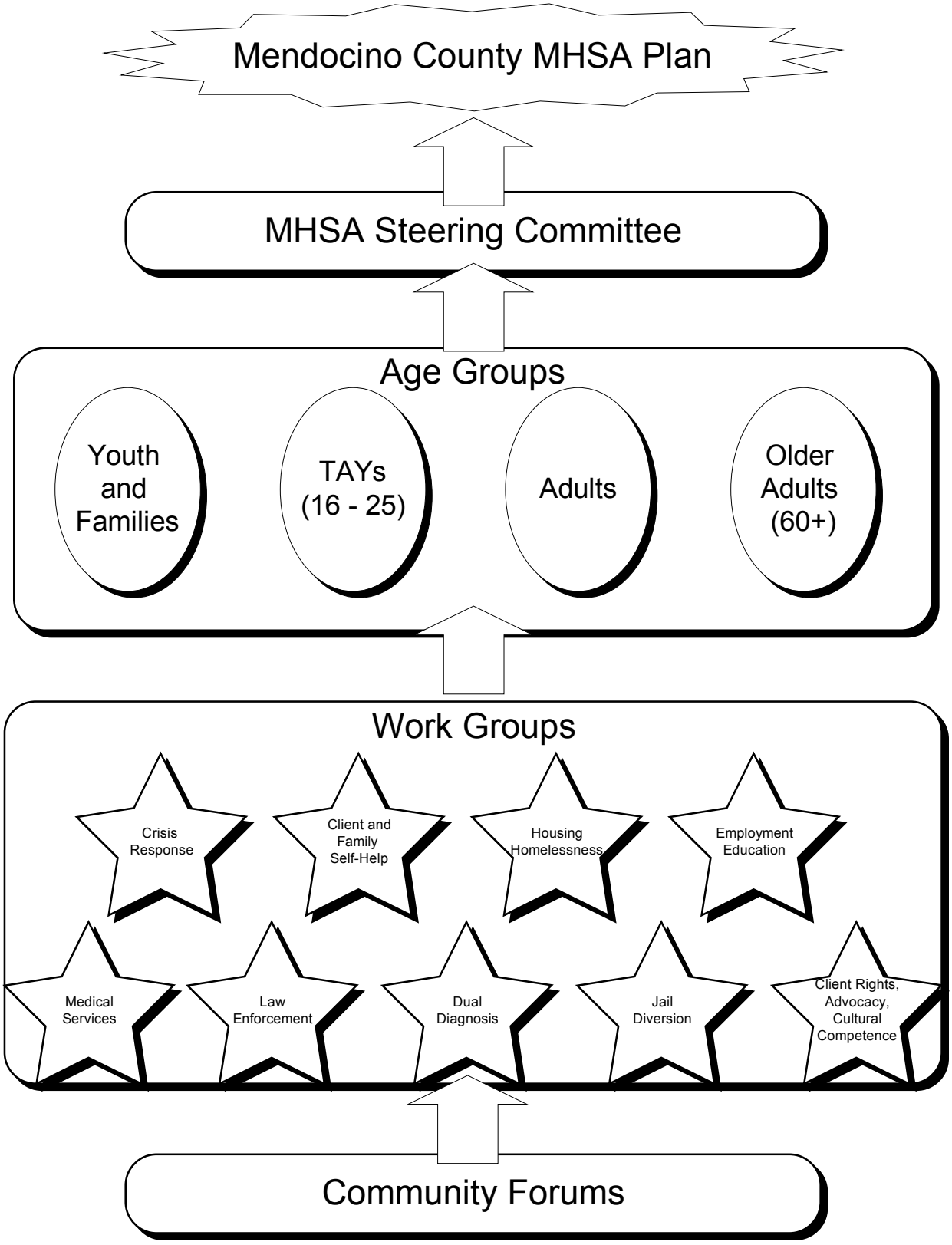
1. **Briefly describe how your local planning process included meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities.**

Mendocino County's planning process focused on including new and previously unheard voices as well as stakeholders from all interest groups and all parts of the county in the development of a comprehensive Plan that would result in transformation of the county's mental health system. From the beginning, this process focused on identifying *all* needs in a long-term Plan that would incorporate but not be limited to the activities proposed for funding in this Community Services and Support Plan.

Consumers and family members were active participants at every stage of the planning process, sharing their stories and providing feedback on how proposed activities would work from a consumer's point of view. In addition to this input, their participation served to keep bureaucrats grounded in the real world. These sometimes difficult conversations underscored the understanding that, as one consumer said, *"we are all in this learning experience together, even as we are all embedded in own cultures."* The planning process resulted in the unanticipated benefit of forging new and stronger relationships and alliances among clients, family members, service providers, and previously uninvolved community members and entities. To encourage participation, the Mendocino County Mental Health Department (MCMHD) offered transportation, childcare assistance, Spanish translation, refreshments, and staggered meetings to accommodate different schedules. The Department opened a dedicated MHSA Office in Ukiah, and also worked out of available office space in Willits and Fort Bragg. The planning process was staffed with an MHSA Planning Team comprising consumers and family members. MCMHD actively recruited the MHSA Planning Team by providing expense reimbursements, stipends, contracts, or hourly wages, depending on consumer preference. Recruitment for volunteer and paid positions was conducted through local media and listservs, flyers posted in public places, and word of mouth. The MHSA offices provided a meeting place for community members and facilitated community input by providing computer and phone access for individuals to write comments or communicate via phone.

The planning structure was designed to facilitate the greatest possible community input, beginning with the Community Forums, where community concerns and suggestions were discussed and passed on to Work Groups focused on specific topics or areas of need. Findings from each Work Group were then funneled to Age Groups, each tasked to use the Work Group findings to develop and prioritize proposals. Finally, the Age Group proposals, together with new input from outlying communities and special populations, was delivered to the Steering Committee for selection, further development, and incorporation into the County Plan. This planning structure is depicted in Figure 1 below and described in the following paragraphs.

Figure 1. MHSA planning structure



Note that the planning process was carried out differently in different parts of the county. Because Mendocino County is a geographically large and rural county, a variety of strategies were used to ensure that community input from small and geographically isolated communities would be captured and included in the Plan. Strategies utilized in outlying communities included community outreach, community surveys, conversations with key stakeholders, and Regional Meetings with a general focus. In Ukiah, the size of the population enabled the MHSA Planning Team to hold meetings that were specific to mental health issues and/or age groups.

Historically, there has not been a formal countywide client network organization in Mendocino County—the Mental Health Board has served as the only formal voice for consumers in the system. Not surprisingly, the Mental Health Board played a key role in the planning process, both in the preplanning process (development of the Plan-to-Plan) and in the completion of the County's MHSA Plan. To do this, the Mental Health Board created a Strategic Planning Committee (comprising five members of the Mental Health Board and four members of the public, all representing clients and/or family members) to provide oversight to MHSA planning. The members of the Strategic Planning Committee also served on the MHSA Steering Committee. Table One below provides an overall timeline for the County's pre-planning and planning processes.

Table One. MHSA planning timeline, 2005-2006

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
Outreach												
Community Forums												
Approval of Plan-to-Plan												
Work Group Meetings												
Age Group Meetings												
MHSA Steering Committee Meetings												
Public Review of Draft Plan												
Mental Health Board Hearing												
Final Approval by BOS and Submission												

Outreach and Community Forums

The first step in the planning process was outreach to engage stakeholders as the county prepared its initial Plan-to-Plan for the state. MCMHD organized three pre-planning outreach and education forums (two in Ukiah and one in Fort Bragg) to engage residents in the county's inland and coastal regions. These early information and education meetings were attended by a total of 281 individuals, including consumers and family member representatives from advocacy groups and peer and family operated local service organizations; county staff, supervisors and administrators; mental health providers and contractors; other health and social service providers; community and faith based organizations; Mental Health Board and other advisory/oversight board members; and elected officials.

MCMHD conducted extensive outreach, mailing meeting announcements and calendars to lists of 2,600 clients and family members, 30 direct service providers, and 340 additional stakeholders, including agency staff and representatives and all organizations

and entities listed as stakeholders in the County's Plan-to-Plan. All meetings were publicized through Spanish and English radio PSAs, newspaper ads and articles, flyers, and an interactive website (http://www.co.mendocino.ca.us/mh/prop63/). In addition, MHSA staff distributed information and collected surveys through booths at health fairs and other community events.

Table Two. Participation in Community Forums

DATE	LOCATION	NUMBER OF PARTICIPANTS
4 June 2004	Ukiah	36
25 October 2004	Ukiah	119
4 December 2004	Fort Bragg	63

The Department organized an all-staff training on the MHSA in Spring 2005 to educate staff and solicit their input on the planning process. MCMHD also collaborated with other organizations to reach additional stakeholders, making repeated presentations to policy and service groups. These included: the Mendocino County Mental Health Board, the Mendocino County Public Health Advisory Board, the Mendocino County Board of Supervisors, the Mendocino County Policy Council on Children and Youth, the Children's System of Care Cabinet, and the Mendocino County Emergency Services Group. At each of these presentations, participants were invited and encouraged to participate in the on-going MHSA planning process. Community input on the County Plan was also sought through direct contact with a large number of stakeholder groups and individuals, focusing particularly on those who expressed an interest or were thought able to provide alternative perspectives based, for example, on age, ethnicity, or sexual preference. Mendocino County's Mental Health Board, an active NAMI chapter, and two recently established client self-help organizations (A Healing Cooperative in Ukiah and Heart-to-Heart Wellness Center in Fort Bragg) were active participants in the planning process.[1]

Community Surveys

Two community surveys were conducted as part of the planning process. The first survey was conducted by the Mental Health Recovery Coalition, a group developed to augment community input into the MHSA planning process. The Mental Health Recovery Coalition collected survey responses from 141 people. Most of the respondents had first-hand experience with the county's mental health system, as follows: 15 clients (11%), 23 family members (16%), 52 medical providers (37%), 20 county employees (14%), 13 employees of the criminal justice system (9%), and 18 friends/others (13%). Please see Part II, Section I for survey findings and Appendix A for a copy of the Mental Health Recovery Coalition Survey and Summary.

The MHSA Planning Team conducted its own survey from August through October. The survey was conducted by mail and through direct outreach. Of the 2,600 surveys mailed to clients and family members, the MHSA office received 360 responses, a response rate of about 14%. Through direct outreach, the Team was able to collect surveys from 213 additional individuals. These outreach surveys were conducted in 35 locations

[1] There is currently no formally organized countywide consumer network or organization in the county.

around the county, including safety net providers (community kitchens, food banks, homeless shelter); community clinics, including Consolidated Tribal Health Project and Round Valley Indian Health Center; American Indian Rancherias; schools and colleges; markets; community events; homeless camps; and the jail and juvenile hall. The MHSA Planning Team worked together to conduct, compile, and analyze the survey, grouping responses by community and age group. The findings of the survey are presented in Part II, Section I of this Plan. (See Appendix B for the MHSA Planning Team Survey and Summary.) The benefits of the survey process were at least as important as the information collected through the survey. The direct interview approach that the outreach workers used to conduct almost half of the surveys brought the MHSA conversation to the public, raising awareness and generating trust that may well result in increased utilization of system resources.

Issue-Specific Work Groups and Regional Meetings

Nine Work Groups were convened and facilitated by the MHSA Coordinator. Each Work Group focused on one of the issues of concern that emerged during the larger community meetings.[2] The Work Groups were tasked with further study of their assigned topic, identifying service gaps, and developing a range of proposals. Meetings were convened at varying times so that interested parties could participate in multiple topics. Work Groups began meeting on June 20, each meeting at least twice and continuing to meet as many times as necessary to complete their planning and prepare their proposals for submission to the next phase of the process. All Work Groups included at least two consumers, one family member, and one MCMHD staff member, as well as representatives from the community of professional stakeholders. There were an average of 21 participants in each Work Group, for a total of 161 individuals involved in the planning process at the Work Group level. Of these, 34 were consumers (21%), 21 were family members (13%), and 106 (66%) were agency representatives, service providers, or other community stakeholders. In many cases, participants worked with more than one Work Group. While the Work Groups were meeting in Ukiah, the MHSA Planning Team also organized Regional Meetings throughout the county; participation in Work Groups and Regional Meetings is detailed in Table Three below.

Table Three. Participation in Work Group and Regional Meetings

WORK GROUPS	NUMBER OF PARTICIPANTS	NUMBER OF MEETINGS
Client Self-Help Programs	26	4
Clients/Family Rights Advocacy	7	2
Crisis Services	25	5
Dual Diagnosis	29	5
Housing and Homelessness	22	3
Jail Diversion/Law Enforcement	30	3
Medical Services	14	3
Vocational/Educational Opportunities	20	3
TOTAL	**173 total (161 unduplicated)**	**28**

[2] Two Work Groups, Jail Diversion and Law Enforcement, met jointly throughout the planning process.

REGIONAL MEETINGS	NUMBER OF PARTICIPANTS	NUMBER OF MEETINGS
Covelo	15	1
Fort Bragg	19	2
Gualala/Point Arena	4	1
Laytonville	12	2
Consolidated Tribal Health Project Council	25	1
Willits	11	1
TOTAL	**86 (unduplicated)**	**8**

Age Group Planning Meetings

In August 2005, with input from the Work Groups and the Regional Meetings in hand, planning participants began the Age Group phase of the planning process. At this level, planning meetings were facilitated by an outside consultant who assisted the group in surmounting a variety of challenges—incorporating the viewpoint of people who were unable to attend planning meetings; ensuring that participants understood the difference between long-term plans and the plans that would be submitted for funding through this process; and adapting the planning process to fit the needs of communities of different sizes. Each of the four Age Groups was tasked with reviewing the proposals coming from previous phases of the planning process and condensing them to specific proposals to meet the identified need of their age group.

The planning sequence for meetings of the four Age Groups was as follows:

1. Establish ground rules
   - Let the facilitator keep the meeting flowing.
   - Use common courtesy.
   - Let others finish speaking.
   - Stay constructive and stay involved.
   - Respect each person's right to their view of reality.
   - Respect each person's idea of how things should be done.
2. Review the MHSA process and planning requirements
   - Restate MHSA Outcomes and Elements in local terms
   - Explain MHSA funding types
   - Review Mendocino County's planning structure
3. Review progress to-date
4. Establish objectives for current meeting

In guiding the Age Group process, the facilitator used Appreciative Inquiry, an approach that focuses change efforts on building from strengths rather than on fixing deficits, encouraging groups to create compelling visions of what is desired and possible. Each group related success stories of times when mental health systems, both formal and informal, had really worked for a person facing mental illness and then analyzed common factors in the stories. These common factors become the localized version of the MHSA Essential Elements and Outcomes. (This listing can be found in Appendix C.) Next, the Age Groups examined what the outcomes for consumers had been when

things worked well, and again refined and expanded the MHSA Required Outcomes to develop a set of locally-meaningful age-specific outcomes for each age group.

To carry forward the expressed needs and priorities from the Work Groups and Community Forums, the Age Groups reviewed the priorities developed by previous groups and compared them to the approved strategies for each age group in the MHSA Plan Requirements.

Keeping the localized versions of the Essential Elements and the plan's funding categories in mind—and posting summaries on the walls at each meeting—small groups comprised of consumers, advocates, and agency representatives developed specific proposals for supports and services. After each small group reached consensus on at least three proposals, the Age Group as a whole considered all of the proposals and discussed them until three to six top priorities emerged. Between meetings, the MCMHD Director and volunteers from the Age Groups sought additional information, developed more details, and came up with initial cost estimates.

The Age Groups spent subsequent meetings concretizing (sometimes in small groups, sometimes as a whole group) what was really meant by the chosen priorities by asking and answering the following questions:

- What will the activity look like on the ground?
- How will the activity function?
- Is the activity consistent with localized Elements and Outcomes?
- What has already been done in this area by other groups?
- Will the activity result in the group's selected outcomes?
- What partners/collaborators are required for this activity to succeed?
- Is the activity doable? Is it strategic?
- What is the current reality, in terms of resources and barriers?
- What is still needed?
- What action steps will connect current reality to future outcomes?

Results of this process are included in the two-page list of Age Group Priorities (Appendix D).

Table Four. Participation in Age Group meetings

AGE GROUPS	NUMBER OF PARTICIPANTS (UNDUPLICATED)	NUMBER OF MEETINGS
Children and Families	18	4
Transition Age Youth (TAY)	16	3
Adults	20	4
Older Adults	13	4
TOTAL	**67**	**15**

Steering Committee Meetings

The final phase of planning was the responsibility of the MHSA Steering Committee. The Steering Committee's 28 seats were filled by:

- 9 members of the Mental Health Board's Strategic Planning Committee (includes 5 Mental Health Board members and 4 community members)

- 1 representative from each of the 9 Work Groups
- 1 representative from each of the 4 Age Groups
- 3 representatives of outlying communities
- 2 representatives of underserved ethnic communities
- 1 transitional age youth

The Work Groups and Age Groups selected members as representatives to the Steering Committee; additional representatives from smaller communities and ethnic communities were selected during the planning process as the need for increased diversity of representation became clear. (See Appendix E for Steering Committee Roster).

MHSA STEERING COMMITTEE STATEMENT OF PURPOSE

We believe in recovery. To share the meaning and essence of recovery with others, we will create an MHSA Plan for Mendocino County that we can be proud of, is inclusive of the assessment and planning work that has already been done, and condenses ideology and philosophy into clear language and workable program(s) that will be approved by the Board of Supervisors and by the State Mental Health Department. To carry our planning work into the real world, we will reach out to those with unmet needs, work to reduce stigma and discrimination in our communities and systems, and educate ourselves in order to better integrate cultural competence in mental health services. Our work will create a vehicle for continuing input as the County continues the process of transforming the delivery of mental health services.

MHSA STEERING COMMITTEE VISION

The MSHA Steering Committee will design, adopt, and build programs that are innovative and transformative. Services will be planned and delivered by and for clients and families and with the involvement of clients and families, focusing on wellness, recovery, and resiliency. Services will be accessible in terms of both time and location, and they will be integrated through seamless collaboration among agencies, informal networks, and clients and families. Services will be culturally appropriate for underserved ethnic and rural communities. All clients participating in services will have access to Full Service Partnerships. People living with the challenges of mental illness will feel that they belong, be empowered to be responsible for their own recovery, have opportunities for meaningful use of their time and talents, have networks of supportive relationships and wraparound services,[3] and have safe and adequate housing. They will not suffer incarceration, institutionalization, or out-of-home and involuntary placements.

[3] The wraparound service concept references flexible and holistic services that best meet the client's needs, whatever those needs are. Wraparound services holistically address these needs, including utilizing strategies to prevent problems. Rather than simply responding to crises, wraparound services may help clients establish routines, provide respite care, include instruction in life and social skills such as house cleaning and parenting skills, or provide personalized assistance that can range from transportation to medical appointments to lice eradication, or from recognition of age-appropriate behavior to school attendance strategies.

The Steering Committee began its work of making final decisions and developing detailed plans for programs and activities in October 2005, meeting weekly beginning October 17 and continuing until the Draft County Plan was released for public comment in mid-December. The enthusiastic work of the Steering Committee resulted in a steady rise in meeting attendance, as alternates and community members continued to be involved. In fact, the Steering Committee continued to receive input from all prior planning levels throughout the planning process. While this ensured broad access and input, it also made the process more challenging.

The Steering Committee began its work with a review of MHSA planning to-date, focused on things the members had found personally exciting about the process. The responses of Steering Committee members made it clear that, while the Plan was far from finished, systems change was already underway.

COMMENTS OF STEERING COMMITTEE MEMBERS

"A long term vision is forming among committed folks."

"I'm plugging back into the mental health system after an absence and am seeing positive trends."

"We are trying to incorporate client voices meaningfully, and I appreciate the patience of my fellow-planners with this process. Diverse voices are chiming in, and we are acting as equal partners side by side."

"We can do cheerleading for recovery values. We are educating the community that it's about individuals collectively stepping up to say 'I'll be there for you,' and then making that the pattern we follow without 'systematizing.'"

"The presence of representatives of the Hispanic and Native American communities, and having their input on community and multi-agency conversations and their help in understanding Native American and Hispanic family issues, is vital."

"We are creating a system that's integrated and blended behind the scenes, blending families and agencies and dollars creatively."

The Steering Committee's first task was to establish the guidelines by which the planning process would proceed—developing a Statement of Purpose, governance policies, meeting groundrules, and a gradients of agreement decision-making model. With these parameters established, the Steering Committee developed a work plan to guide them in completing the planning process on schedule and began fitting their recommendations into the structure mandated by the State Guidelines. This required a review of all the proposals submitted by each Age Group in light of:

- The MHSA Essential Elements, as localized by the Age Groups
- The MHSA Mandatory Outcomes, as localized by the Age Groups
- The Age Group Priorities

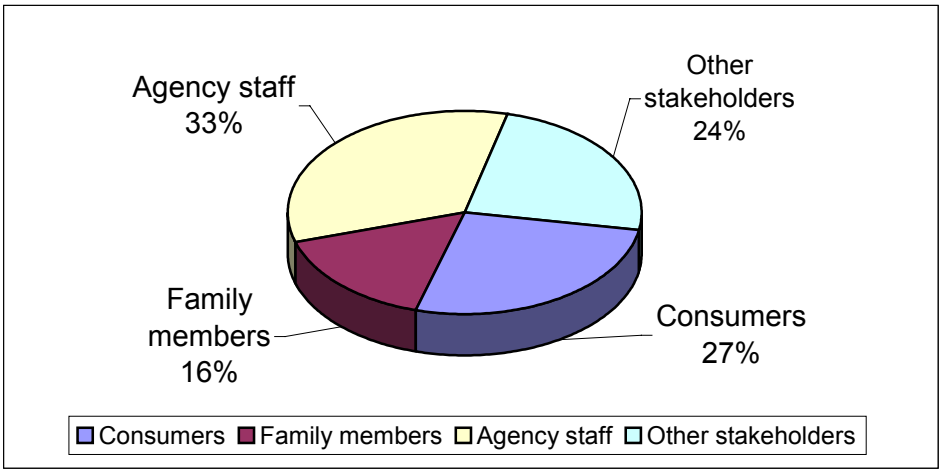
Continued discussion culminated in a prioritization process that was based on identified community needs, availability of other resources, and the ability of the proposal to achieve desired outcomes. The Steering Committee also reviewed local demographics

and service utilization data to inform the prioritization and selection process, which was completed through a combination of consensus and use of Gradients of Agreement.

2. **In addition to consumers and family members, briefly describe how comprehensive and representative your public planning process was.**

Mendocino County's planning process engaged a total of more than 100 active participants.[4] As a direct result of MCHMD's energetic outreach efforts, nearly half (43%) of the planning participants were consumers or family members, as shown below. Although demographic information was not formally collected from participants, the meetings were attended by a representative mix of stakeholders that included community members, advocates, service providers, local government, family members, client consumers, and representatives of local ethnic groups. The utilization of consumers as outreach staff and consumer participation in all planning meetings made the interpersonal dynamics rich with the very issues and frustrations the Plan is intended to address, as counties work to build transformed systems that incorporate a diversity of voices. As difficult as this was at times, it was also truly rewarding. In fact, MCMHD and the MHSA Steering Committee believe that this collaborative process is the only way to build trust and develop an improved array of options for those facing mental illnesses.

Figure 2. Community participation in MHSA planning process[5]



3. **Identify the person or persons in your county who had overall responsibility for the planning process. Please provide a brief summary of staff functions performed and the amount of time devoted to the planning process to date.**

MCMHD Director Beth Robey carried overall responsibility for the development of the County Plan, with the Mental Health Board's Strategic Planning Committee playing an

[4] 218 people participated in the initial community forums, 173 in the Work Groups, 67 in the Age Groups, and 28 on the Steering Committee. Although these numbers are unduplicated within each group, duplication across groups was not tracked.

[5] Please note that when participants identified themselves as both consumers and family members, they were counted as consumers to ensure an accurate picture of consumer input into the planning process. Participants were also counted as consumers when they identified themselves as both consumers and agency staff.

integral role by providing early guidance and recommendations. MCMHD appointed Jennie Vinyard, an MCMHD employee who is a family member and was already working as a Parent Partner, as MHSA Coordinator. Under the supervision of the MCMHD Director, the MHSA Coordinator conducted the day-to-day operation of the planning process including consultation with the MHSA Steering Committee, coordination of Work Groups, and supervision of the consumer and family member outreach and clerical staff, both paid and volunteer. MCMHD contracted a professional meeting facilitator/mediator to lead the Age Group meetings of the second tier of the planning process and the meetings of the Steering Committee. Overall, MCMHD estimates that more than 10,000 person-hours were spent on planning activities, more than double the 4,600 hours the County had estimated would be required to complete the planning process (not including the countless hours contributed by Steering Committee members and other stakeholders throughout the county).

Table Five. Staffing functions and contributions

FULL-TIME CONSUMER/FAMILY MEMBER STAFF	**PLANNED**	**ACTUAL**
MHSA Coordinator	867 hrs	2080 hrs
Part-time Consumer (client)/Family Member Staff:		
Office Assistant	650 hrs	6,000 hrs
Outreach Workers	1000 hrs	
Outreach Worker-Youth	100 hrs	
Family Outreach Workers	1000 hrs	
Sub-total	*3,617 hrs*	*8,080 hrs*
DEDICATED TIME OF EXISTING MENTAL HEALTH STAFF (NON- MHSA FUNDING)	**PLANNED**	**ACTUAL**
Mental Health Director (300 hours will be charged to MHSA funding)	250 hrs	800 hrs
Administrative/Data Analyst	40 hrs	40 hrs
Adult Crisis Services Manager	80 hrs	40 hrs
AB 2034 Coordinator and Staff	80 hrs	80 hrs
Vocational Rehabilitation Staff	80 hrs	80 hrs
Youth and Family Services Manager	80 hrs	80 hrs
OASOC Supervisor and OASOC Coordinator	80 hrs	80 hrs
Fiscal Manager	80 hrs	40 hrs
Bi-lingual Human Services Worker	80 hrs	80 hrs
Sub-total	*850 hrs*	*520 hrs*
CONTRACTOR AND CONSULTANT TIME	**PLANNED**	**ACTUAL**
Plan Writer	140 hrs	280 hrs
Trainers		---
Facilitator		200 hrs
MH Board Members (5 members at 200/hrs each)		1000 hrs
Sub-total	*140 hrs*	*1,480 hrs*
TOTAL	**4,607 hrs**	**10,080 hrs**

4. **Briefly describe the training provided to ensure full participation of stakeholders and staff in the local planning process.**

MCMHD coordinated the participation of consumers and stakeholders in local and statewide training activities. Clients and family members were especially encouraged and supported in their participation in the MHSA planning process through a variety of capacity building trainings. For statewide trainings, the county's MHSA Coordinator served as liaison for arranging participation of local consumers and stakeholders. For local trainings, the Coordinator arranged for trainers, facilities, media/promotion, and follow-up. In addition to teaching participants about the MHSA's purpose, state requirements, and local processes, local training schedules were developed to provide training on mental health concepts such as recovery and resiliency, client self-help programming, and cultural competency. Trainings were open to staff, clients and family members, advocates and other stakeholders, and the general public. In addition to the specific training activities detailed in Table Six below, training was purposively integrated throughout the planning process through discussions of the MHSA, recovery and wellness, plan requirements, local data and demographics, and progress to-date in all planning activities. Of course, the planning process itself was educational for all participants, as they learned to understand the goals and constraints of other stakeholder groups.

Table Six. MHSA training activities

Date	Topic	Participants					
		Consumers	Family Members	Stake Holders	Staff	Mental Health Board	Community
January 2005	California Clients: The Power for Change	✓	✓			✓	
February 2005	All-staff Training on MHSA			✓	✓		
	Training on Clubhouse Model	✓	✓	✓	✓	✓	✓
	Mental Health Policy Forum		✓	✓	✓		
	Cultural Competency	✓	✓	✓	✓	✓	
	MHSA Requirements Conference Calls	✓	✓		✓	✓	
	UACC on MHSA		✓		✓	✓	
March 2005	MHSA Requirements Conference Calls	✓	✓	✓	✓	✓	
	MHSA Requirements for Small Counties	✓	✓	✓	✓	✓	
	MHSA Requirements for Age Groups (2)	✓	✓	✓	✓	✓	
April 2005	MHSA for Stakeholders	✓	✓	✓	✓	✓	
	MHSA Conference Calls	✓	✓	✓	✓	✓	✓
May 2005	Small County Regional Training	✓	✓	✓	✓	✓	
	CMHACY on MHSA & Youth		✓	✓	✓		
	Disabilities Training	✓	✓		✓		
	MHSA Requirements Conference Call	✓	✓	✓	✓	✓	
June 2005	MHSA Stakeholder Meeting	✓	✓		✓	✓	
	MHSA Performance Measures/Capital/IT	✓	✓	✓	✓	✓	
	Local Training on MHSA & Recovery (Ukiah)	✓	✓	✓	✓	✓	✓
	MHSA Requirements Conference Calls	✓	✓	✓	✓	✓	
	MHSA Requirements Education & Training	✓	✓		✓	✓	

Date	Topic	Participants					
		Consumers	Family Members	Stake Holders	Staff	Mental Health Board	Community
August 2005	Training on MHSA & Recovery in Fort Bragg and Willits	✓	✓	✓	✓	✓	✓
September 2005	Recovery: Realities, Hopes, and Practices	✓	✓	✓	✓	✓	✓
	Recovery Video by Mark Ragins	✓	✓	✓	✓	✓	
	Alternatives to Traditional Medications	✓	✓	✓	✓	✓	
October 2005	Regional MHSA training	✓	✓	✓	✓	✓	
November 2005	Cultural Competency	✓			✓		

PART I, SECTION II. PLAN REVIEW

NOTE: This section will be completed after the conclusion of the public comment period and Mental Health Board review. Section II will include the following:

1. **Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.**

2. **Provide documentation of the public hearing by the mental health board or commission.**

3. **Provide the summary and analysis of any substantive recommendations for revisions.**

4. **If there are any substantive changes to the plan circulated for public review and comment, please describe those changes.**

PART II. PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

PART II, SECTION I. IDENTIFYING COMMUNITY ISSUES RELATED TO MENTAL ILLNESS

1. **Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years by placing an asterisk (*) next to these issues. (Please identify all issues for every age group even if some issues are common to more than one group.)**

Major community issues were identified through the planning process described in the preceding section. To the extent possible, the Steering Committee drew on the discussions and issues generated by earlier phases of the planning process to develop the following listing of the major issues and concerns of county residents.

Mendocino County's MHSA Planning Team conducted a broad-based community survey to assess mental health needs among clients and family members. In all, 573 surveys were collected, 360 through a mass mailing and 213 conducted through direct outreach in 35 separate locations throughout the county (36 surveys in Fort Bragg, 65 surveys in Ukiah, 63 surveys in Willits, and 49 surveys in outlying communities). Demographics of individuals who participated in the surveys that were conducted directly by the Outreach Workers are detailed in Table Seven below; analysis of the surveys that were returned by mail has not yet been completed. As the table shows, more than two-thirds of the respondents to surveys administered directly by the Outreach Workers were female, and almost two-thirds were consumers. Most respondents (73.7%) were white/non-Hispanic, but the Outreach Workers were able to survey 25 American Indians (11.7%) and 11 Hispanic individuals (5.2%). Just over half of the respondents reported their sexual orientation as heterosexual (61.6%), while 12.7% identified themselves as gay, bisexual, or transgender and 35.7% declined to state their sexual orientation. More than 1/3 of the respondents reported that they had experienced homelessness at some time in their lives. (See Appendix B for further details.)

Table Seven. Survey demographics[1]

		AGE GROUP				TOTAL	PERCENT
		16-24	25-34	35-59	60+		
	N=	25	26	152	10	213	
Gender	Male	4	12	51	1	68	31.9%
	Female	22	14	100	9	145	68.1%
Service Category[2]	Consumer	16	15	96	7	134	62.9%
	Family	8	10	61	2	81	38.0%
	Other or No Response	3	2	10	1	16	7.5%

[1] As noted above, Table Seven includes only demographics of individuals who participated in the surveys conducted directly by the Outreach Workers.

[2] Note that the total for this category exceeds 100% because some respondents reported themselves as both consumer and family member.

		AGE GROUP				TOTAL	PERCENT
		16-24	25-34	35-59	60+		
	N=	25	26	152	10	213	
Ethnicity	Native American	4	3	17	1	25	11.7%
	Black/African American	0	0	6	0	6	2.8%
	Asian	0	0	1	0	1	0.5%
	Mexican/Hispanic/Latino	4	1	6	0	11	5.2%
	White	16	20	112	9	157	73.7%
	Other or No Response	0	2	11	0	13	6.1%
Sexual Orientation	Heterosexual	10	18	76	6	110	51.6%
	Bisexual	5	2	2	1	10	4.7%
	Gay	3	0	5	1	9	4.2%
	Transgender	2	1	5	0	8	3.8%
	Other or No Response	5	5	64	2	76	35.7%
Ever Been Homeless	Yes	8	11	54	3	76	35.7%
	No	10	13	53	7	83	39.0%
	Other or No Response	7	2	45	0	54	25.3%

In response to questions about recovery, only 20% reported that they were familiar with the concept of recovery, and only one in four (26.8%) said that they knew someone who had recovered from a mental illness like their own. Nearly 40% of the respondents reported that they had experienced difficulty in accessing mental health services. The survey's open-ended questions made it difficult to pinpoint specific needs for mental health services. However, early analysis indicates the following:

- Top priorities identified by 34 surveyed high school students: a drop-in center with peer counseling (74%), a 24-hour crisis center (68%), and after school activities (62%).
- Top priorities for the 61 college age participants included: a 24-hour crisis center (61%), a drop-in center (52%), and peer counseling (41%).
- Ukiah area adults (110 surveyed) identified affordable housing (47%), social activities and recreation (38%), and therapy/counseling (26%).
- Top priorities for inmates in the County Jail (19 surveyed) included: medication while incarcerated (63%), crisis residential services (47%), and peer counseling (32%).

Overall, the following themes emerged from the survey as high priority needs:

- Crisis services and 24/7 response
- Access to services in home communities
- Services provided with respect and client control
- Treatment that leads to and supports self-sufficiency

CLIENT AND FAMILY COMMENTS FROM MHSA SURVEY

"We need treatment that helps us to be a valuable person in society while being mentally disabled and feeling worthless and hopeless because of it."

"We need anger management classes and young adult programs--PLEASE!"

"It's a challenge to remain sane while residing within an insane death culture."

"There are no services available if you're not acute or in crisis."

In July 2005, the Mental Health Recovery Coalition, a family and consumer advocacy group, conducted an independent survey on mental health needs in the county. The 141 respondents to this survey included clients, family members, county employees, medical providers, employees in the criminal justice system, and other community members. (See Appendix A for further details.) Top concerns identified by the survey included the following:

- Two of the top three highest ranked concerns were related to psychiatric treatment for jail inmates, with 96% of the respondents expressing concern about inmates receiving adequate psychiatric treatment, including alternatives to detention, crisis care, recovery support, case management, etc.
- Second highest rated response, with 94%, was the need for services that enable children to remain living with their families and attending local schools.
- Ranked fourth (92%) was the need to provide local medical providers with training on meeting the healthcare needs of people with mental illnesses.
- The need for a mobile service unit to serve residents in outlying communities was also identified by 92% of the respondents.
- Finally, improved crisis care, including 24/7 response, an inpatient psychiatric unit, and a mobile crisis response team with cross-training for law enforcement officers, was identified by 91% of the respondents.
- Respondents indicated extensive support for a variety of peer-led and consumer support services, including a consumer hostel, supported housing, supported jobs and job training, wellness recovery plans, drop-in centers, peer counseling, a warm line, etc.

COMMENTS FROM MENTAL HEALTH RECOVERY COALITION SURVEY

"We have a desperate need for a 24-hour crisis unit and for mental health workers to do outreach."

"There needs to be a program that talks with parents about mental illness as it relates to bonding between parent and child."

"A society that does nothing to help people with mental illness find ways to stay out of jail will pay huge social costs that go far beyond the dollar costs of incarceration."

"Please consider seriously these client supports and services. It is a nightmare to try to help a loved one without them."

Table Eight. Mental health issues identified through the public planning process[3]

AGE GROUP	COMMUNITY ISSUES
Children and Families	*** Inability to be in a mainstream school environment / school failure** • Multiple opportunities for success, allowing access to educational opportunities • Resources for uninsured and other children who don't qualify for special education • Community-based ways to reach children sooner *** Involvement in child welfare and juvenile justice systems / out-of-home placement** • An integrated service experience with open-ended services that are not interrupted by age boundaries • Collaborative partnering and a supportive team that respects family know-how • Crisis response that includes the whole family exploring solutions together • Safe living environments and a reduction in homelessness *** Peer and family problems** • Peer support for parents and children • Focus on wellness and recovery, addressing all aspects of each person's situation • Cultural competency with a "small town" personal touch • Outreach that is structured enough to support and human enough to be supportive
Transition Age Youth	*** Homelessness** • Safe living environments • Reduction in homelessness • Communal living environments *** Inability to manage independence / work** • Self-advocacy modeled by peers • Results include employment, education, and personally meaningful activities • Cultural competency that brings youth together with their peers • Focus on wellness with advocacy that translates "being different" into a strength • Integration into age group *** Involvement in child welfare and juvenile justice systems** • Community collaboration in providing meaningful connected services • Seamless personal service coordination and family involvement in transitions • Individualized attention that recognizes each TAY's unique goals and desires • Intensive wraparound services • Reduction in incarceration and involuntary services

[3] As instructed by the State, issues selected to be the focus of MHSA activities over the next three years are indicated with an asterisk.

AGE GROUP	COMMUNITY ISSUES
Adults	*** Homelessness** • Safe and adequate housing • Reduction in homelessness *** Inability to manage independence** • Supportive peer networks • Peers available to help at all entry points and levels of mental health system • Cultural competency, both racial ethnic and client culture • Full community integration • Focus on goals, not rules, and focus on service first, not money *** Inability to work** • Meaningful use of time and capabilities, with trained client leaders • Opportunities for clients to do what they are good at • Flexible work settings that reduce stress *** Involuntary care / institutionalization / incarceration** • Timely access to supports and services in all communities • Focus on wellness, recovery, and resiliency • Client self-determination • One-to-one relationships, an approach that's human, individualized, and supportive • Personal service coordination (not case management)
Older Adults	*** Homelessness** • Safe and adequate housing • Reduction in homelessness *** Inability to manage independence / involuntary care / isolation** • Culturally competent services (racial ethnic and client culture) that feel personal • Someone to share stories with who shares the client's culture • Personal service coordination (not case management) • Community collaboration with creative care shared by agencies • Client/family-driven services that are voluntary • Focus on wellness and recovery, with clients viewed as a whole person with both strengths and needs • Focus on keeping older adults healthy, before problems arise • Integrated care that brings services to older adults • Persistence and advocacy until diagnosis and medications are correct

Please see Appendix G for a listing of all issues that were raised during the early phases of the planning process.

2. **Please describe what factors or criteria led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were issues prioritized for selection? (If one issue was selected for more than one age group, describe the factors that led to including it in each.)**

The Steering Committee's priority was to develop and select programs and services that would transform the county's mental health system by creating client leadership and supports for recovery and wellness. As the Steering Committee reviewed and repackaged the proposals and concerns that were collected earlier in the planning process, they reviewed each in light of its transformative potential and congruence with the MHSA's Essential Elements and Required Outcomes as defined and reworded by the groups to address local realities and the unique needs of each age group. To complete the prioritization process, the Steering Committee members assessed each proposed strategy by asking whether the strategy would:

- Result in transformation of the mental health system
- Reflect the work conducted by previous levels of the planning process
- Conform with MHSA criteria, essential elements, and required outcomes
- Express the needs of outlying communities
- Provide culturally competent services for all, with special attention to Hispanic and American Indian clients
- Fulfill the MHSA's Full Service Partnership requirement
- Provide equity and fairness to all age groups
- Fit with and complement other proposed strategies

3. **Please describe the specific racial, ethnic, and gender disparities within the selected community issues for each age group, such as access disparities, disproportionate representation in the homeless population and in county juvenile or criminal justice systems, foster care disparities, access disparities on American Indian rancherias or reservations, school achievement drop-out rates, and other significant issues.**

Inability to be in a mainstream environment/school failure (children)

Although MCMHD is serving nearly two-thirds of income-eligible children with serious mental illness of all ages, this level of service does not reach children of all ethnic groups. While 62% of the white/non-Hispanic children estimated to need mental health services are receiving some level of services, the percentage of Native American children served is only half this amount (36%), and the percentage of Hispanic children served is only 12% of the 324 income-eligible Hispanic children expected to need mental health services. The most frequent childhood diagnoses seen by MCMHD are ADHD, anxiety, major depression, and adjustment disorders. (Diagnoses were not reported or were reported as deferred for approximately 10% of the children served by MCMHD.) The data show a number of discrepancies among children in the three largest ethnic groups:

- Among Native American children, the most frequent diagnoses are major depression (39%) and ADHD (23%). Native American children are also most likely to have no diagnosis or to have their diagnosis deferred (15%).

- Among Hispanic children, the most frequent diagnoses are ADHD (27%), anxiety (24%), and major depression (18%).
- Among white/non-Hispanic children, the percentages are very close in the top four childhood diagnoses, ranging from 14% to 20%.

Mendocino County's one-year school drop-out rate was 1.8% compared with 3.3% statewide for the 2003-2004 school year. By district, the rate ranged from 4.9% in the county's Court and Community Schools to zero drop-outs in several smaller districts. Ethnically, the drop-out rate was 3.3% for American Indians, 2.7% for Hispanic students, and 1.3% for white/non-Hispanic students.[4]

Homelessness (TAYs, adults, and older adults)

The following information is from the 2005 Mendocino County Homeless Census and Survey.[5] In June 2005, Mendocino County conducted a peer-oriented point-in-time count of street and sheltered homeless persons. The street count was accomplished through a systematic canvassing of all 18 census tracts in the county, while the shelter count involved the reporting of occupancies from shelters and institutions for the night prior to the count. From the point-in-time count, the researchers extrapolated an estimate of the number of people who experience homelessness in a calendar year. A second component of this project involved comprehensive interviews with 334 homeless individuals. The interviews were conducted by trained homeless workers and service providers to provide a profile of the county's homeless population.

The point-in-time count identified 1,947 homeless people on the streets and in shelters, transitional housing, permanent supportive housing, domestic violence shelters, voucher motels, hospitals, jails, and rehabilitation facilities. Survey data regarding the average length of homelessness indicates that for every person that is experiencing homelessness at a given point in time, 2.74 people experience homelessness annually. Based on this figure, the researchers estimate that 5,335 persons were homeless at some time during 2005, almost 6% of the county population and well above the statewide figure of 3-4%. Through the interviews, the researchers found that 58% of the homeless experienced depression and 43% experienced some form of mental illness. Of these, less than half were receiving mental health services at the time of the interviews. Although the survey did not address the issue of dual diagnosis, 22% of the respondents reported drug addictions and 20% reported alcoholism; less than 1/3 were receiving substance abuse treatment.

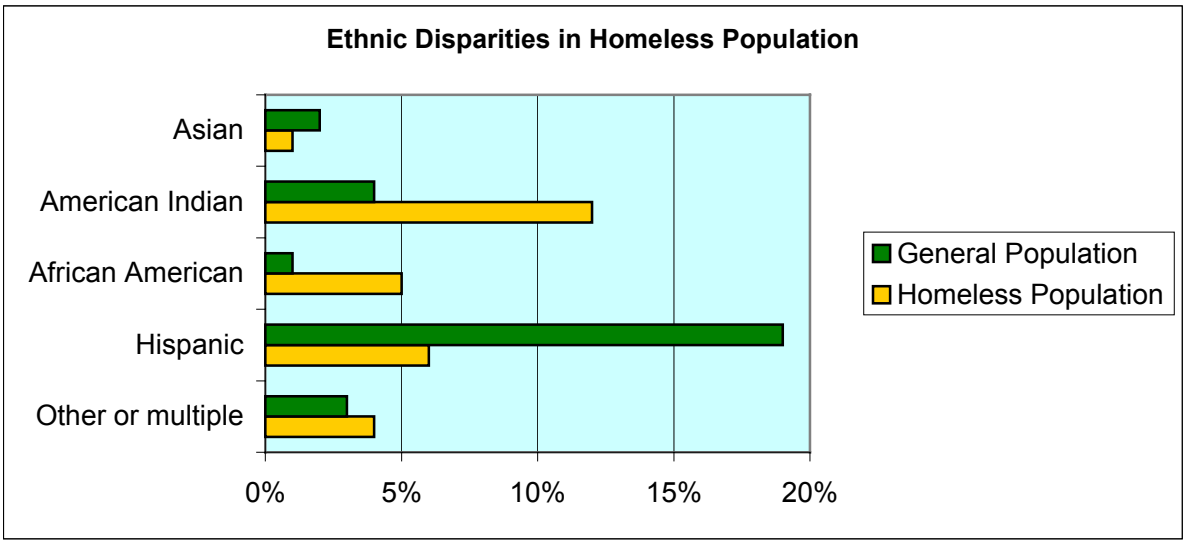
Demographics of the homeless population show a number of ethnic disparities that are depicted in Figure 3 below. As the chart shows, at 6%, Hispanics are underrepresented in the homeless population, and the representation of White/non-Hispanics and Asians corresponds with their proportion in the general population. However, American Indians at 12% and African Americans (5%) are over-represented. Similarly, males are considerably over-represented, comprising 67% of the homeless population but slightly

[4] Many authorities consider the drop-out rates to under-report the actual number of students that leave school before graduating.

[5] 2005 Mendocino County Homeless Census and Survey. Applied Survey Research, Watsonville CA.

less than half of the general population. However, the data do not indicate whether the incidence of mental illness among the homeless is proportionate across ethnicities.

Figure 3

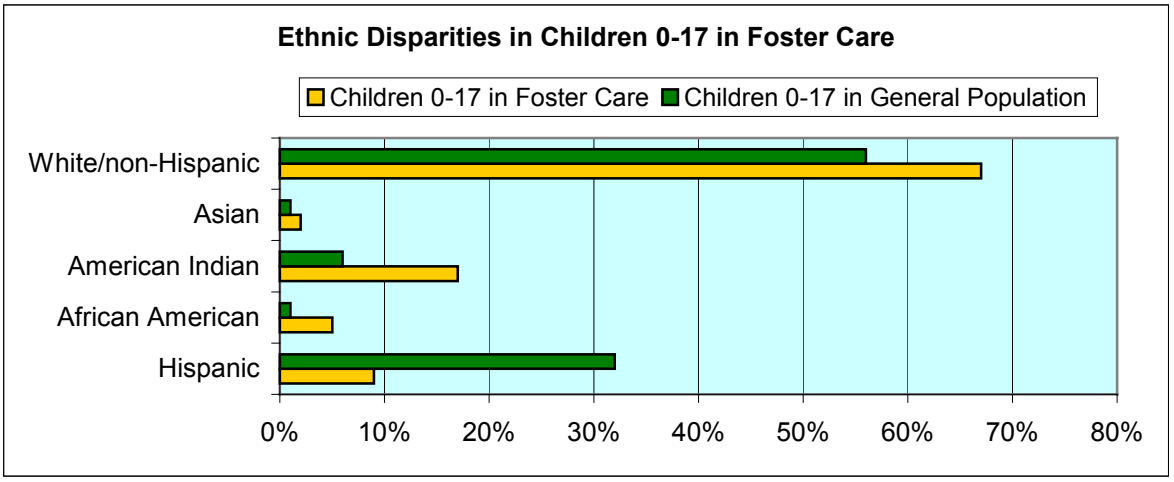


Involvement in Child Welfare and Juvenile Justice Systems (children and TAYS)

During the past year, the Department of Social Services provided supervision to 289 children (unduplicated count) in 535 foster care placements. Demographic data on these children shows a great deal of ethnic disparity when compared to children in the general population. Of the 289 children in foster care last year:

- 4.8% were African-American, compared with 1.3% in the general population.
- 17.3% were American Indian, compared with 5.8% in the general population.
- 2.1% were Asian/Pacific Islander, compared with 1.4% in the general population.
- 9.3% were Hispanic, compared with 31.7% in the general population.
- 68.5% were White/non-Hispanic, compared to 55.9% in the general population.

Figure 4



The Superintendent of the County's Juvenile Hall reports that the facility served 705 youth in 2004, of which 76% were male and 24% female. While the majority of the youth were white/non-Hispanic (53%), the percentage of youth of other ethnicities exceeds their representation in the 10-17 age group in the general population as shown below:

- 2% were African-American, compared with <1% in the general population
- 17% were American Indian, compared with 5% in the general population
- 26% were Hispanic, compared with 18% in the general population
- 53% were White/non-Hispanic, compared to 72% in the general population
- 2% were other ethnicities, compared with 7% in the general population

The Juvenile Hall also reports that they are serving an increasing number of youth with mental health issues, especially youth at risk of harming themselves or others, with 30% of the incarcerated youth in this category in 2004. Furthermore, most of the youth booked into the Juvenile Hall use alcohol or another drug on a regular basis, and 80% are considered to be dually-diagnosed. Finally, 95% of the youth admitted to the Juvenile Hall come from families with incomes at or below the federal poverty level.

Inability to manage independence/isolation (older adults)

Clients served through the county's Older Adult System of Care (OASOC) have generally been those who are already involved in the social services system. There are, however, many older adults whose paths simply do not intersect with OASOC. For some, this is because they live in remote areas. For the Latino and Native American communities, isolation from mainstream services is related in part to the deep cultural chasm that exists between them and the majority White population. The Department of Social Services reports that OASOC has been serving approximately 50 seniors each month, and that all of these individuals have mental health diagnoses. Among clients served by the Department of Social Services' In-Home Support Services program, which serves disabled and elderly individuals in their homes, 82.7% are White, 5.2% are Latino, and 10.9% are Native American.[6]

Approximately 200 of the 700 referrals that Mendocino County Adult Protective Services receives each year for suspected adult abuse and neglect are for older adult self-neglect. Of the self-neglect cases, the vast majority are associated with untreated mental illness; ethnic breakdown of these data is not available. The social conditions of older adults are compounded by functional impairments that affect 34.4% of the elderly population in the county.[7]

Disparities in independent living among older adults are more significantly gender-related than they are related to ethnicity. The 2000 Census reported 340 Mendocino County adults in nursing homes, 254 of whom (75%) were female and 86 (25%) of whom were male. Comparing the percentages of older adults in nursing homes with their proportion in the larger population suggests that the county's ethnic groups are

[6] Department of Social Services program data are used here to report ethnicity of older adults in the County because they are considered more accurate than census data.

[7] Area Agency on Aging, 1997.

underrepresented in the nursing home population, with 95% of nursing home residents white/non-Hispanic compared with 88% white/non-Hispanic among older adults countywide. (Note that for smaller ethnic groups percentage data are not statistically meaningful.)

Table Nine. Older adults in nursing homes

	African American		American Indian		Asian		Hispanic		White/non-Hispanic	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Number	0	8	2	2	0	0	0	4	84	240
Percent of total male/female nursing home population	0%	3%	2%	<1%	0%	0%	0%	2%	98%	94%

Incarceration (adults and older adults)

The Mendocino County Detention Center reports that 4,020 individuals were incarcerated during 2004. Of these, 866 (22%) were women. These data reveal a number of discrepancies when comparing demographics with those in the general population:

- The percentage of incarcerated American Indian men in all age groups is two to three times their representation in the general population, and incarcerated American Indian women in the 25-59 age group comprise 15% of their age group in the jail, but only 4% of the general population for the age group.
- Among Hispanics, the percentage of incarcerated men in the 25-59 age group is nearly double the percentage in the general population.
- In the 18-24 age group, the percentage of incarcerated African American women and men is 3 times the proportion of these groups in the general population.
- Approximately 33% of the incarcerated population are on psychotropic medications; of these nearly all are dually diagnosed with substance abuse issues.

Table Ten. Jail demographics compared with general population

	Women age 18-24		Women age 25-59		Women age 60+	
	Inmates	Gen Pop	Inmates	Gen Pop	Inmates	Gen Pop
African American	3%	<1%	<1%	<1%	<1%	<1%
Hispanic	9%	26%	6%	12%	11%	3%
American Indian	10%	6%	15%	4%	<1%	3%
White	76%	64%	76%	80%	89%	92%

	Men age 18-24		Men age 25-59		Men age 60+	
	Inmates	Gen Pop	Inmates	Gen Pop	Inmates	Gen Pop
African American	3%	<1%	3%	<1%	2%	<1%
Hispanic	27%	28%	27%	15%	9%	4%
American Indian	9%	5%	9%	3%	5%	2%
White	59%	63%	59%	78%	82%	91%

4. **If you selected any community issues that are not identified in the "Direction" section above, please describe why these issues are more significant for your county/community and how the issues are consistent with the purpose and intent of the MHSA.**

All of the issues addressed by the Mendocino County Plan are consistent with those listed in the MHSA Guidelines.

PART II, SECTION II. ANALYZING MENTAL HEALTH NEEDS IN THE COMMUNITY

General Information

Mendocino County covers a large rural area in northern California with 3,510 square miles of land—equal in size to Puerto Rico—and a population of 90,816. Mendocino County's population density is 25.9 persons per square mile, slightly over one-tenth the statewide average of 217.2. The inland and coastal regions are separated by a mountain range with limited 2-lane highway access. Outlying communities can be more than two hours away from Ukiah, the county seat of government, and are frequently isolated during inclement weather. Public transportation outside incorporated cities is minimal. The US Census Bureau's Small Area Income and Poverty Estimates for 2002[8] reports that the median income in Mendocino County is $35,664 (compared to $47,493 statewide) and that 14.6% of Mendocino County's population lives below the federal poverty level. Approximately 38% of the population lives at or below 200% of the federal poverty level.

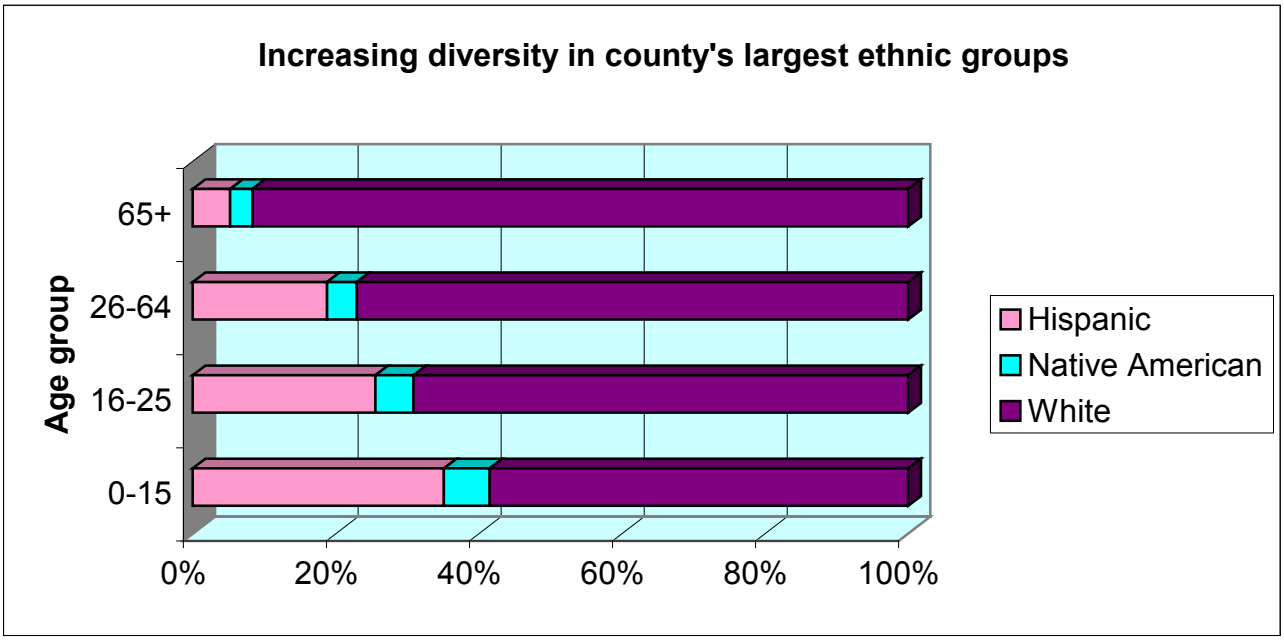
In the 2000 Census (which was widely assumed to have undercounted minority populations), 80.8% of Mendocino County residents reported themselves as White, 4.4% as Native American, 2.4% as Asian, 0.6% as Black, and 12.7% as some other race or of mixed race. The percent of persons reporting Hispanic or Latino origin was 16.5%. At 4,023 individuals (4.4%), Mendocino County's American Indian population, primarily of the Pomo Tribe, comprises a significant minority that greatly exceeds the statewide percentage (1%) and national percentage (.9%) of American Indians. According to 2005 data from the State Department of Finance, Mendocino County is home to 1,087 American Indian children and youth in the 0-15 age group, 714 TAYs, 1,711 adults (age 26-59), and 511 adults age 65+. Mendocino County tribes are organized in 11 rancherias, each governed by a tribal council:

Coyote Valley Reservation	Potter Valley Rancheria
Guidiville Rancheria	Redwood Valley Rancheria
Hopland Reservation	Round Valley Reservation
Laytonville Rancheria	Sherwood Valley Rancheria
Manchester/Point Arena Rancheria	Stewarts Point Rancheria
Pinoleville Indian Reservation	

The overall proportion of each ethnic group in the total population differs significantly from their proportion in each age group as shown below, with the white/non-Hispanic percentage smaller in younger age groups. (Note that the percentages of African Americans and Asians, which are not shown on all charts, remain fairly constant across age groups.)

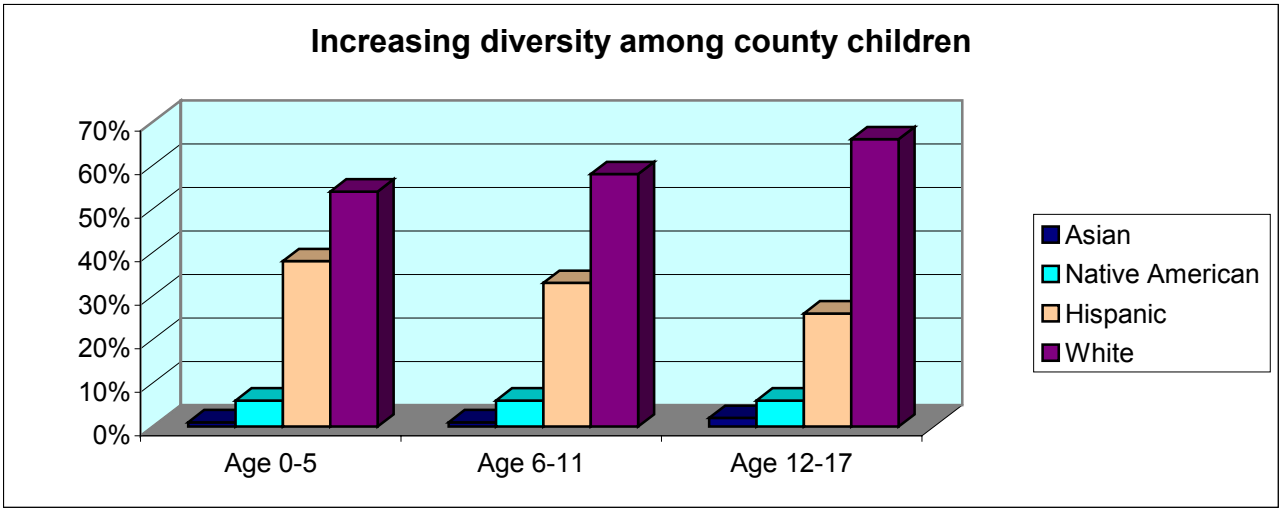
[8] The 2002 updates, released in December 2004, are the most recent available.

Figure 5



With regard to age, 28.3% of the county's population is between the ages of 0 and 19, and 17.9% is age 60 or older. From 1999-2004, Hispanic enrollment in Mendocino County schools increased by 34%, from 20.5% in 1999 to 27.5% in 2004. During the same period, Native American enrollment increased by 16% (from 7.3% to 8.5%), and the number of students identifying themselves as multiracial or of other ethnicities quadrupled. Mendocino County's increasing diversity is even more striking when looking only at younger age groups, as depicted below.

Figure 6



Based on MCMHD utilization data and state prevalence data,[9] it appears that the county is providing services to approximately three of every four individuals who are both eligible for and in need of mental health services (77%). When assessing the extent to which services are provided within each age group and in specific population groups, the picture changes, as summarized in Table Eleven below and detailed in the subsequent age group sections. As the table shows, MCMHD is meeting 17% of the need in the Hispanic population, 62% of the need in the American Indian population, and 73% in the White/non-Hispanic population. (Unless otherwise noted, numbers represent unduplicated counts.)

Table Eleven. Estimated number of unserved individuals, based on service and state prevalence data

	PREVALENCE	SERVED (2003-2004)	UNMET NEED
TOTAL	**2,991**	**2,296**	**695**
African American	18	28	**-10**
Asian/PI	51	26	**25**
Hispanic	702	116	**586**
American Indian	146	92	**54**
White/non-Hispanic	1,951	1,427	**524**
Other / Multi	118	607	**-484**

(Note that the data in Table Eleven above consider only those individuals served by MCMHD, although mental health services are also provided by organizational providers, private therapists, and local clinics. Furthermore, the large number of individuals served whose ethnicity is not identified—26% of the total number served—lessens the reliability of the data.) Service data reported by other providers include the following:

- **Consolidated Tribal Health Project.** Mental health services are provided to a significant number of mental health clients by Consolidated Tribal Health Project (CTHP). CTHP serves members of a consortium of eight American Indian tribes. During the past year, CTHP made 1,769 behavioral health contacts with 243 individuals. Of these, 70 were children ages 0-16. Services provided by CTHP include counseling, psychotherapy, psychological testing, neurophsychological testing, forensic testing and evaluation, community consultation, critical incident response, and substance abuse treatment.
- **Mendocino Community Health Clinics** (MCHC) provided mental health services to 1,315 clients during the past year; these clients accounted for approximately 10% of the clinic's total caseload. Of clients receiving mental health services, 35% were dually-diagnosed, 75% were living on incomes below the federal poverty level, and 95% had incomes 200% or less of the federal poverty level. MCHC's mental health clients were predominantly white/non-

[9] The prevalence data provided by the California Department of Mental Health were developed through a contract with Dr. Charles Holzer, Ph.D. using information from the Epidemiological Catchment Area (ECA) studies, the National Co-Morbidity Study (NCS), and rates of SED for youth published in the Federal Register based on a compilation of prevalence studies for youth ages 9 through 17 years. National prevalence rates were applied to each county based on the demographic characteristics that correlate with differential rates. For further information see http://psy.utmb.edu./estimation/estimation.htm.

Hispanic (87%), with 8% Hispanic and 1% American Indian. Most clients were between the ages of 25 and 59 (83%).

The narrative analysis of the unserved population that follows is presented by age group, in accordance with the instructions. Note, however, that many of the situational characteristics apply to individuals of all ages; these disparities are detailed in Part II, Section I, #3 above. Note also that the only clients MCMHD considers fully served are the 41 individuals who are receiving services through the county's wraparound and AB 2034 programs.

1. **Using the information from population data for the county and any available estimates of unserved populations, provide a narrative analysis of the unserved populations in your county by age group. Specific attention should be paid to racial ethnic disparities.**

Children and Youth

Based on state prevalence data and MCMHD service utilization data, it appears that approximately **64% of the 957 eligible children in need of mental health services are receiving some level of services**, although MCMHD considers that only the seven children who are receiving wraparound services through the Family Strengths Program are fully served. However, when reviewing prevalence data for the general population and not only those who are eligible for MCMHD services, the number of unserved rises to 1,226. Some indicators and disparities in services within the unserved children and youth population are highlighted below:

- **Mental Health Services**. Based on MCMHD service utilization and prevalence data, the percentage of eligible children in the 0-17 age group who are being served varies by ethnicity, ranging from a high of 62% for white/non-Hispanic children to 36% for American Indian and 12% for Hispanic children. Note, however, that the Consolidated Tribal Health Project reports that they provide mental health services to children of all ages, with most being between the ages of 3 and 13, and that approximately 45 children are served each year. Combining this number with the 13 individuals served by MCMHD suggests that 86% of American Indian children with severe emotional disorders are receiving treatment.
- **Foster care**. Of the 289 children in foster care last year, 4.8% were African-American, compared with 1.3% in the general population; 17.3% were American Indian, compared with 5.8% in the general population; 2.1% were Asian/Pacific Islander, compared with 1.4% in the general population; 9.3% were Hispanic, compared with 31.7% in the general population; and 68.5% were White/non-Hispanic, compared to 55.9% in the general population.
- **Health Insurance**. The 2003 California Health Interview Survey (CHIS) found that 77% of Mendocino County[10] children and youth age 0-17 had full health insurance coverage for the entire year (including 28% covered through MediCal or Healthy Families), while 13% were uninsured all or part of the year, up from

[10] The California Health Interview Survey combines Mendocino and Lake County data.

10.8% in 2001. According to the State Department of Health Services, 2,024 Mendocino County children were enrolled in the Healthy Families program at the beginning of the current fiscal year, equal to approximately 9% of the total number in this age group, and more than 9,000 children had MediCal coverage.[11]

- **Alcohol and drug use**. In responding to the 2003-2004 California Healthy Kids Survey questions assessing drug and alcohol use in the past 30 days, 6% of Mendocino County 7th graders reported binge drinking, 7% reported smoking marijuana, and 18% reported drinking alcohol.
- **Assets and resiliency**. 65% of Mendocino County 7th graders responding to the California Healthy Kids Survey scored in the high range in external assets (caring relationships, high expectations, and meaningful participation) and 71% scored high in internal assets (cooperation and communication, self-efficacy, empathy, problem solving, self-awareness, and goals and aspirations); 23% of the county's 7th graders reported feeling sad or hopeless in the past year.

Transition Age Youth (TAY)

Based on state prevalence data and MCMHD service utilization data, it appears that **82% of the 363 eligible TAYs in need of mental health services are receiving some level of services**, although MCMHD considers that only the 10 TAYs who are receiving wraparound services are fully served.[12] Some indicators and disparities in services within the unserved TAY population are highlighted below:

- **Mental Health Services.** State prevalence data does not provide a separate breakdown for the TAY age group. However, MCMHD service utilization data can be used to compare the percentage served in each ethnic group to the representation of these groups in the general population. While the percentage of white/non-Hispanic TAYs served by MCMHD is approximately equal to that in the general population (65%), this picture changes when looking at ethnic groups: 10% of MCMHD's TAY clients are Hispanic, compared with 24% in the general TAY population; and 6% are American Indian, compared with 5% in the general population.
- **Juvenile justice system.** Probation statistics show clear ethnic disparities—of the 282 youth on probation, 57% are white, 21% are Hispanic, and 20% are American Indian. Studies of incarcerated juveniles suggest that 2/3 of males and 3/4 of females meet diagnostic criteria for one or more disorders, and about half are addicted to drugs or alcohol.[13] The Superintendent of the County's Juvenile Hall reports that the facility served 705 youth in 2004, of whom 76% were male and 24% female. While the majority of the youth were White/non-Hispanic (53%), the percentage of youth of other ethnicities exceeds their representation in the

[11] These data are not disaggregated by ethnicity.

[12] Three TAYs who are age 18 or older receive wraparound services through the AB 2034 program, and seven TAYS age 17 or younger receive wraparound services through the Family Strengths Program.

[13] Teplin LA, et al (2002). Psychiatric disorders in youth in juvenile detention. Archives of General Psychiatry: 59:12.

10-17 age group in the general population as follows: 2% are African-American, compared with <1% in the general population; 17% are American Indian, compared with 5% in the general population; and 26% are Hispanic, compared with 24% in the general population. The Juvenile Hall reports that they are serving an increasing number of youth with mental health issues, especially youth at risk of harming themselves or others, with 30% of the incarcerated youth in this category in 2004. Furthermore, most of the youth booked into the Juvenile Hall use alcohol or another drug on a regular basis, and 80% are considered to be dually-diagnosed. Finally, 95% of the youth admitted to the Juvenile Hall come from families with incomes at or below the federal poverty level.

- **Alcohol and drug use.** In responding to the 2003-2004 California Healthy Kids Survey questions assessing drug and alcohol use in the past 30 days, 30% of Mendocino County 9th and 11th graders reported binge drinking, 28% reported smoking marijuana, and 44% reported drinking alcohol.
- **School drop-out rate.** Mendocino County's one-year drop-out rate was 1.8% compared with 3.3% statewide for the 2003-2004 school year. By district, the rate ranged from 4.9% in Court and Community Schools to zero drop-outs in several smaller districts. Ethnically, the drop-out rate was 3.3% for American Indians, 2.7% for Hispanic students, and 1.3% for white/non-Hispanic students.
- **Assets and resiliency.** 59% of Mendocino County 9th graders responding to the California Healthy Kids Survey scored in the high range in external assets (caring relationships, high expectations, and meaningful participation) and 63% scored high in internal assets (cooperation and communication, self-efficacy, empathy, problem solving, self-awareness, and goals and aspirations); 40% of the county's 9th graders and 36% of 11th graders responding to the California Healthy Kids Survey in 2003-2004 reported feeling sad or hopeless in the past year.

Adults

Based on state prevalence data and MCMHD service utilization data, it appears that **92% of the 1,436 eligible adults in need of mental health services are receiving some level of services**, although MCMHD considers that only the 24 adults who are receiving wraparound AB 2034 services are fully served. However, when considering all 2,940 adults identified by state prevalence data as in need of services, whether or not they meet eligibility criteria, the unserved percentage rises to 45%. If the extent of need is based on responses to the California Health Interview Survey (2003), the need appears to be much greater: 20,000 Lake and Mendocino County adults age 18 and older (19.4% of the total adult population) responded to the survey by reporting a perceived need for mental health services in the past 12 months, compared with 15.1% statewide. Some indicators and disparities in services within the unserved adult population are highlighted below:

- **Mental Health Services.** State prevalence data does not provide a separate ethnic breakdown for the adult age group. However, MCMHD service utilization data can be used to compare the percentage served in each ethnic group to the representation of these groups in the general population. While the percentages of white/non-Hispanic adults and American Indian adults served by MCMHD are

approximately equal to their representation in the general population, this picture changes when looking at Hispanic clients: 5% of MCMHD's adult clients are Hispanic, compared with 18% in the general adult population.

- **Homelessness.** National estimates of psychiatric disorders among homeless people average 50%.[14] The 2005 Mendocino County Homeless Census and Survey Interviews with 334 homeless individuals found that 58% experienced depression, and 43% experienced some form of mental illness. Of these, less than half were receiving mental health services. Although the survey did not address the issue of dual diagnosis, 22% of the respondents reported drug addictions and 20% reported alcoholism, with less than 1/3 receiving substance abuse treatment. Demographics of the homeless population show a number of ethnic disparities, with Hispanics underrepresented (6% compared with 18% in the adult population), and American Indians (12% compared with 4% in the general population) and African Americans (5% compared with <1% in the general population) over-represented. Similarly, males are considerably over-represented, comprising 67% of the homeless population but slightly less than half of the general population. The data do not indicate whether the incidence of mental illness among the homeless is proportionate across ethnicities.
- **Hunger and food insecurity.** Data from the 2003 California Health Interview Survey show increasing food insecurity (38%, up from 28% in 2001) and outright hunger (21%, up from 12% in 2001) in the county.
- **Criminal justice system.** The Mendocino County Jail carries an average daily census of 272 and booked 4,020 individuals in 2004. Of these, approximately 78% were male and 22% female. The data reveal a number of discrepancies when comparing inmate demographics with those in the general population. The percentage of incarcerated American Indian men in all age groups is two to three times their representation in the general population, and incarcerated American Indian women comprise 15% of the adult age group in the jail, but only 4% of the general adult population. Among Latinos, the percentage of incarcerated men in the 25-59 age group is nearly double their percentage in the general population. Approximately 33% of the incarcerated population are on psychotropic medications, and 11% have serious mental illness; of these, nearly all are dually diagnosed with substance abuse issues.
- **Suicide**. According to statistics from the California Department of Health Services, during the years 1998-2002 the number of Mendocino County deaths attributable to suicide ranged from 13-18 per year. This exceeded the 2002 statewide rate of 9.4 suicide deaths per 100,000 persons. However, recently released statistics for 2004 indicate 25 deaths by suicide in Mendocino County, a very troubling increase. During this same period, 322 individuals were hospitalized due to being a danger to themselves, meaning nearly 350 persons in the community had reached that point of extreme hopelessness and despair. Of

[14] Fischer PJ, Breakey WR (1991). The Epidemiology of alcohol, drug, and mental disorders among homeless persons. American Psychologist: 46:1115-1125.

the 25 persons who committed suicide, only five had ever sought services from the Mental Health Department.

- **Health insurance**. The 2003 California Health Interview Survey (CHIS) found that 73% of non-elderly adults[15] had full health insurance coverage for the entire year (including 28% covered through MediCal), while 27% were uninsured all or part of the year.

Older Adults

Based on state prevalence data and MCMHD service data reporting services provided to 68 older adults, it appears that **less than 30% of the 235 eligible older adults in need of mental health services are receiving some level of services**, and none can be considered fully served. When considering all 611 older adults identified by state prevalence data as in need of services, whether or not they are eligible, the unserved percentage rises to 89%. Disparities in services within the unserved older adult population are highlighted below. Note, however, that percentages can be misleading when based on low numbers such as those reported in older adult statistics.

- **Mental Health Services.** State prevalence data does not provide a separate ethnic breakdown for older adults. However, MCMHD service utilization data can be used to compare the percentage served in each ethnic group to the representation of these groups in the general population. While the percentages of white/non-Hispanic and American Indian older adults served by MCMHD are approximately equal to their representation in the general population, this picture changes when looking at Hispanic clients: only 1 of MCMHD's older adult clients was Hispanic (1.5%), compared with 5% in the general older adult population.
- **Elder abuse.** Approximately 30% of the 700 referrals that Mendocino County Adult Protective Services receives each year for suspected adult abuse and neglect are for older adult self-neglect. Of the self-neglect cases, the vast majority are associated with untreated mental illness. In fact, functional impairments characterize 34.4% of the elderly population in the county.[16]
- **Institutionalization.** Disparities in independent living among older adults are more significantly gender-related than they are related to ethnicity. The US Census 2000 reported 340 adults in nursing homes, of whom 254 (75%) were female and 86 (25%) were male. Comparing the percentages of older adults in nursing homes with their proportion in the larger population suggests that older adults of Hispanic and American Indian ethnicity are underrepresented in the nursing home population, with 95% of nursing home residents white/non-Hispanic compared with 88% white/non-Hispanic among older adults countywide.
- **Older Adult System of Care (OASOC).** The Department of Social Services reports that OASOC has been serving approximately 50 seniors each month, and that all of these individuals have mental health diagnoses. Mendocino County Department of Social Services data from the In-Home Support Services program,

[15] The California Health Interview Survey combines Mendocino and Lake County data.

[16] Area Agency on Aging, 1997.

which serves disabled and elderly individuals in their homes, show that 83% of older adult clients are white/non-Hispanic (compared with 88% in the general older adult population, 5% are Hispanic (the same as the general older adult population), and 11% are American Indian (compared with 3% in the general older adult population). Hispanics are the fastest-growing ethnic group among older adults, with numbers expected to triple in the next 20 years.[17]

- **Mental illness and substance abuse.** Local case managers report that much of the older adult population is socially isolated, with little or no family support, leaving them at risk for depression, self-neglect, and abuse by others. Department of Social Services reports that approximately 11% of the 879 older adults on the In-Home Supportive Services and Adult Protective Services caseloads suffer from dementia, and 5% suffer from other mental impairments. An informal poll of social workers estimates that substance abuse averages 20%, and anecdotal data from OASOC indicate that 20% of clients are dually-diagnosed with a co-occurring mental illness and substance abuse problem.

2. Using the format provided in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/inappropriately served, by age group, race ethnicity, and gender. Provide total county and poverty population by age and ethnicity.

The following tables (collectively "Chart A") estimate the total number of persons needing MHSA mental health services who are being served, either fully or partially. According to MHSA Guidelines, a client is fully served if s/he is: diagnosed with serious mental illness or severe emotional disorder; receiving mental health services through an individual service plan; and both client and service provider agree that the client is getting the services s/he needs and wants in order to achieve wellness/recovery goals. **Note that only 41 of the clients currently served by MCMHD—those in wraparound service programs—can be considered fully served.**

MCMHD estimates that only 41 of the 2,296 clients served in FY 2003-2004 were fully served—those clients served through the county's AB 2034 program and those receiving CSOC wraparound services through the Family Strengths Program. The figures provided under the "Percentage Served" heading in the following charts are based on those who are *both eligible for and expected to need* mental health services. Under this section, the first column is the **number of clients served** by MCMHD. The second column provides the 200% Poverty Population, which is the **number of individuals with incomes below 200% of the federal poverty level**. The third column, **prevalence,** is derived from state data on the estimated number of individuals in the 200% poverty population who could be expected to need mental health services.[18] The fourth column, **percent,** divides the number served (from the Total Served column) by the prevalence number yielding the percentage of those who are both eligible for and in need of services that MCMHD is serving.

[17] California Department of Health Services, 2003.

[18] See http://www.dmh.ca.gov/sada/SDA-Prevalence_rates.asp for prevalence data tables.

Chart A. Service Utilization by Race/Ethnicity

ALL AGES	Fully Served		Under- or Inappropriately Served			Service Utilization				County Population[19]	
	F	M	F	M	U[20]	Total Served	200% Poverty	Prevalence	Percent	#	Percent
TOTAL	**15**	**26**	**1,289**	**954**	**12**	**2,296**	**33,731**	**2,991**	**76.8%**	**90,816**	**100%**
African American	0	0	13	15	0	28	228	18	155%	781	0.9%
Asian/PI	1	0	18	7	0	26	561	51	51.0%	1,471	1.6%
Hispanic	0	1	72	41	2	116	7,924	702	16.5%	17,490	19.3%
Native American	2	0	56	33	1	92	2,014	146	63.0%	4,023	4.4%
White	9	16	816	579	7	1,427	21,773	1,951	73.1%	64,830	71.4%
Other / Multi	3	9	314	279	2	607	1,232	118	514%	2,221	2.4%

CHILDREN AND YOUTH (AGE 0-15)	Fully Served		Under- or Inappropriately Served			Service Utilization				County Population	
	F	M	F	M	U	Total Served	200% Poverty	Prevalence[21]	Percent	#	Percent
TOTAL	**1**	**6**	**240**	**238**	**0**	**485**	**10,823**	**957**	**64.0%**	**18,535**	**100%**
African American	0	0	1	3	0	4	34	Prevalence data disaggregated by both age and ethnicity are not available.		246	1.3%
Asian/PI	0	0	3	0	0	3	62			230	1.2%
Hispanic	0	1	16	16	0	33	3,822			6,127	33.1%
Native American	0	0	7	6	0	13	950			1,087	5.9%
White	1	5	124	123	0	253	5,491			10,119	54.6%
Other / Multi	0	0	89	90	0	179	450			726	3.9%

TRANSITION AGE YOUTH (AGE 16-25)	Fully Served		Under- or Inappropriately Served			Service Utilization				County Population	
	F	M	F	M	U	Total Served	200% Poverty	Prevalence[22]	Percent	#	Percent
TOTAL	**1**	**9**	**226**	**181**	**1**	**418**	**3,869**	**363**	**81.0%**	**13,737**	**100%**
African American	0	0	6	1	0	7	27	Prevalence data disaggregated by both age and ethnicity are not available.		96	0.7%
Asian/PI	0	0	0	2	0	2	11			283	2.1%
Hispanic	0	0	17	6	1	24	1,365			3,245	23.6%
Native American	1	0	12	11	0	24	286			714	5.2%
White	0	7	133	104	0	244	1,980			8,948	65.1%
Other / Multi	0	2	58	57	0	117	188			451	3.3%

[19] County populations statistics are from State of California, Department of Finance, 2005 – pivot table of county, race/ethnicity, gender and age.

[20] U = unknown or not reported.

[21] State prevalence data cover ages 0-17. The percentage provided here is based on the 606 youth served in the 0-17 age group, not the 485 youth in the 0-15 age group in the Total Served column.

[22] State prevalence data cover ages 18-24. The percentage provided is based on the 294 TAY served in the 18-24 age group rather than the 418 TAY in the 16-25 age group in the Total Served column.

ADULT (AGE 26-64)	FULLY SERVED		UNDER- OR INAPPROPRIATELY SERVED			SERVICE UTILIZATION				COUNTY POPULATION	
	F	M	F	M	U	Total Served	200% Poverty	Prevalence	Percent	#	Percent
TOTAL	**13**	**11**	**780**	**512**	**9**	**1,325**	**14,348**	**1,436**	**92.2%**	**41,049**	**100%**
African American	0	0	6	11	0	17	142	Prevalence data disaggregated by both age and ethnicity are not available.		262	0.6%
Asian/PI	1	0	11	5	0	17	179			733	1.8%
Hispanic	0	0	38	19	1	58	3,154			7,263	17.7%
Native American	1	0	34	16	1	52	837			1,711	4.2%
White	8	4	531	338	5	886	9,491			30,328	73.9%
Other / Multi	3	7	160	123	2	295	504			752	1.8%

OLDER ADULT (AGE 65+)	FULLY SERVED		UNDER- OR INAPPROPRIATELY SERVED			SERVICE UTILIZATION				COUNTY POPULATION	
	F	M	F	M	U	Total Served	200% Poverty	Prevalence	Percent	#	Percent
TOTAL	**0**	**0**	**43**	**23**	**2**	**68**	**3,377**	**235**	**28.9%**	**17,495**	**100%**
African American	0	0	0	0	0	0	17	Prevalence data disaggregated by both age and ethnicity are not available.		177	1.0%
Asian/PI	0	0	4	0	0	4	65			225	1.3%
Hispanic	0	0	1	0	0	1	131			855	4.9%
Native American	0	0	3	0	0	3	154			511	2.9%
White	0	0	28	14	2	44	2,944			15,435	88.2%
Other / Multi	0	0	7	9	0	16	66			292	1.7%

3. **Provide a narrative discussion/analysis of the ethnic disparities in the fully served, underserved, and inappropriately served populations in your county by age group as identified in Chart A. Include any available information about their age and situational characteristics as well as race ethnicity, gender, primary language, sexual orientation, and special needs.**

In FY 2003-2004, MCMHD served 2,296 clients, a decrease of 7.8% over the number served the previous year. In 2004-2005, the number of clients fell to 1,832. Services provided by MCMHD included crisis intervention and hospitalization, medication management, individual and family therapy, case management, and wrap-around services. MCMHD services are provided through offices in the county's three largest population centers in the following proportions: Fort Bragg (22%), Ukiah (69%), and Willits (9%). Service availability is limited by financial and staffing resources, and access to services may be limited by a variety of barriers, including service location, language, and culture. As a result of these and other limitations, MCMHD considers most of its clients to be underserved, i.e. they are not receiving the full array of services they need to improve their quality of life. In fact, of the 2,296 clients served, MCMHD considers less than 2% to be fully served. These are the 41 clients served through the county's AB 2034 program and those receiving wraparound services. Of clients served in the county's wraparound program:

- A total of 14 youth were served, 12 males and 2 females.
- 12 of these clients were white, 1 was Hispanic, and 1 was American Indian.
- 7 clients were below the age of 16 and 7 were between the ages of 16-24.

Of clients served in the county's AB 2034 Program:

- A total of 27 adults were served (including 3 TAYs), 14 males and 13 females.
- 14 of these clients were white, 1 was American Indian, 1 was Asian, and 11 were of unknown ethnicity.
- 3 clients were age 16-24 and 24 were between the ages of 25 and 60.

Penetration rates reported by the State Department of Mental Health are based on the number of clients served as a percentage of the total number of county residents that are *eligible* for services, whether or not they need the services. As the following table shows, Mendocino County's penetration rate overall compares favorably with the statewide penetration rate. The county's penetration rate is well below state averages, however, for the Hispanic, American Indian, and Asian populations.

Table Twelve. Mendocino County penetration rate

	Total	White	Hispanic	African American	American Indian	Asian Total	Islander Total	Pacific Islander	Other / Unknown
Eligible County residents	17,650	10,288	4,706	168	1,331	93	51	89	924
Clients Served by MCMHD	1,998	1,584	134	52	84	2	5	12	125
County Penetration Rate	**11.32**	**15.40**	**2.85**	**30.95**	**6.31**	**2.15**	**9.08**	**13.48**	**13.53**
State Penetration Rate	7.81	14.80	3.81	12.41	12.94	3.21	2.55	9.92	9.30

Taking a closer look at MCMHD service data, we find that, for clients who were diagnosed,[23] the most frequent diagnoses were major depression (30%), schizophrenia (21%), bipolar mood disorders (19%) and anxiety (10%). Disaggregation of these data reveal ethnic discrepancies that are explained in each of the following age group discussions; the charts compare the most frequent diagnoses for each ethnicity in each age group. Note that only the three largest ethnic groups are included in this analysis because the low numbers do not provide representative percentages for other ethnic groups. For the same reason, a breakdown is not provided for older adults.

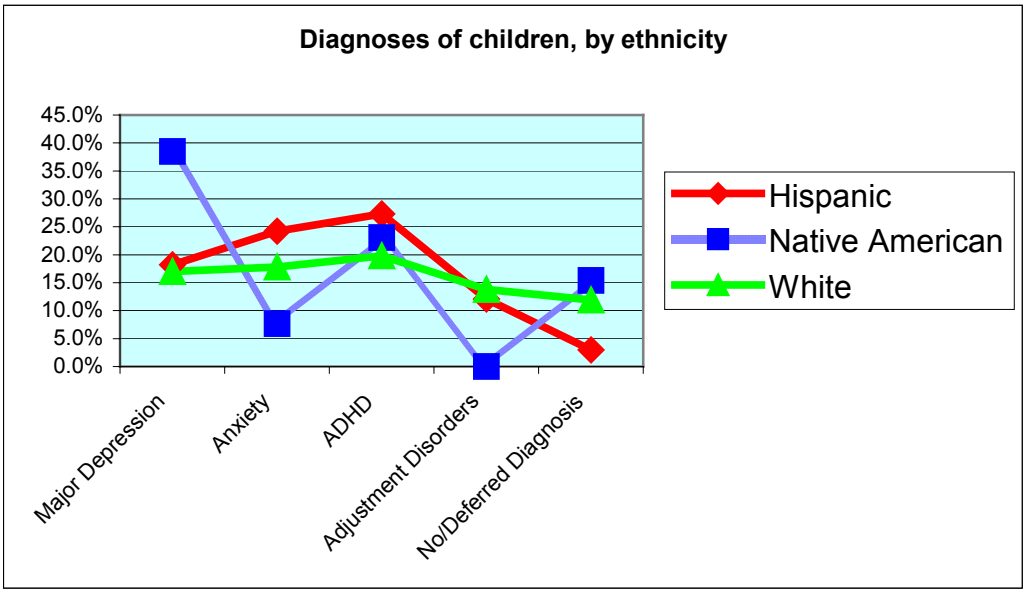
Children and Youth

Of the 485 children served by MCMHD in 2003-2004, 52% were white, 7% Hispanic, and 3% American Indian, while ethnicity was not identified for 179 clients (37%). The percentage of Hispanic clients falls far short of their 33% representation in the general population of children, and the percentage of American Indian clients is only half that of their 6% representation in the general population. The most frequent MCMHD services for children include wraparound care management and telepsychiatry. The most frequent diagnoses for the 485 children served by MCMHD in 2003-2004 were ADHD (20%), anxiety (18%), major depression (16%), and adjustment disorders (15%). Diagnoses are not reported or are reported as deferred for approximately 17% of the children served by MCMHD. The data show a number of discrepancies among children in the three largest ethnic groups:

[23] In FY 2002/03, diagnoses were reported as deferred or were not provided for 24% of the clients served.

- Among Native American children, the most frequent diagnoses are major depression (39%) and ADHD (23%). Native American children are also most likely to have no diagnosis or to have their diagnosis deferred (15%).
- Among Hispanic children, the most frequent diagnoses are ADHD (27%), anxiety (24%), and major depression (18%).
- Among white/non-Hispanic children, the percentages are very close in the top four childhood diagnoses, ranging from 14% to 20%.

Figure 7



Although MCMHD is one of the primary providers of mental health services to low-income children, in 2003-2004 MCMHD provided mental health support to only 33 children in the 0-5 age group. This equals 11% of the 304 children in the 200% below poverty income level who are expected to need mental health services each year, and less than 7% of the 498 children of all income levels that are expected to need mental health services.

When considering older children, the picture is significantly different—MCMHD is serving 88% of the 653 income-eligible older children who are expected to need mental health services, and 35.6% of the 1,213 children in the general population who are expected to need mental health services. These higher service levels for older children skew the data when assessing the percentage of children of all ages served—in fact, when considering only youth in the 12-17 age group, the number served by MCMHD *exceeds* the estimated prevalence in the income-eligible population (387 served, compared with estimated prevalence of 324).[24]

[24] A problem with this figure is that the number of clients served includes all children and youth with Individual Education Plans (IEP). These children do not have to be income-eligible for services. The prevalence figures, however, include only income-eligible children. As a result, the percentage served appears to be higher than it actually is.

In younger age groups, the picture is much different, with the county serving 57% of eligible children age 6-11 and only 11% of the eligible children in the 0-5 age group. Note, however, that even though MCMHD is serving nearly two-thirds of income-eligible children of all ages, this level of service does not reach children of all ethnic groups. While 62% of white/non-Hispanic children are served, the percentage of Native American children served is just over half this amount (36%), and the percentage of Hispanic children served is only 12% of the 324 income-eligible children expected to need mental health services.

Transition Age Youth (TAY)

Of the 418 TAYs served by MCMHD in 2003-2004, 58% were white, 6% Hispanic, and 6% American Indian, while ethnicity was not identified for 117 clients (30%). The percentage of Hispanic clients falls far short of their 24% representation in the general TAY population. The most frequent diagnoses overall are major depression (16%), anxiety (12%), bipolar mood disorders (10%), and schizophrenia (8%). Diagnoses are deferred or not reported for 32% of the clients in this age group. Variations in the frequency of diagnoses among the three largest ethnic groups include the following:

- Among Native American youth, the most frequent diagnoses are ADHD (25%) and major depression (13%). However, no diagnosis or deferred diagnoses are reported for one-third of Native American youth.
- Among Hispanic youth, the most frequent diagnoses are major depression (17%), anxiety (13%), and adjustment disorders (13%). For nearly half (46%) of Hispanic youth, no diagnosis is reported or diagnoses are deferred.
- Among white youth, the most frequent diagnoses are major depression (20%), anxiety (11%), and bipolar mood disorders (11%). No diagnosis or deferred diagnoses are reported for 31% of white/non-Hispanic youth.

Figure 8

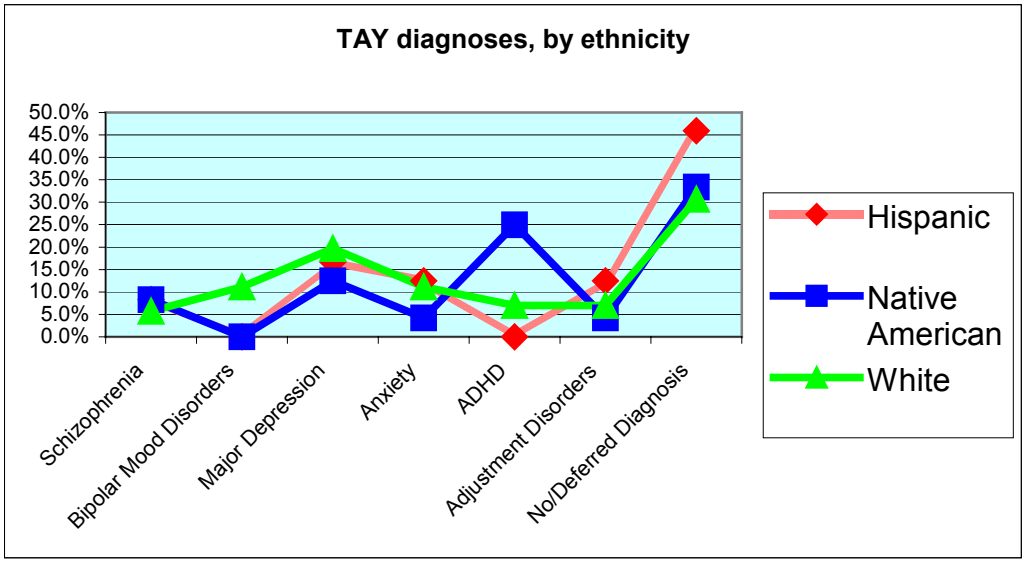
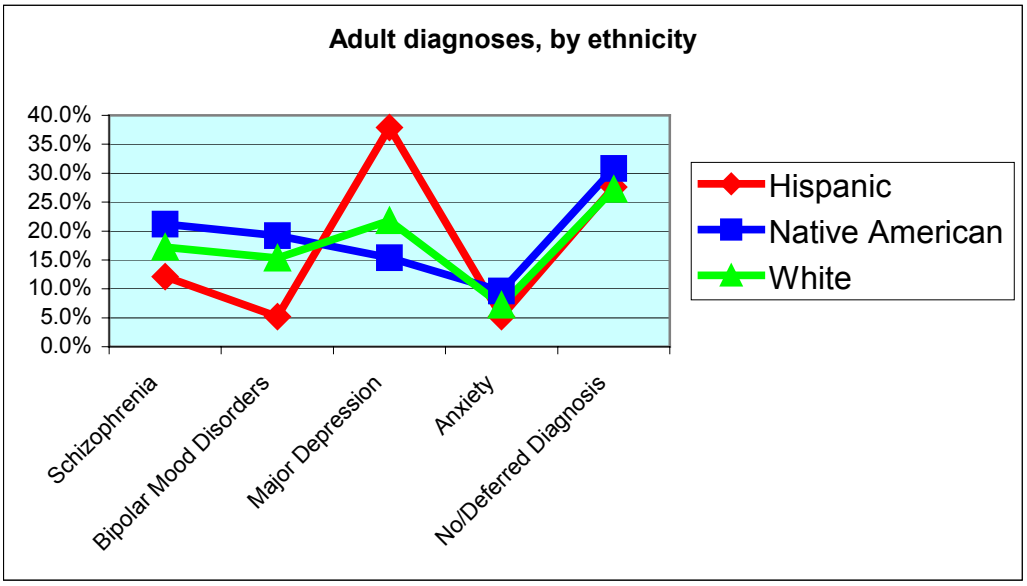


Figure 9



Adults

Of the 1,325 adults served by MCMHD in 2003-2004, 67% were white, 4% Hispanic, and 4% American Indian, while ethnicity was not identified for 295 clients (22%). The percentage of Hispanic clients falls far short of their 18% representation in the general adult population. The county is serving 94% of the estimated number of adult males who need and are eligible for service, but only 76% of eligible females. For adults, the most frequent diagnoses overall are major depression (22%), schizophrenia (17%), and bipolar mood disorders (15%). Diagnoses are not reported for one-fourth of the adults seen by MCMHD, and this percentage is similar across ethnicities. Although the most frequent diagnoses are similar for all ethnicities, the percentages vary as detailed below.

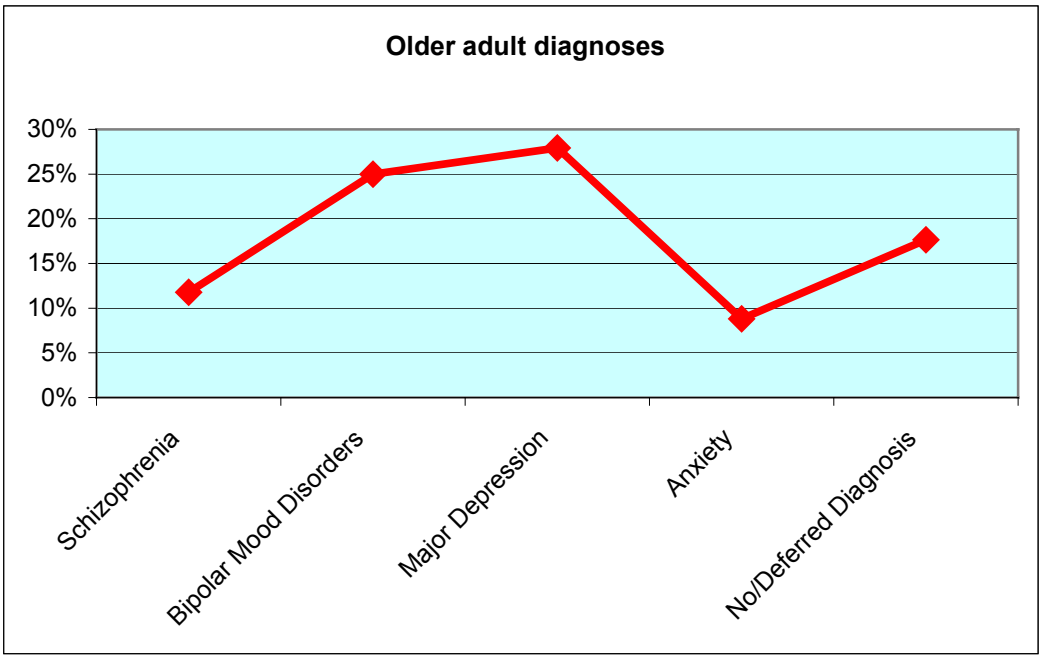
- Among Native American adults, the most frequent diagnoses are schizophrenia (21%), bipolar mood disorders (19%), and major depression (15%).
- Among Hispanic adults, the most frequent diagnoses are major depression (38%), schizophrenia (12%), and bipolar mood disorders and anxiety (5% each).
- Among white/non-Hispanic adults, the most frequent diagnoses are major depression (22%), schizophrenia (17%), and bipolar mood disorders (15%).

Older Adults

Of the 68 older adults served by MCMHD in 2003-2004, 65% were white, 1.4% Hispanic, and 4% American Indian, while ethnicity was not identified for 16 clients (24%). The percentage of Hispanic clients falls short of their 3% representation in the general older adult population. For older adults, the most frequent diagnoses overall are major depression (28%), bipolar mood disorders (25%), and schizophrenia (12%). Diagnoses are not reported for 18% of the older adults seen by MCMHD. Note that the

chart does not show diagnosis by ethnic groups because the number served in each ethnic group was too low to calculate representative percentages.

Figure 10



4. **Identify objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population assessment, the county's threshold languages, and the disparities or discrepancies in access and service delivery that will be addressed in this Plan.**

Mendocino County is committed to addressing discrepancies and disparities in access and service delivery related to race ethnicity, gender, and age, and cultural competency is a mandatory area of training for all staff. Over the past two years, the Department has conducted all-staff trainings on client culture, involvement of families in treatment, and client-centered treatment plans. Staff will continue to receive on-going training from subject matter experts, including consumers (clients) and family members.

In keeping with MCMHD's commitment, cultural and linguistic competency issues were woven throughout the MHSA planning process at all levels. Based on issues articulated through the assessment activities conducted during the planning process, the Steering Committee has identified as a priority the need for culturally competent service capacity for rurally isolated communities and local ethnic groups.

While MCMHD has the capacity to provide culturally sensitive and linguistically appropriate services in both Spanish and English to individuals that request such services, the percentage of Hispanic clients is significantly lower than would be expected, given the county population statistics. Cultural Competency objectives for the three-year period of 2006-2008 are detailed in Table Thirteen below.

Table Thirteen. Cultural competency objectives, 2006-2008

OBJECTIVE	INDICATOR	TIMELINE
Develop and implement outreach strategies focused on Hispanic and American Indian communities.	Penetration rates for American Indian and Hispanic communities	Year One
Reduce service disparities to Hispanic and Native American residents.		Year 3
Conduct bi-annual Client Satisfaction Survey.	Satisfaction rate among Hispanic, American Indian, and White clients	Bi-annually
90% staff participation in Annual Cultural Competency Training.	Cultural sensitivity and competency of staff	Annually
Provide a full array of services in Spanish, the county's only threshold language.	Client retention rate	On-going

PART II, SECTION III. IDENTIFYING INITIAL POPULATIONS FOR FULL SERVICE PARTNERSHIPS

1. **From your analysis of community issues and mental health needs in the community, identify which initial populations will be fully served in the first three years. Please describe each population in terms of age and the situational characteristics described above (e.g., youth in the juvenile justice system, transition-age youth exiting foster care, homeless adults, older adults at risk of institutionalization, etc.). If all age groups are not included in the Full Service Partnerships during the three-year plan period, please provide an explanation specifying why this was not feasible and describe the county's plan to address those age groups in the subsequent plans**

MCMHD relied on the community planning process to identify the initial and continuing Full Service Partnership populations and situational characteristics. The Full Service Partnerships proposed for Mendocino County will be created through expansion of the numbers served by existing programs, extension of existing programs into new parts of the county, and completely new programs. These Full Service Partnerships are summarized by age group and year in Table Fourteen below and described by age group in the following paragraphs.

Table Fourteen. Proposed new Full Service Partnerships, by year

	YEAR 1 (2 MONTHS)	YEAR 2	YEAR 3
Children, Youth, and Families	5	45	45
Transition Age Youth	4	12	12
Adults	10	50	50
Older Adults	10	50	50

Full Service Partnerships for Children, Youth, and Families

Twenty children in the 0-5 age group who are screened through the Mental Health Screening, Assessment, and Treatment Strategy proposed in Work Plan #2 will receive full services. All children and families with Full Service Partnerships, including those already in place through the Children's System of Care wraparound services program, will have the opportunity to benefit from the Parent Partners Program, the Family Respite Service Program, and if appropriate, the Bicultural Therapy services provided through contracts with Nuestra Casa and Consolidated Tribal Health Project (all described in Work Plan #2). In all MHSA-sponsored programs, a total of 5 new Mendocino County children will have Full Service Partnerships in Year One, and 45 will have Full Service Partnerships in Years Two and Three.

Full Service Partnerships for Transition Age Youth

All of the strategies proposed for the Transitional Age Youth System of Care (TSOC) Program in Work Plan #3 will be available to TAYs with Full Service Partnerships. TAYs living in the Congregate Living Facility in Fort Bragg and TAYs in the non-MediCal Full Service Partnerships slots will be 100% Full Service Partnerships, all of whom will have access to flex funding and utilize the services provided through the Peer Mentoring Program, the Supported Education Program (described in Work Plan #3), and the Resource Centers (described in Work Plan #1). In all MHSA-sponsored programs, a

total of 4 new Mendocino County TAYs will have Full Service Partnerships in Year One, and 12 will have Full Service Partnerships in Years Two and Three.

Full Service Partnerships for Adults

All participants in North County Wraparound Services for homeless adults in Willits and other north county communities, the Forensic Mental Health Program, and the Health Clinic-Based Program in Ukiah and Willits will have Full Service Partnerships. These individuals, as well as clients with existing Full Service Partnerships, will have the opportunity to access additional services through all of the strategies proposed in Work Plan #1 (Recovery Coach Program, Resource Centers, Warm Line, Mobile Crisis Response, and Client Empowerment Coordination). In all MHSA-sponsored programs, a total of 10 new Mendocino County adults will have Full Service Partnerships in Year One, and 50 will have Full Service Partnerships in Years Two and Three.

Full Service Partnerships for Older Adults

All older adults enrolled in OASOC will have Full Service Partnerships. (In the past, older adults enrolled in OASOC have received a variety of support but have been underserved in that they did not receive the full array of supports they needed.) In all MHSA-sponsored programs, a total of 10 new Mendocino County older adults will have Full Service Partnerships in Year One, and 50 will have Full Service Partnerships in Years Two and Three.

2. **Please describe what factors were considered or criteria established that led to selection of the initial populations for the first three years. (Distinguish between criteria for each age group if applicable.)**

MCMHD relied on the community assessment and input process, stakeholder prioritizations, and the MHSA Guidelines for small counties to determine the selection of the Full Service Partnership population for the initial Three-Year Plan. Factors and criteria unique to each age group are detailed below the bulleted list. Factors and criteria common to all age groups included the following:

- Alignment with community concerns and responsiveness to stakeholder input from all sources, including expertise brought to the planning process by clients and family members.
- Opportunity to intervene at points of increased vulnerability and risk, i.e., transitions from foster care, jail, etc.
- Cost-effectiveness (reduced out-of-county placements, hospitalizations, nursing home care, etc.) and MHSA guidance to start “small and smart.”
- Non-duplication of services.
- Existence of willing partners to supplement or leverage services to create a continuum of culturally competent care.
- Feasible targeting of ethnic and racial disparities in services.
- Service utilization and prevalence data on number/percent of un/underserved individuals within each age and ethnic group.

Criteria for Selection of Initial Child and Family Populations

Selection of the initial populations for Full Service Partnerships for children and families was based the extent to which the 0-5 age group has been underserved and the racial ethnic disparities in services to children and families.

Criteria for Selection of Initial TAY Populations

Seriously mentally ill young people are at especially high risk as they take on adult tasks. Empowering them to develop resiliency as they learn to manage their own lives is a key concept in all TAY strategies, including the Full Service Partnerships. While MCMHD currently offers Full Service Partnerships for TAYs, these services are limited to individuals who are MediCal beneficiaries. The proposed strategies will enable the County to also serve uninsured youth. Although the Congregate Living Facility serves only a small number of TAYs at one time, the benefit of having this opportunity to address these issues and develop life goals while in a stable housing situation cannot be measured in dollars.

Criteria for Selection of Initial Adult Populations

The racial ethnic disparities among the incarcerated population and the high incidence of mental illness in this population, as identified through the community assessment process, pointed to the need to provide intensive support for adults transitioning from the criminal justice system. These Full Service Partnerships will be reinforced through the Mobile Crisis Response strategy that is included in Work Plan #1. The ethnic disparities revealed in the recent study on Mendocino County's homeless population motivated the Steering Committee to expand access to Full Service Partnerships for the homeless population. The proposed CARE strategies (Work Plan #1), while they will benefit all age groups, will be of special benefit to adults who are participating in Full Service Partnerships by providing a wide array of recovery-focused peer support.

Criteria for Selection of Initial Older Adult Populations

The need to support older adults with mental illness is not a newly identified need—the proposed OASOC strategies address an existing need that the county has lacked the resources to address. Specific issues with which older adults need support include their difficulty in maintaining independence, the need for medication management, the lack of comprehensive service coordination, and the lack of understanding of mental illness among the elderly by physicians, other providers, and the general public. With the anticipated aging of the county population, the need for OASOC supports will continue to increase. Criteria for selection of older adult populations were based on the ethnic and geographic disparities identified through the community assessment.

3. Please discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

Reduction of Ethnic Disparities for All Populations

MHSA System Development funds will be used to build the capacity and cultural competency of MCMHD and its provider partners and conduct targeted outreach to local

ethnic groups in a way that is designed to lead to reduction of racial ethnic and gender disparities at all levels of the mental health system. Through MHSA funding, MCMHD is working to increase the array of culturally competent services, from traditional therapy to ethnically diverse self-help, so that meaningful Full Service Partnerships can be offered to people from different racial ethnic backgrounds.

Reduction of Ethnic Disparities for Initial Child and Family Populations

With only three new Full Service Partnerships for this age group, the program cannot be expected to have a significant impact on racial ethnic disparities. However, children in need of intensive services are an ethnically diverse group[1] and the program will continue to serve children of all ethnic groups. Of the 14 children and youth currently served through the wraparound program, 12 are white/non-Hispanic, 1 is American Indian, and 1 is Hispanic.

Reduction of Ethnic Disparities for Initial TAY Populations

A review of the demographics of the current foster care caseload makes it clear that the proposed Full Service Partnerships for TAYs will be effective in reducing racial ethnic disparities in this age group. Of the 289 children in foster care last year, 4.8% were African-American, compared with 1.3% in the general population; 17.3% were American Indian, compared with 5.8% in the general population; 2.1% were Asian/Pacific Islander, compared with 1.4% in the general population; 9.3% were Hispanic, compared with 31.7% in the general population; and 68.5% were White/non-Hispanic, compared to 55.9% in the general population.

Reduction of Ethnic Disparities for Initial Adult Populations

Racial ethnic disparities among the incarcerated population are high. The percentage of incarcerated American Indian men in all age groups is two to three times their representation in the general population, and incarcerated American Indian women in the 25-59 age group comprise 15% of their age group in the jail, but only 4% of the general population for the age group. Among Hispanics, the percentage of incarcerated men in the 25-59 age group is nearly double the percentage in the general population. In the 18-24 age group, the percentage of incarcerated African American women and men is 3 times the proportion of these groups in the general population. Although data on the ethnicity of the 33% of the incarcerated population that are on psychotropic medications and the 11% that have been diagnosed with serious mental illnesses are not available, it is anticipated that Full Service Partnerships will begin to address the racial ethnic disparities.

The North County Wraparound Service program will provide Full Service Partnerships to address racial ethnic disparities among the homeless population in Willits. The recent

[1] For example, the children served by Redwood Children's Services Children's Therapeutic Services program last year were primarily white/non-Hispanic (63%), with significant numbers of Hispanics (10%), Native Americans (4%), and bi- or multi-racial children (22%).

countywide homelessness study reported that 43% of the homeless population experience some form of mental illness. Although demographic data on those that experience mental illnesses are not available, demographics of the homeless population as a whole show a number of ethnic disparities, with over-representation of American Indians (12% compared with 4% in the general population) and African Americans (5% compared with <1% in the general population).

Key to the reduction of disparities in adult services is the development of ethnically diverse peer support networks as well as continued development of culturally competent mental health professionals.

Reduction of Ethnic Disparities for Initial Older Adult Populations

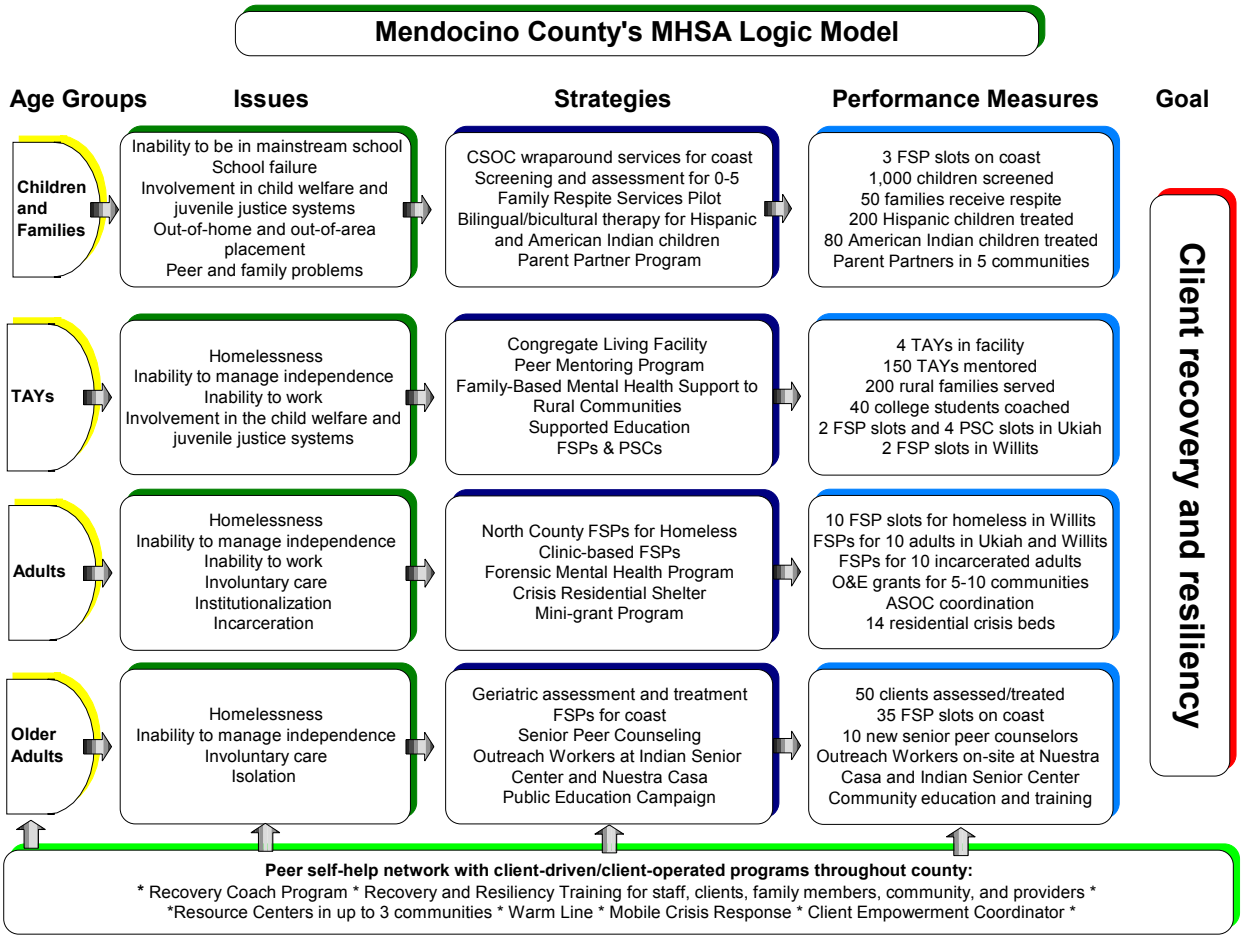
American Indian and Latinos, the largest minority populations in the county, have in the past been underserved by OASOC. Over the past year, the OASOC Project Director began meeting with the executive director of Nuestra Casa and the executive director of the Indian Senior Center to plan strategies for reaching older adults from the Hispanic and American Indian communities. The plans developed as a result of these meetings have been incorporated into the proposed OASOC Program by contracting for outreach workers in these organizations. As these engagement efforts bring older adults into the program and Full Service Partnerships are developed with them, OASOC will be individualizing services to address the cultural and linguistic needs of each participant.

PART II, SECTION IV. IDENTIFYING STRUCTURAL AND SERVICE STRATEGIES

1. **If your county has selected one or more strategies to implement with MHSA funds that are not listed in this section, please describe those strategies in detail in each applicable program work plan including how they are transformational and how they will promote wellness/recovery/resiliency and are consistent with the intent and purpose of the MHSA. No separate response is necessary in this section.**

All the strategies selected to be implemented with MHSA funds are drawn from those listed in the MHSA Guidelines. Please see Section VI for detailed description of planned programs and strategies in each program work plan. The program Logic Model in Figure 11 below provides a graphical depiction of the proposed project.

Figure 11



PART II, SECTION V. ASSESSING CAPACITY

1. **Provide an analysis of organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county. This analysis must address bilingual staff proficiency for threshold languages.**

MCMHD is a county government agency with an annual budget of more than $15 million. The Department employs 126 regular staff and contracts with 3 organizational providers and 57 providers in a MediCal Managed Care Plan. The Department employs six staff members who receive bilingual pay, two of whom have received specialized training in interpreting for mental health clients. MCMHD is committed to working with consumers, community members, and other organizations to strengthen the development of a consumer-centered, family-focused, culturally competent, community-based, comprehensive, and collaborative system of care for adults with mentally illnesses. In recognition of the Department's limitations, MCMHD is striving to further develop partnerships with ethnic service organizations such as Nuestra Casa and Consolidated Tribal Health Project.

MCMHD MISSION

The Mendocino County Mental Health Department serves the people of Mendocino County whose lives are affected by mental illness. The Department strives to delivers services in a respectful, responsive, and efficient manner and with sensitivity to cultural diversity. It is our goal to educate ourselves, individuals, families, and the community about mental illness and the hopeful possibilities of treatment and recovery. Those we serve are supported in their efforts to maximize independent living and to improve quality of life through community-based treatment. In collaboration with other agencies, we seek to maximize the resources available and attend to concerns for the safety of individuals and the community. We will strive to manage our fiscal resources effectively and responsibly while insuring that productivity and efficiency are important organizational values, which results in maximum benefits for all concerned.

MCMHD delivers and supports its services through five divisions: Administrative Services, Adult Services, Business Services, Children's Services, and Medical Services.

The **Children's Services Division** manages the Mendocino County Children's System of Care and funds eight full-time therapists and one half-time therapist at nine county school districts to conduct assessments and provide treatment for children with serious emotional disturbances (SED). The Department also operates a children's day treatment program in Ukiah, consults with four Primary Intervention Projects, and sits on the Policy Council on Children and Youth. In August 1997, the Mental Health Department adopted a protocol for Transition of Minor Clients to Adult Services. The protocol guides the seamless transition of SED mental health clients into Adult System of Care programs, providing access to transitional living homes and targeted day treatment services within the greater Ukiah community. The protocol helps prepare

clients for the psycho-legal-social issues of reaching the age of eighteen years, i.e., housing and independent living skills, job skills, and substance abuse and health care issues. The Children's Services Division also delivers services through contracts with three organizational providers.

The **Adult Services Division** provides on-going attention to persons over the age of 18 who have been diagnosed with a serious mental illness (including those who are dually-diagnosed) and persons of all ages who are experiencing mental health crises. Crisis services include 24-hour response and links to hospitalization services for persons who are in acute need of mental health care. Clients are offered an immediate response which can include assessment, stabilization, treatment, medication evaluation, counseling, emergency housing, aftercare planning, and family support. Ongoing adult services include case management, rehabilitative services, housing assistance, medication management, and outreach and intervention to engage seriously mentally ill homeless in mainstream mental health supportive services. Many services are provided on a contracted or collaborative basis with other departments or agencies. For example, the Older Adult System of Care (OASOC) is operated in coordination with the Department of Social Services and the Department of Public Health. Adult Services collaborates with and helps meet the training needs of law enforcement, hospitals, clinicians, and agencies in the community.

MCMHD strives to incorporate cultural competency into all its services, through staff training, client orientation and advocacy, and organizational policy. Furthermore, all services are individualized to meet the unique needs of participants, including cultural and linguistic needs. Upon entry into treatment programs, all clients participate in an intake session that includes discussion of the Department's non-discrimination policies and tolerance guidelines. Annual staff training includes a heavy emphasis on diversity.

MCMHD participates in the State Department of Mental Health's Adult Performance Outcome System, which includes a 26-item consumer survey of client perceptions of access to care, appropriateness of care, outcomes of care, and general satisfaction, including satisfaction with linguistic and cultural competency. Semi-annual reports from the State assist MCMHD to review its services and make appropriate adjustments to programs. Specific strategies for ensuring treatment that is competent in all areas of diversity is detailed below:

- **Age.** MCMHD programs serve clients of all ages, although most are in the adult age range. To ensure that services meet the needs of children, TAYs, and older adults, MCMHD seeks to recruit staff that are experienced in working with these age groups and includes clients, family members, and youth in client advisory groups and satisfaction surveys.
- **Race and ethnicity.** MCMHD's clients are primarily white/non-Hispanic (62%). However, service utilization data for 2003-2004 shows that race was not reported for more than one-quarter of the clients seen. Treatment services for American Indians are often arranged through referral arrangements with Consolidated Tribal Health Project. As discussed in the following section, American Indians comprise 4% of MCMHD's and its contracted providers' management staff, 3% of the direct service staff, and 8% of the support staff. Approximately 5% of

MCMHD's clients are Hispanic, well below their representation in the greater community. Currently, 8% of the direct service staff and 13% of the support staff are Hispanic.

- **Culture.** Communicating with clients in their native language is just one element in providing culturally competent services. MCMHD attempts to accommodate the needs of a rural culture by tailoring time and place of treatment to local needs, including family members, and providing treatment in a comfortable and informal atmosphere. Many of the strategies proposed in this Plan will strengthen the Department's ability to provide services that address the recovery needs of the consumer culture.
- **Language.** Spanish is the only threshold language in the county. MCMHD ensures that all materials are available in both Spanish and English and currently 40 MCMHD and contracted provider staff are Spanish speakers. With 13% of Mendocino County residents speaking only Spanish and only two private therapists providing therapy in Spanish, the burden of serving Spanish-speaking clients falls on the safety net clinics and MCMHD. To date, MCMHD has been able to successfully communicate with and provide services to every individual who has requested services in any language. While not optimal, the Language Line is available to provide over-the-phone interpretation and document translation, ensuring that bilingual capabilities in all languages are available 24/7.
- **Gender and sexual orientation.** MCMHD's client base is approximately 57% female, and a similar percent of the staff are female. MCMHD strives to customize services for clients with various sexual orientations through staff training, non-discrimination policies, referral to specialized 12-step groups, and educational presentations to meetings of the Pride Alliance Network. Staff are trained to respect each client's frame of reference, be nonjudgmental and accepting of each client's cultural, behavioral, and value differences, and adjust strategies in accordance with client characteristics, including sexual orientation. Approximately five MCMHD staff members are openly self-identified as LBGT, and all staff participate in training in this area.
- **Disability.** All MCMHD facilities are in compliance with *Americans with Disabilities Act* requirements, and services are individualized to meet special needs of disabled clients. For visually impaired clients, MCMHD staff or volunteers are available to read program materials aloud. To meet the needs of hearing impaired clients, MCMHD retains staff that can serve as American Sign Language translators. If MCMHD is not able to provide quality services through these efforts, clients are referred to specialized treatment providers.
- **Literacy.** MCMHD's program materials are accessible to individuals with reading capacity at the 6th grade level. For clients who are not able to read program materials, staff or volunteers are available to read materials aloud and also make referrals to literacy programs such as that offered by the Mendocino County Library system.

2. **Compare and include an assessment of the percentages of culturally, ethnically, and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county and the total population currently served in the county.**

The primary language in Mendocino County is English. A language other than English is spoken in 16.1% of county homes, less than half the statewide average of 39.5%. Last year, MCMHD served clients who spoke American Sign Language, Arabic, Cantonese, French, Japanese, Mandarin, and Polish. However, speakers of these languages amounted to less than 1% of the clients served, with English speakers accounting for 82% and Spanish speaking clients for 2%[2] of MCMHD clients.

MCMHD has been quite successful in its efforts to hire and retain bilingual staff. With 13% of Mendocino County residents speaking only Spanish and even more whose English is limited, there is a clear shortage of bilingual personnel in all medical and service professions, including mental health professionals. Table Fifteen below compares MCMHD staff demographics with those of the general population and MCMHD's service population.

Table Fifteen. Staffing demographics (Totals > 100% indicate responses in more than one category)

	MCMHD and Organizational Provider Staff			MCMHD Clients	County Population
	Mgmt/S'vision	Direct Service	Support		
n=	27	75	52	2,296	90,816
Gender					
Female	81%	63%	33%	57%	50.2%
Male	19%	36%	67%	43%	49.8%
Ethnicity					
African American	0	1%	2%	1%	0.6%
Asian/Pacific Islander	0	0	0	1%	2.4%
Hispanic	0	8%	13%	5%	16.5%
American Indian	4%	3%	8%	4%	4.8%
White/non-Hispanic	100%	91%	81%	63%	80.8%
Other/Mixed Race	0	4%	6%	26%	12.7%
Languages Spoken					
English	96%	96%	98%	82%	83.9%
Sign Language	0	3%	6%	<1%	<1%
Spanish	67%	19%	15%	2%	13.1%
Other	11%	13%	2%	<1%	3.0%
Not Provided	11%	13%	2%	15%	---
Consumer Culture					
Consumer	19%	16%	24%	100%	---
Family Member	7%	20%	24%	Unknown	
Neither	78%	67%	62%	---	

[2] Language was not recorded for 15% of the clients served, although it is likely that most of these were English speakers.

3. **Provide an analysis and include discussion of the possible barriers your system will encounter in implementing the programs for which funding is requested in this Plan and how you will address these barriers and challenges. Challenges may include such things as difficulty in hiring staff due to human resources shortages, lack of ethnically diverse staff, lack of staff in rural areas and/or on Native American reservations and rancherias, difficulties in hiring clients and family members, need for training of staff in recovery/wellness/ resiliency and cultural competence principles and approaches, need to increase collaborative efforts with other agencies and organizations, etc.**

With the challenge of developing the Mendocino County Plan successfully accomplished, MCMHD and the Steering Committee look forward to continued problem solving as implementation of the proposed programs and strategies begins. Potential barriers that have been identified to date, and plans for addressing them, are detailed below.

- **Embedding the principles of recovery and resiliency in all components of the mental health care system.** Resolution of this challenge will be an on-going process that utilizes training, community education, and demonstrations of success to overcome bias among some traditional mental health providers who may believe that they know what is best, don't know how to involve consumers in their own recovery, or haven't experienced the benefits of this approach. One of the responsibilities of the Client Empowerment Coordinator (see Work Plan #1) will be to continually monitor and advise MCMHD's Management Team on any and all issues related to client-centered recovery-driven services.
- **Serving residents of remote rural communities.** Service delivery in Mendocino County is challenged by geographical barriers—the county's inland and coastal roads connect communities in good weather, but are often closed in winter by mudslides and falling trees. In all outlying communities, public transportation is minimal, if it exists at all. Service providers also confront an independent rural mindset that distrusts government services. This is especially true for many individuals involved in the production or cultivation of illegal substances who fear any type of government scrutiny.
- **Building and retaining a culturally and linguistically diverse and competent workforce.** MCMHD anticipates that recruiting bicultural/bilingual staff to fill MHSA positions will be challenged by the scarcity of qualified applicants. This challenge is exacerbated by the lack of four-year colleges in the county and the high cost of housing in comparison with prevailing wages. This challenge will be addressed through targeted recruiting and collaboration with MHSA partners, especially those representing the Hispanic and American Indian communities, and Mendocino College. MCMHD also offers a pay differential for bilingual staff members, and will continue to provide a variety of diversity training opportunities for all internal and contracted staff. MCMHD is also actively researching strategies to "grow its own" culturally competent staff by offering educational opportunities to existing bicultural/bilingual staff members, and plans to access MHSA Education and Training Component Funds to further support this strategy.
- **Development of client-run network infrastructure.** Acquiring new facilities, recruiting and hiring new staff, issuing new contracts, and incorporating new positions into organizational cultures may challenge the current human and

physical infrastructure of MCMHD partners. These challenges will be addressed in part through provision of technical assistance, including support from established community-based organizations.

- **Remaining true to system transformation and community involvement.** Related to this challenge will be the ongoing work of retaining consumer involvement and consumer participation through the MHSA Steering Committee while complying with State administrative requirements. The Steering Committee is a heterogeneous group that includes clients, family members, agency staff, and other stakeholders representing the ethnic, age, and gender diversity of the county. The Steering Committee will continue to meet on a regular basis to provide oversight and help ensure fidelity to the spirit and the content of Mendocino County's MHSA Plan.
- **Program monitoring and program improvement.** MCMHD will use the State's reporting system and mandatory MHSA outcomes to track and monitor the proposed services and activities, but will also work with the Steering Committee to develop monitoring and evaluation strategies that track the process of transforming the system to reflect the values of recovery and resiliency. The Steering Committee will continue to meet regularly to monitor progress on implementation of this Community Services and Supports Plan and to review outcome data.

PART II, SECTION VI. DEVELOPING WORK PLANS WITH TIMEFRAMES AND BUDGETS/STAFFING

1. **Summary information on programs to be developed or expanded: 1. Please complete Exhibits 1, 2, and 3, providing summary information related to the detailed work plans contained in the Program and Expenditure Plan.**

The terms Full Service Partnership, System Development, and Outreach and Engagement refer to the three types of system transformation funding available through the MHSA. Full Service Partnership Funds provide "whatever it takes" to support recovery success. According to MHSA Guidelines, System Development Funds help counties improve programs, services, and supports to change service delivery systems and build transformational programs and services for all clients and families. Examples of strategies covered by System Development Funds include mobile crisis teams and community trainings. Outreach and Engagement Funds cover the costs of special activities to reach un/underserved populations, such as peer support programs and resource centers. In all cases, however, clients will experience services as seamless regardless of the type of funding paying for their services.

Exhibit 1, Program and Expenditure Plan Face Sheet is fully executed and is included at the beginning of this Plan.

Exhibit 2, County Program Work Plan Listings (one for each year) show the allocation of funds to Full Service Partnership Funds, System Development Funds, and Outreach and Engagement Funds and to each age group. Exhibit 2 follows this Section.

Exhibit 3, Full Service Partnership Population, follows Exhibit 2. As permitted by the MHSA Guidelines, some of the funding for System Development and Outreach and Engagement programs will also serve individuals who have Full Service Partnerships. MCMHD has estimated those amounts and included them in the Full Service Partnership totals in Exhibit 2. Some strategies funded through One-Time Funding will also serve individuals with Full Service Partnerships and are also included in Exhibit 2.

Table Sixteen. Funding allocation by year and funding type

	YEAR ONE (TWO MONTHS	YEAR TWO	YEAR THREE	TOTAL
1. Full Service Partnerships	$79,657	$444,786	$468,576	**$993,019**
2. System Development Funds	$43,988	$258,750	$258,750	**$561,488**
3. Outreach and Engagement	$28,899	$193,784	$169,994	**$392,677**
4. One-Time Funds	$447,600	---	---	**$447,600**
5. Administration	$3,431	$20,180	$20,180	**$43,791**
TOTAL	**$603,575**	**$917,500**	**$917,500**	**$2,438,575**

2. **The majority of a county's total three-year CSS funding must be for Full Service Partnerships. If individuals proposed for Full Service Partnerships also receive funds under System Development or Outreach and Engagement, please estimate the portion of those funds that apply toward the requirement for the majority of funds during the three-year period. (Small counties are exempt from this requirement until Year 3 of the three-year plan.) Please provide information demonstrating that this requirement has been met.**

Mendocino County is a small county and, therefore, the small county exception for implementation of Full Service Partnerships applies. By the end of the three-year funding period, a majority of the Community Services and Supports funding (51%) will provide 157 Full Service Partnership slots.

3. **Please provide the estimated number of individuals expected to receive services through System Development Funds for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.**

System Development funds are expected to serve an estimated 53 individuals in Year One, with 10 of these individuals in Full Service Partnership programs. In Years Two and Year Three, 530 individuals are expected to receive services through System Developments funds, with 136 of those individuals in Full Service Partnership programs.

4. **Please provide the estimated unduplicated count of individuals expected to be reached through Outreach and Engagement strategies for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.**

The proposed programs are expected to reach 32 clients through Outreach & Engagement strategies during Year One, (with 3 in Full Service Partnerships), and 320 in Years Two and Three (with 55 in Full Service Partnerships).

5. **For children, youth, and families, the MHSA requires all counties to implement wraparound services, pursuant to W&I Code Section 18250, or provide substantial evidence that it is not feasible in the county in which case counties should explore collaborative projects with other counties and/or appropriate alternative strategies. Wraparound programs must be consistent with program requirements found in W&I Code Sections 18250-18252. If wraparound services already exist in a county, it is not necessary to expand these services. If wraparound services are under development, the county must complete the implementation within the three-year plan period.**

Since 1997, MCMHD has been providing children's wraparound services through the Mendocino County Children's System of Care. These services are in full compliance with the program requirements in the relevant Welfare & Institution Codes and will be expanded through Work Plan #2, the Children and Family Services Program.

EXHIBIT 2: COMMUNITY SERVICES AND SUPPORTS – PROGRAM WORK PLAN LISTING

County: **MENDOCINO**
Fiscal Year: **05-06**
(please complete one per fiscal year)

		TOTAL FUNDS REQUESTED				FUNDS REQUESTED BY AGE GROUP			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	**CARE**	**$ 25,209**	**$ 14,833**	**$ 20,988**	**$ 61,030**	**$**	**$ 6,100**	**$48,830**	**$ 6,100**
2	**Children & Family Serv.**	**9,520**	**18,190**		**27,710**	**27,710**			
3	**TAY Systems of Care**	**18,833**	**10,965**	**4,171**	**33,969**		**33,969**		
4	**Adult Systems of Care**	**14,110**			**14,110**			**14,110**	
5	**Older Adult SOC**	**11,985**		**3,740**	**15,725**				**15,725**
	Admin				**3,431**				
	One Time-Start Up								
1	***CARE Flyers***				***15,000***				
2	***Respite Program***				***30,000***				
3	***TAY Congregate Living***				***27,600***				
4	***Crisis Residential***				***200,000***				
4	***SRO Remodel***				***50,000***				
Admin	***Electronic Charting***				***125,000***				
	Total Funds Requested:	**$ 79,657**	**$ 43,988**	**$ 28,899**	**$603,575**	**$27,710**	**$40,069**	**$62,940**	**$21,825**

EXHIBIT 2: COMMUNITY SERVICES AND SUPPORTS – PROGRAM WORK PLAN LISTING

County: **MENDOCINO**
Fiscal Year: **06-07**
(please complete one per fiscal year)

		TOTAL FUNDS REQUESTED				FUNDS REQUESTED BY AGE GROUP			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	CARE	$ 124,500	$ 87,250	$ 147,250	$ 359,000	$	$ 35,900	$287,200	$ 35,900
2	Children & Family Serv.	56,000	107,000		163,000	163,000			
3	TAY Systems of Care	110,786	64,500	24,534	199,820		199,820		
4	Adult Systems of Care	83,000			83,000			83,000	
5	Older Adult SOC	70,500		22,000	92,500				92,500
	Admin				20,180				
	Total Funds Requested:	$ 444,786	$258,750	$193,784	$917,500	$163,000	$235,720	$370,200	$128,400

EXHIBIT 2: COMMUNITY SERVICES AND SUPPORTS – PROGRAM WORK PLAN LISTING

County: **MENDOCINO**
Fiscal Year: **07-08**
(please complete one per fiscal year)

		TOTAL FUNDS REQUESTED				FUNDS REQUESTED BY AGE GROUP			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	CARE	$ 148,290	$ 87,250	$ 123,460	$ 359,000	$	$ 35,900	$287,200	$ 35,900
2	Children & Family Serv.	56,000	107,000		163,000	163,000			
3	TAY Systems of Care	110,786	64,500	24,534	199,820		199,820		
4	Adult Systems of Care	83,000			83,000			83,000	
5	Older Adult SOC	70,500		22,000	92,500				92,500
	Admin				20,180				
	Total Funds Requested:	$ 468,576	$258,750	$169,994	$917,500	$163,000	$235,720	$370,200	$128,400

EXHIBIT 3: FULL SERVICE PARTNERSHIP POPULATION – OVERVIEW

Number of individuals to be fully served:
FY 2005-06: Children and Youth: 5 Transition Age Youth: 4 Adult: 10 Older Adult: 10 TOTAL: 29
FY 2006-07: Children and Youth: 45 Transition Age Youth: 12 Adult: 50 Older Adult: 50 TOTAL: 157
FY 2007-08: Children and Youth: 45 Transition Age Youth: 12 Adult: 50 Older Adult: 50 TOTAL: 157

PERCENT OF INDIVIDUALS TO BE FULLY SERVED

	% Unserved				%Underserved				
	%Male		%Female		%Male		%Female		
Race/Ethnicity	%Total	%Non-English Speaking	%Total	%Non-English Speaking	% Total	%Non-English Speaking	%Total	%Non-English Speaking	%TOTAL
				2005/06					
% African American	1%		1%						2%
% Asian Pacific Islander	1%		1%						2%
% Latino	10%	4%	3%	4%					13%
% Native American	6%		2%						8%
% White	10%		10%		30%		15%		65%
% Other	6%		4%						10%
Total Population	10	1	6	1	9		4		29
				2006/07					
% African American	1%		1%						2%
% Asian Pacific Islander	1%		1%						2%
% Latino	10%	5%	3%	5%					13%
% Native American	6%		2%						8%
% White	10%		10%		30%		15%		65%
% Other	6%		4%						10%
Total Population	53	8	33	8	47		24		157
				2007/08					
% African American	1%		1%						2%
% Asian Pacific Islander	1%		1%						2%
% Latino	10%	5%	6%	5%					13%
% Native American	6%		4%						8%
% White	10%		10%		25%		15%		65%
% Other	6%		4%						10%
Total Population	53	8	40	8	40		24		157

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County:	Fiscal Year:	Program Work Plan Name:
MENDOCINO	**05/06 – 07/08**	**COMMUNITY ACTION FOR RECOVERY AND EDUCATION (CARE) PROGRAM**
Program Work Plan # 1		Estimated Start Date: **1 MAY 2006**
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Community Action for Recovery and Education (CARE) Program is a coordinated effort to identify, empower, and train client leadership; provide training and resources for emerging client groups; and train MHSA partners and the community in recovery issues.	
Priority Population: *Describe the situational characteristics of the priority population*	CARE is a client-operated and client-driven program of support to un/underserved clients of all ages and ethnicities.	

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
a. Recovery Coach Program to conduct outreach to homeless and other chronically mentally ill individuals and provide peer support**.**	☒	☐	☒	☒	☒	☒	☒ ☐
b. Resource Centers in up to 3 communities, with outreach services in outlying communities.	☒	☐	☒	☒	☒	☒	☒
c. Warm Line to prevent hospitalizations and other intensive interventions.	☒	☐	☒	☒	☒	☒	☒
d. Mobile Crisis Response partnering trained peer support counselors with Ukiah Police Department officers to respond to mental health crisis calls (pilot program).	☒	☐	☒	☐	☒	☒	☒
e. Client Empowerment Coordination to ensure continuous client input in the development of the recovery vision for MCMHD and all MHSA programs and strategies.	☒	☒	☒	☒	☒	☒	☒

1. (EXHIBIT 4)
2. **Detailed Description**. In keeping with the transformative goals of Proposition 63, the Community Action for Recovery and Education (CARE) Program has been developed as the primary vehicle for delivery of new transformative components through a client-driven support network. CARE is a coordinated effort to identify, empower, and train client leadership; provide training and resources for emerging client groups; and educate MHSA partners and the community in recovery issues. The program strategies were developed through consideration of Boston University Center for Psychiatric Rehabilitation's "Myths about Mental Illness" and the principles of recovery propounded by Dr. Mark Ragins in his keynote address to the California Association of Social Rehabilitation Agencies, "Taking Transformation Personally." These principles include the following:

    - Everyone's recovery is as individual as a fingerprint.
    - To recover, people must have someone who truly believes in them and in their recovery.
    - Recovery must be self-directed and client-run.
    - Recovery depends on responding to needs expressed by the client, including hope and empowerment, emotional connections and a social network, self-direction, and a meaningful role in the community.

SELECTED MYTHS ABOUT MENTAL ILLNESS[3]

People with psychiatric disabilities cannot recover.

Rehabilitation outcomes can be accurately predicted by professionals.

Traditional inpatient therapies (psychotherapy, group therapy, and drug therapy) positively affect rehabilitation outcome.

Increasing compliance with drug treatment can affect rehabilitation outcome.

Where a person is treated is more important than how a person is treated.

A diagnostic label provides significant information relevant to outcomes.

While the majority of clients served through the CARE Program will be in the adult age group, the program will serve consumers and family members of all ethnicities and age groups. Components of the CARE program are detailed in the following paragraphs.

a. **Recovery Coach Program.** MHSA funding will be used to develop client leadership, based on the belief that people who have recovered from mental illness are the very ones who are best suited to provide support and guidance in the self-help process of their peers. Recovery Coaches

[3] Anthony, W.A., Cohen, M., Farkas, M, & Gagne, C. (2002). *Psychiatric Rehabilitation, 2nd edition*. Boston: Boston University Center for Psychiatric Rehabilitation.

are people who are recovering or have recovered from mental illness and have a passion to share their recovery. They function as change agents in the community by meeting people where they are, providing support for self-directed recovery, providing leadership in outreach efforts, and providing training to and supporting the development of emerging client groups. (For example, the Heart-to-Heart Wellness Center in Fort Bragg is a consumer group that began meeting last year and has played a key role in the MHSA planning process, including developing a variety of community-specific proposals that will be incorporated into the CARE Program. Many Heart-to-Heart priorities will be addressed through the Recovery Coach strategy.) MCMHD will contract with a community-based organization to manage the Recovery Coach Program. The equivalent of 3.00 FTE[4] Recovery Coaches will be recruited from the recovering and survivor community, and each participant will complete a 12-14 week training modeled on the SPIRIT (Service Provider Individualized Recovery Intensive Training) Program developed in Contra Costa County. Two trainings will be offered each year, and at least 20 people will complete the training during the first full year of implementation. All participants will receive certificates of completion of the training. The contractor will hire trained and competent Recovery Coaches to conduct outreach to homeless and other people with chronic mental illnesses, model the work of gaining and utilizing peer support, coordinate with emerging groups and MHSA partners, support the Warm Line (see Strategy D below), especially by networking with people who are referred following calls to the Warm Line, maintain service records, and participate in planning future strategies. MCMHD envisions that 1.00 FTE of the Recovery Coach effort will serve coastal communities, and 2.00 FTE will serve inland communities. Together, the Recovery Coaches will make at least 100 unduplicated contacts with un/underserved persons with mental illness each year. Of these, at least 50 will become involved in recovery activities.

b. **Resource Centers.** MHSA funds will be used to rent and furnish drop-in client Resource Centers in Ukiah, Willits, and possibly Fort Bragg as well, depending on rental and other costs. In outlying communities, space will be rented for scheduled meetings and trainings until resources become available to rent and furnish dedicated space. Support services available in the Resource Centers will be responsive to community need, but may include 12-step meetings, dual diagnosis groups, support groups, etc. In addition to providing a variety of services and resources for clients, the Resource Centers will provide office space for Recovery Coaches, MCMHD staff, and Department of Rehabilitation staff (as appropriate to address community needs) and a central location for trainings and social

[4] Mental health recovery work requires significant emotional investment and skill development. Recovery Coaches are typically utilized at 0.40 FTE, equal to 16 hours per week, but the actual rate of employment will match each Recovery Coach's capacity.

activities. Resource Centers will be operated through contracts with community-based organizations to provide a 1.00 FTE Resource Center Coordinator position with time divided among the centers. At each site, the Resource Center Coordinator will be supported by community volunteers that enable the centers to meet the cultural and linguistic needs of clients from different ethnic backgrounds. MCMHD anticipates that, in all, Resource Centers will operate for a minimum of 60 hours each week and will be used by at least 50 individuals each month.

c. **Warm Line.** MCMHD will contract with a community-based organization to establish a toll-free Warm Line to provide support for people in not-yet-dire crises in order to prevent hospitalization and other more extensive interventions. The Warm Line will also create an on-going opportunity for volunteers and staff to provide support to a wider base of clients. The Warm Line will be staffed by peer counselors who have completed the Recovery and Resiliency Training Program and additional training in crisis response. MCMHD anticipates that the Warm Line will respond to at least 175 calls during the first program year. This strategy will be promoted, initially, in inland communities.

d. **Mobile Crisis Response.** MCHMD will develop a pilot program in Ukiah to provide recovery-based response to mental health crisis calls, with the goal of reducing use of force, emergency room admissions, officer injuries, and arrests for victimless crimes. The Mobile Crisis Response Program will partner trained peer support counselors with Ukiah Police Department officers to respond to mental health crisis calls where the peer counselors will provide direct support to the individual in question. On the scene, the law enforcement officer and the peer counselor will determine whether the individual should be transported to MCMHD's Crisis Center for triage or can be supported through alternative referrals. MCMHD and the Ukiah Police Department have experience providing this type of support through the AB 2034 program, and the Police Department's Operations Captain is fully committed to the proposed strategy. During the first year, at least 5 peer counselors will complete the 14-week Recovery Coach training and additional training in crisis response. Cross-training for peer counselors and law enforcement officers will be provided through the Police Department and MCMHD's Crisis Supervisor. The Police Department estimates that volunteers will be needed approximately 6 hours each week, and that approximately 100 clients will be served each year, including some clients with Full Service Partnerships. Because it is impossible to predict when this support will be needed, an on-call schedule will be developed that ensures 24/7 coverage, and MCMHD's 24-hour Crisis Service Line will be responsible for dispatch when calls are received from the Police Department. MCMHD consumer staff will provide mobile crisis support during regular work hours and MHSA funds will be used to pay trained consumers on weekends, holidays, and after hours. The Mobile Crisis Response program will be coordinated by a collaborative group of crisis responders, including MCMHD, law

enforcement, hospitals, clinics, resource centers, etc. Following an initial pilot period, MCMHD will seek to expand the program to other communities in the county.

e. **Client Empowerment Coordination**. MCMHD will recruit and hire a client or family member as a Client Empowerment Advocate to ensure continuous client input in the development of the recovery vision for the department and in all MHSA programs and strategies. The Client Empowerment Advocate will serve as a liaison between MCMHD and community providers contracted to carry out MHSA strategies and will provide technical assistance in solicitation and utilization of consumer input, staff trainings, and client advocacy. Additional responsibilities will include developing job opportunities for clients wanting to work in the Department, providing staff support to client councils, and liaising with client networks. This half-time position will be combined with MCMHD's existing Patient Rights Advocacy function, which includes responding to and investigating client grievances and serving on the Department's Quality Improvement Committee, to create a full-time position that is funded jointly through MHSA (50%) and MCMHD Realignment Funds (50%).

STRATEGIES INCLUDED IN LONG-TERM MHSA PLAN BUT NOT PROPOSED FOR MHSA FUNDING AT THIS TIME

Warm Line Staffing. MCMHD and the Steering Committee will see additional funding to provide stipends for peer counselors and other individuals working on the Warm Line.

3. **Housing and Employment**. Neither housing nor employment services are included as direct services in this program.
4. **Cost per FSP**. Full Service Partnerships for CARE Program participants are expected to cost $2,965/Full Service Partnership by Year Three.
5. **Recovery and Resiliency**. The proposed strategies are completely focused on resiliency and recovery by incorporating client leadership development, peer support, client advocacy, and provider training. The focus on recovery will be continually promoted and reinforced through ongoing monitoring, client satisfaction surveys, and staff training.
6. **Program Expansion**. All of the proposed strategies are new programs; none are expansions of existing MCMHD services.
7. **Services Provided by Clients**. All of the proposed strategies are provided directly by clients, including the Client Empowerment Coordination strategy. Clients will also be involved through client focus groups and satisfaction surveys.
8. **Collaboration Strategies**. CARE strategies will be supported through MHSA funding and a variety of community partnerships, as detailed below:
    - The Department of Rehabilitation will provide services at CARE Resource Centers.

- As MCMHD's partner in the Mobile Crisis Response strategy, the Ukiah Police Department will provide assistance in developing and conducting training for Mobile Crisis Response team members.
- The Ukiah Community Center will assist in extension of the Warm Line to the entire county.
- Mendocino College is in the process of developing a recovery-based curriculum for Mental Health Workers.
- Mendocino Community Development Commission's Shelter Plus Care Program will provide on-site services at the CARE Resource Centers.
- The California Network of Mental Health Clients and the California Institute for Mental Health will provide free and/or fee-for-service training workshops.
- Mendocino County Library will circulate recovery resources throughout the county.

9. **Cultural and Linguistic Competency**. The proposed strategies address racial ethnic disparities described in Part II, Section II by serving clients from the Hispanic and American Indian communities. (Resource Center activities for the Hispanic and American Indian communities will be developed through mini-grants, funded through MCMHD's One-Time System Development request.) Cultural competency will also be ensured through annual participation of MCMHD and partner staff in cultural competency training.
10. **Sensitivity to gender issues**. MCMHD and partner staff will participate in annual training on sensitivity to sexual orientation and gender issues and on customizing services for clients with different sexual orientations. This priority will also be addressed through non-discrimination policies, referral to specialized 12-step or other groups, and educational presentations. Staff will be trained to respect each client's frame of reference, be nonjudgmental and accepting of each client's cultural, behavioral, and value differences, and adjust strategies in accordance with client characteristics, including sexual orientation. These best-practice methods are critical when working with lesbian, gay, bisexual, and transgender (LGBT) clients.
11. **Individuals residing out-of-county**. Recovery Coaches, Resource Centers, and the Warm Line will provide important support for individuals who are returning from out-of-county placements.
12. **Unlisted strategies**. All of the strategies in this program are included in the MHSA listing.

13. **Timeline**.

STRATEGY	ACTIVITY	RESP	DATE
a. Recovery Coach Program	Develop contract with CBO. Schedule and conduct first 12-14 week training. Recruit and hire 3.00 FTE Recovery Coaches. Begin providing services. Conduct 2nd 12-14 week training.	MCMHD CBO CBO Coaches CBO	Month 2 Month 3 Month 6 Month 7 Month 9
b. CARE Resource Centers	Develop contract with CBO. Recruit and hire Resource Center Coordinator. Rent and furnish centers in up to 3 communities. Secure meeting space in outlying communities. Develop operating schedules. Recruit and schedule community volunteers. Begin operation.	MCMHD CBO Coordinator Coordinator Coordinator Coordinator Coordinator	Month 2 Month 3 Month 5 Month 6 Month 6 Month 6 Month 7
c. Warm Line	Develop contract with CBO. Train volunteers. Establish toll-free number. Publicize in the community and promote to partners. Develop volunteer schedule. Begin operation.	MCMHD CBO CBO CBO CBO CBO	Month 2 Month 3 Month 6 Month 6 Month 6 Month 7
d. Mobile Crisis Response	Develop contract with CBO and MOU with UPD. Develop cross-training schedule and conduct training. Develop on-call system and schedule. Initiate crisis response. Begin planning program expansion.	MCMHD MCMHD MCMHD MCMHD/UPD MCMHD	Month 2 Month 5 Month 6 Month 6 Month12
e. Client Empowerment Coordination	Recruit and hire Client Empowerment Coordinator. Develop detailed job description and work plan, including training schedule. Begin meeting with CBOs and client networks.	MCMHD Coordinator Coordinator	Month 2 Month 3 Month 4

14. **Budget Requests**. Please see Exhibits 5a, Budget Worksheet and 5b, Staffing Detail Worksheet, together with Budget Narrative, following all Program Work Plans.

15. **Quarterly Progress Report**. Please see Exhibit 6 with estimated population service numbers following Exhibit 5.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County:	Fiscal Year:	Program Work Plan Name:
MENDOCINO	**05/06 – 07/08**	**CHILDREN AND FAMILIES SERVICES PROGRAM (CFSP)**
Program Work Plan # 2		Estimated Start Date: **1 MAY 2006**
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Children and Families Services Program will address unmet needs throughout the county utilizing a variety of strategies, including: Parent Partners; wraparound services; culture-specific treatment services for Hispanic and American Indian children and families; broad screening and assessment of very young children (ages 0-5); and coordination of Family Respite Services.	
Priority Population: *Describe the situational characteristics of the priority population*	The Children and Families Services Program will serve children of all ages, with a focus on the underserved 0-5 age group and underserved Hispanic and American Indian children.	

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
a. Mental health screening, assessment, and treatment for children ages 0-5 countywide.	☒	☒	☐	☒	☐	☐	☐
b. Family Respite Service Pilot Program serving 50-60 families each year**.**	☒	☐	☒	☒	☐	☐	☐
c. Bilingual/bicultural therapy for up to 200 Hispanic children and families through contract with Nuestra Casa**.**	☒	☒	☐	☒	☒	☒	☒
d. Parent Partners Program expansion that increases the number of Parent Partners and links them with Family Resource Centers or community clinics in 5 rural communities.	☒	☐	☒	☒	☐	☐	☐
e. Bicultural therapy for 80 American Indian children, through contract with Consolidated Tribal Health Project for the services of a bicultural child psychologist**.**	☒	☒	☐	☒	☒	☐	☐

1. (EXHIBIT 4)
2. **Detailed Description**. The goal of the Children and Families Services Program (CFSP) is to increase resiliency through new strategies that address service gaps and by extending successful services to underserved communities and populations throughout Mendocino County. All MCMHD and partner staff working with children and families will participate in training that includes the principles of resiliency and recovery, cultural competency, and gender sensitivity. The proposed strategies will establish and nurture collaborative and cooperative relationships between the public mental health and social services systems and community agencies working to serve children and families, using approaches that reflect the unique needs of the county's rural communities. CFSP will be coordinated through the county's existing Children's System of Care (CSOC). In keeping with MHSA goals, elements, and outcomes, children and parents will continue to be involved in planning and developing the programmatic details of the proposed strategies, each of which is described below:

    a. **Mental Health Screening, Assessment, and Treatment for Children ages 0-5 Countywide.** Children 0-5 who exhibit symptoms of emotional or behavioral disorders may go unnoticed until the child is older and their symptoms have become unmanageable. By then, these behavior patterns may have become engrained, leaving the family increasingly frustrated. Locally and throughout the state, most mental health funds flow toward those with the most serious illnesses, despite widespread agreement that early assessment and treatment, particularly with young children, are more cost-effective. During the past year, MCMHD served only 33 children in the 0–5 age group, less than 7% of the 498 children of all income levels that are expected to need mental health services in the general population. During the same period, 188 children ages 0–5 received special education services through SELPA, 45 children received some mental health support from Head Start, and a few children received help from other sources. Even assuming that these figures are unduplicated, that still leaves unrecognized and untreated approximately 60% of the Mendocino County children in this age group who are likely to be significantly impaired by social-emotional delays or disorders. In collaboration with partners throughout the county, First Five Mendocino has recently completed an eight-month planning process that is culminating in adoption of the evidence-based Positive Parenting Program (Triple P) through which parents of all cultures and ethnicities learn commonsense strategies to manage the challenges—both large and

small—of day-to-day parenting.[5] In coordination with First Five Mendocino, MCMHD will use MHSA funding to screen up to 1,000 children ages 0–5 for social-emotional delays or disorders. Screening will be conducted countywide by agency and non-profit staff, individual child care providers, and medical providers. (Ultimately, screening will be integrated into routine CHDP exams administered by medical providers.) MCMHD will hire a Mental Health Clinician to coordinate referrals[6] and link families with an assessment and treatment provider trained in the Triple P protocol. The Mental Health Clinician will conduct assessments and provide or arrange for treatment in areas of the county where no trained providers are available. The Mental Health Clinician position will be co-funded through MHSA funds, MediCal reimbursement, and First Five Mendocino funding for non-MediCal children. The proposed screening program is family-driven and strength-based, involving parents in education as well as the screening and assessment processes. It is estimated that 20 children identified through the screening process will receive Full Service Partnerships in Years Two and Three.

b. **Family Respite Service Pilot Program**. Emergency or planned respite services assist families by offering "time out" for children and parents who are struggling with mental health issues. Together with therapy, medication management, social support, and community compassion, respite is an essential tool for families struggling with the effects of mental illness. Respite services reduce stress and provide opportunities for reflection, protective factors that keep children with their families and build family capacity to reflect, plan, and adequately respond to on-going and crisis situations. MHSA funds will be used to recruit and hire a 1.00 FTE Family Respite Coordinator who will be housed in the Department of Social Services to maximize the placement and family options already existing in the county. The Family Respite Coordinator will further assess community needs and resources and, through a network of foster families and community support agencies, develop a working list of potential respite options throughout the county and a protocol that enables MCMHD and the Department of Social Services to access all public and private respite options. The Family Respite Coordinator will arrange the provision of 300 days of respite for 40 families of children and youth of all ages.[7]

---

[5] Triple P's evidence-based program brings the whole community together to offer solutions for every family: Level 1, coordinated media and promotional campaign; Level 2, anticipatory developmental guidance for mild behavior difficulties; Level 3, primary care intervention for children with mild to moderate behavior difficulties; Level 4, intensive individual, group or self-help parenting sessions for more severe behavior difficulties; and Level 5, family intervention for families where parenting is complicated by other sources of family distress.

[6] Through First Five Mendocino, children whose Ages and Stages Screenings show positive symptoms will be referred to the Mental Health Clinician.

[7] Respite services will be available in blocks of time ranging from 4 to 24 hours, following a successful model currently implemented by the Redwood Coast Regional Center.

This project is requesting MHSA One-Time Funds to match local funds to pay respite care providers.

c. **Bilingual/bicultural therapy serving Hispanic children and families.** MCMHD service utilization data shows that the Department is serving fewer than 15% of the eligible Hispanic children who are estimated to need mental health services. In part, this disparity is the result of a continuing shortage of bilingual/bicultural Mental Health Clinicians and of the high percentage Hispanic residents who do not have insurance or MediCal coverage. Data from the Latino Access Survey conducted during FY 2004-2005 by MCMHD through Nuestra Casa, a Latino service organization, indicated that Hispanic clients, especially those who are undocumented, would be more comfortable accessing services if they were provided through Nuestra Casa. MHSA funds ($45,000) will be used to contract with Nuestra Casa for a 0.75 FTE Clinician to serve up to 200 people of all ages in need of mental health services. Nuestra Casa is currently providing a wide array of services to 3,000 people each year, and estimates that up to 50% could benefit from mental health interventions for depression, anxiety, post-traumatic stress syndrome, attachment disorders, paranoia, etc. Nuestra Casa markets services directly to the Spanish-speaking community through radio advertising and informational presentations, and is enthusiastic about providing this new service to the Latino community. Because Nuestra Casa provides an array of health and social services, clients will not face the stigma of being singled out as mental health clients. *Note that this strategy will serve all ages.*

d. **Parent Partner Program Expansion**. Parent Partners provide support and advocacy related to due process and other client rights, aid in problem-solving for effective interaction with public agencies, respond to crises, offer resource and referral information, and serve as mentors to the parents of children with serious emotional impairments. Parent Partners have demonstrated that they are an important support for families that are struggling with mental illness. To qualify as a Parent Partner, an applicant must be a parent of a child who is currently receiving, or has received in the past, services for mental health related issues. To increase access to this support, Parent Partners will be located at Family Resource Centers or community clinics in the underserved communities of Laytonville, Booneville, Gualala, and Round Valley, as well as Nuestra Casa in Ukiah. These communities are geographically isolated and/or serve large Hispanic and American Indian communities. Family Resource Centers are natural partners for this strategy because of their emphasis on youth and their mission of linking families with resources that address their needs and capitalize on their strengths. One Parent Partner will be recruited for each of the five communities and hired through the community-based partner. Recruiting Parent Partners who live in the communities they serve will ensure their understanding of the local culture and unique local needs and priorities. Parent Partners will participate in training provided through

the Children's System of Care, which will also link them with support from current and past Parent Partners and community advocates. Training topics will include resiliency and recovery, cultural competency, and gender sensitivity. Parent Partner positions will require approximately $7,000 each in MHSA funds; in some locations, the Parent Partner positions may be filled by AmeriCorps members.

e. **Bicultural Therapy for American Indian Children**. Local data show that American Indians are over-represented in the child welfare and juvenile justice systems, and there is significant disparity in their participation in mental health services when compared to their representation in the general population. To improve and increase the level of clinical support available to rural Native populations, MHSA funds will be used to contract with Consolidated Tribal Health Project for a 0.50 FTE bicultural Child Psychologist to serve approximately 80 American Indian children ages 0-17 each year. This position will be based at Consolidated Tribal Health Project in Redwood Valley, but will also be made available to American Indians residing in other remote communities.[8] These services will be provided either through weekly on-site visits, where services can be coordinated with health centers or local schools, or by providing transportation from outlying communities to Consolidated Tribal Health Project's Redwood Valley clinic. MHSA funding will enable Consolidated Tribal Health Project to double their capacity to provide mental health services for American Indian children by increasing the time of their current child counselor from 0.50 FTE to 1.00 FTE. *Note that this strategy will also serve TAYs.*

STRATEGIES INCLUDED IN LONG-TERM MHSA PLAN BUT NOT PROPOSED FOR MHSA FUNDING AT THIS TIME

Children's System of Care Wraparound Program Expansion. Mendocino County's wraparound program has been successful in keeping many children in their homes and communities, avoiding placement in the Level 10-12 facilities which are generally located more than three hours away. Since beginning to provide wraparound services with 6 slots in 1998, the program has grown to 25 slots, more than quadrupling in capacity over the past seven years. Mendocino County's wraparound services are family-focused, and planned with full participation of the youth and family (as appropriate). The Children's System of Care estimates that there are 7 to 10 coastal children in out-of-home placement at any point in time. MCMHD will expand the existing wraparound program by adding 3 new Full Service Partnership slots for children ages 3-18 living in coastal communities. Expansion of the wraparound program will be implemented

[8] Consolidated Tribal Health Project, Inc. has been providing physical, dental, mental, and community health services to a consortium of eight Indian tribes in Mendocino County for nearly 20 years. During the past year, a 0.50 FTE child counselor provided 355 units of mental health services to 44 children. Although not all Mendocino County tribes are members of this consortium, Consolidated Tribal Health Project will collaborate to ensure that services are available to all American Indian children and families.

by a full-time Facilitator supported by a full-time Youth Mentor and a Parent Partner. Wraparound services will be overseen by the Children's System of Care Interagency Case Management Team, which provides representation and accountability from schools, community based organizations, the Departments of Social Services and Probation, and most importantly, the children and their families. The two full-time positions will be funded through SB 163 and MediCal, requiring no MHSA funding. The Parent Partner is already in place through Children's System of Care funding.

Family Crisis Services for Coastal Communities. The planning process prioritized the need to expand Family Crisis Services to the coast, although it is not included in the current funding proposal because of limited funding availability. MCMHD's Ukiah-based family crisis services model, which provides a Family Systems Clinician during the business day for crisis counseling, assessment, and linkage with services supports, has proven successful in exploring and utilizing the natural strengths of families to avoid costly and unwanted hospitalizations of their children. As the Clinician serves children and families, s/he opens a formal chart on each client and immediately begins considering strategies to diffuse the situation so that treatment and family stability can begin without delay. Families have the option of six additional sessions without charge. Availability of a full-time Mental Health Clinician knowledgeable in family systems theory makes it possible for a family experiencing a crisis situation to get help without an appointment, even when they lack the ability to pay for services. The MHSA Steering Committee plans to replicate this service for coastal communities in the future.

3. **Housing and Employment**. Neither housing nor employment services are included in this program.
4. **Cost per FSP**. Full Service Partnerships for children and families are expected to cost $1,245/Full Service Partnership by Year Three.
5. **Recovery and Resiliency**. The proposed strategies will advance the goal of resiliency by providing support and capacity-building to parents (through wraparound services, Parent Partners, and Family Respite) and involving parents in education, screening, and assessment through the Triple P Program. Where children are participating in Full Service Partnerships or other direct clinical services, both the child (as appropriate) and the parent will be fully involved in developing and monitoring the full service plan. Providing culture-specific services for Hispanic and American Indian children and families will increase protective factors related to identity and community support. The focus on resiliency will also be continually promoted and reinforced through ongoing monitoring, client satisfaction surveys, and staff training. Evaluation will identify strengths and barriers related to implementation, while baseline data on individual and program outcomes will be collected for outcome evaluation.
6. **Program Expansion**. Program strategies that focus on expansion of existing services are described in the preceding paragraphs and include Family Respite Services (Strategy B) and the Parent Partner Program (Strategy D). The

proposed expansion of the Parent Partner Program will result in the provision of Parent Partners to nearly every community in the county.

7. **Services Provided by Clients**. The Parent Partner Program is a client/family-operated service, while parents and children (as appropriate) are involved in design and implementation of other strategies through treatment planning and client satisfaction surveys.
8. **Collaboration Strategies**. The Children's System of Care includes representatives of all organizations partnering in the Children and Families Services Program and will provide guidance and oversight of all strategies. MCMHD's partners specific to each strategy include the Department of Social Services (playing a leading role in the Family Respite Program), First Five Mendocino (leading with the Triple P Program and mental health screening), Nuestra Casa for the provision of bilingual/bicultural therapy, and Consolidated Tribal Health Project for bicultural therapy for American Indian children. For the Parent Partner Program, MCMHD will partner with Family Resource Centers or community clinics in 5 rural communities.
9. **Cultural and Linguistic Competency.** MCMHD will intentionally partner with organizations (and individuals, in the case of Parent Partners) that live and work in the county's diverse rural communities. This strategy will ensure that rural and ethnic needs and resources are fully acknowledged and understood. The proposed strategies address many of the racial ethnic disparities described in Part II, Section II by designing services that are specific to the needs of the underserved Hispanic and American Indian communities, and by increasing access to services in the county's outlying communities. Cultural competency will also be ensured through annual participation of MCMHD and partner staff in cultural competency training.
10. **Sensitivity to gender issues**. MCMHD and partner staff will participate in annual training on sensitivity to sexual orientation and gender issues and on customizing services for clients with different sexual orientations. This priority will also be addressed through non-discrimination policies, referral to specialized 12-step or other groups, and educational presentations. Staff will be trained to respect each client's frame of reference, be nonjudgmental and accepting of each client's cultural, behavioral, and value differences, and adjust strategies in accordance with client characteristics, including sexual orientation.
11. **Individuals residing out-of-county**. Treatment providers will track and stay involved in treatment and discharge planning for all clients who are temporarily placed outside the county. To facilitate the return of children who are in out-of-county placements, appropriate staff will meet with the family and child to plan and implement necessary preparations for the smooth transition home.
12. **Unlisted strategies**. All of the child and family strategies in this program are included in the MHSA listing.

13. **Timeline**.

STRATEGY	ACTIVITY	RESP	DATE
a. Mental Health Screening, Assessment, and Treatment for children ages 0-5 countywide	Recruit and hire Mental Health Clinician. Develop protocol for positive screening referrals. Identify providers for assessment and treatment. Begin accepting referrals and providing services.	MCMHD Clinician Clinician Clinician	Month 3 Month 4 Month 5 Month 5
b. Family Respite Service Pilot Program	Recruit and hire Family Respite Coordinator. Conduct needs/resource assessment. Coalesce network of foster families and community support agencies. Develop and maintain listing of respite options. Publicize service in the community and promote through presentations to service providers. Begin coordination of respite services.	MCDSS Coordinator Coordinator Coordinator Coordinator Coordinator	Month 3 Month 4 Month 4 Month 5 Month 5 Month 5
c. Bilingual/ bicultural therapy for Hispanic children and families	Develop MOU with Nuestra Casa. Recruit and hire bilingual/bicultural clinician. Publicize service countywide and promote through presentations to service providers. Begin providing services.	MCMHD Nuestra Casa Clinician Clinician	Month 1 Month 2 Month 2 Month 3
d. Parent Partner Program Expansion to 5 rural communities	Develop contracts with community partners. Recruit and hire Parent Partners. Provide initial training. Develop schedules and work plans. Begin providing services.	MCMHD Partners Partners Parent Partners Parent Partners	Month 2 Month 3 Month 4 Month 4 Month 5
e. Bicultural Therapy for American Indian children	Develop MOU with Consolidated Tribal Health Project. Recruit and hire bicultural child psychologist. Publicize service countywide and promote through presentations to tribes and service providers. Begin providing services.	MCMHD Consolidated Psychologist Psychologist	Month 1 Month 3 Month 4 Month 5

14. **Budget Requests**. Please see Exhibits 5a, Budget Worksheet and 5b, Staffing Detail Worksheet, together with Budget Narrative, following all Program Work Plans.
15. **Quarterly Progress Report**. Please see Exhibit 6 with estimated population service numbers following Exhibit 5.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County:	Fiscal Year:	Program Work Plan Name:
MENDOCINO	**05/06 – 07/08**	**TRANSITION AGE YOUTH SYSTEM OF CARE (TSOC)**
PROGRAM WORK PLAN # 3		Estimated Start Date: **1 MAY 2006**

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Transition Age Youth program contains the initial components of a Transition Age Youth System of Care (TSOC). Building on the principles of resiliency and recovery, the proposed strategies seek to minimize risk factors and increase protective factors for TAYs by assisting them to: • Develop healthy relationships with family, peers, mentors, employers, teachers, and counselors; • Access employment, education, and career or vocational development; • Obtain housing in supportive, clean, affordable, and productive environments; • Access mental and physical health care; • Learn healthy strategies for coping with stress and setbacks; and • Be in control of their own lives.
Priority Population: *Describe the situational characteristics of the priority population*	The TSOC Program will serve all transition age youth, with special focus on those who are transitioning from the foster care system, pursuing educational goals, and seeking to enter the work environment.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
a. Congregate Living Facility to provide transitional housing support for 4 transitional age youth with mental health disorders.	☒	☐	☐	☐	☒	☐	☐
b. Peer Mentoring Program services for 150 TAYS in Ukiah, Willits, and Fort Bragg	☒	☐	☒	☐	☒	☐	☐
c. Family-Based Mental Health Support to Rural Communities (Anderson Valley, Covelo, Laytonville, and South Coast), serving up to 200 youth and families each year.	☐	☒	☒	☒	☒	☐	☐
d. Supported Education for 40 TAYs attending Mendocino College in Ukiah and Willits each year	☒	☐	☒	☐	☒	☒	☐
e. Full Partnership Services in Ukiah and Willits (4 slots) and flex funding for four existing FSP clients in Ukiah (4 slots).	☒	☐	☐	☐	☒	☐	☐

1. (EXHIBIT 4 ABOVE)
2. **Detailed Description**. The goal of the TSOC Program is to develop resiliency and support youth development through a broad spectrum of support by creating new services that address identified service gaps while extending successful services to rural communities. All staff and peer mentors working with TAYs will participate in training that includes the principles of resiliency and recovery, cultural competency and gender sensitivity, and the linkages between mental health issues and substance abuse to ensure the delivery of best practice services to dually diagnosed youth. Only individuals that have a genuine interest in transition age youth will be hired to work with the program, whether services are delivered by MCMHD or contracted providers. The proposed strategies will establish and nurture collaborative and cooperative relationships between the public mental health and social services systems and community agencies working to serve TAYs and their families, using approaches that reflect the unique needs of the county's rural communities. In keeping with MHSA goals, elements, and outcomes, youth will continue to be involved in planning and developing the programmatic details of the proposed strategies, each of which is described below:
    a. **Congregate Living Facility to provide transitional housing support for transition age youth with mental health disorders.** Through an open bidding process, MCMHD will contract with a private non-profit organization to rent, develop, and operate a Congregate Living Facility where a caseload of four TAYs will live for up to 18 months while they develop skills and a support system and work toward educational and/or vocational goals. Participants must be learning to cope with mental illness, at-risk for homelessness, and willing to live with peers and participate in the program. Supervision will be provided by a live-in House Manager (possibly an AmeriCorps member), and a 0.50 FTE Personal Services Coordinator (PSC) employed by MCMHD will provide each youth with five hours/week of direct service focused on development of vocational training, college education, and employment goals. MHSA funding will provide up to $200/person/month to further these goals. The PSC will work with the TAY to develop a plan to access the flexible funding assigned to each slot. This funding will be administered by MCMHD. The Congregate Living Facility will be located in Fort Bragg, but is a countywide strategy that will be available for youth from all Mendocino County communities, whether or not they have MediCal or private insurance to cover costs. Residents will pay a monthly program fee that will go into a personal savings account to be used upon their departure for rental security deposit, vocational school, etc. Referrals to this program will come through all organizations working with transition age youth—County Departments of Social Services, Mental Health, and Probation; Redwood Children's Services, Mendocino County Youth Project, etc.—as well as tribal entities and families and youth themselves. One-time funding will be used to pay start-up costs, including the security deposit on the

facility, furnishings, and vehicle. On-going monitoring and evaluation of this pilot strategy will establish the level of need and support future efforts to expand the program to serve a larger number of TAYs.

b. **Peer Mentoring Program.** In the county's larger communities (Ukiah, Willits, and Fort Bragg), MCMHD will contract with a community-based organization to develop a peer mentoring program to work in each community and on college campuses. Three college-age students will be hired to work 10 hours/week to make contacts with TAYs who are struggling with symptoms of mental illness and who want support in any life domain. Peer mentors will be trained to identify and understand issues related to mental health, peer support, resiliency and recovery, etc. While the peer counselors will themselves have experienced adversity in their lives, they will not currently be actively dealing with issues of mental illness. The MHSA planning team estimates that peer mentors will make contact with approximately 10 TAYs each week, with an average of 2 being new contacts and 8 being returning contacts. In all, each peer mentor will serve an unduplicated count of approximately 30 TAYs each year, for a total of 90 youth served/year in the three communities. Existing high school peer counseling programs that train students in many issues related to mental health will provide a pool of potential mentors for the program. MHSA funding will cover costs of program coordination, mentor stipends, travel reimbursement, training, and cell phones for mentors.

c. **Family-Based Support to Rural Communities.** The county's smaller rural communities (Laytonville, Covelo, Anderson Valley, and the South Coast) have requested that MCMHD provide access to professional mental health services for families with children age 0-24, whether or not they have insurance or MediCal coverage. MCMHD will respond to this request by fielding a full-time Mental Health Clinician who will schedule at least one full day of support each week in each of these communities, working through existing Family Resource Centers or community clinics to provide strength-based support through informal consultations and community trainings. The MHSA planning team estimates that the rural Clinician will make approximately 5 contacts during each site visit, comprising 1 new client and 4 returning clients. In all, the Clinician will serve an unduplicated count of approximately 30 TAYs in each community each year, for a total of 120 youth and families served/year. *This strategy also serves the Children and Families age group, and the Mental Health Clinician will interface with the Parent Partners Program described in Work Plan #2.*

d. **Supported Education.** Education is a cornerstone for the development of personal and cognitive skills and protective factors. To support the success of TAYs attending Mendocino College, MCMHD will collaborate with the college and the State Department of Rehabilitation to fund a campus-based Mental Health Clinician as the College Coach. MHSA funding will support approximately 0.25 FTE of this position; MCMHD will

seek to leverage funding for an additional quarter-time through the participating partners. At 0.50 FTE, the College Coach is expected to devote at least 10 hours/week to direct student contacts that serve at least 1 new TAY each week. In all, the College Coach will serve an unduplicated count of approximately 40 TAYs each year. Mendocino College's current enrollment is 5,400, and approximately 1% of the student body is expected to need the services of the College Coach. If the demand for supported education services exceeds 40 students/year, MCMHD will seek to leverage additional funding through its partners; some costs associated with this position will be recovered through MediCal draw-down. The College Coach will also interface with college counselors on both Ukiah and Willits campuses and spend time planning and delivering trainings to college staff. *This strategy also serves the Adult age group.* The College Coach will:

- Provide training to college counselors about interventions to assist students with specific disabilities.
- Welcome newly-enrolled TAYs to college and schedule regular office hours for development of personal relationships, support, conversation, advice, and advocacy.
- Provide group opportunities for development of supportive relationships and individual or group guidance in development of study skills, test-taking skills, and management of symptoms of mental illness.
- Coordinate with the Department of Rehabilitation and college counselors to ensure that students are taking advantage of all possible entitlements.

e. **Full Service Partnerships and Personal Service Coordinators.** Intensive services to TAYs will be expanded through the addition of 4 Full Partnership slots (2 in Ukiah and 2 in Willits) and flex funding for 4 existing non-MediCal TAY slots in the Ukiah Valley. Knowing that a Personal Services Coordinator really cares provides youth with a powerful protective factor as they navigate the hazardous transition to adulthood. For the Full Service Partnerships, the Personal Services Coordinator will have flexible funding of up to $250/month/TAY to facilitate provision of "whatever it takes" to ensure the youth's success. The PSC will also link participating TAYs with community resources, including peer mentoring (described in Strategy B above). Currently, the Ukiah-based Personal Services Coordinator has resources to serve only MediCal-eligible youth and also has older adults on her caseload. This change will allow her to be totally dedicated to TAYs.

STRATEGIES INCLUDED IN LONG-TERM MHSA PLAN BUT NOT PROPOSED FOR MHSA FUNDING AT THIS TIME

Youth Employment Program in Willits and Laytonville. The planning process prioritized the extension of the Youth Employment Program to Willits

and Laytonville, although it is not included in the current funding proposal because of limited funding availability. The MHSA needs assessment and other surveys have shown that the highest priority for many TAYs is finding jobs. In addition to providing TAYs with needed funds, work also develops life skills that TAYs need as they transition to adulthood. In the future the Youth Employment Training Program will be extended to Willits and Laytonville through placement of a 0.50 FTE Employment Coach to provide employment services that include job development, job skills training, job mentoring, and other job placements.

3. **Housing and Employment**. As detailed above, the TSOC Program will provide housing services (see Strategy A).
4. **Cost per FSP**. Full Service Partnerships for TAYs are expected to cost $9,232/Full Service Partnership by Year Three.
5. **Recovery and Resiliency**. The TSOC advances the MHSA goal of resiliency through focused and ongoing training, family involvement, peer mentoring, and housing support. The focus on resiliency will be continually promoted and reinforced through ongoing monitoring, youth focus groups, and client satisfaction surveys. On-going evaluation will identify strengths and barriers related to implementation, while baseline data on individual and program outcomes will be collected for outcome evaluation. For youth in Full Service Partnerships, the principles of resiliency will also be incorporated through self-directed care plans that incorporate problem-solving skills and self-sufficiency
6. **Program Expansion**. As noted previously, the proposed TSOC Program incorporates Expansion of Full Service Partnerships and PSC slots, as detailed in Strategy E above.
7. **Services Provided by Clients**. The TSOC Program will recruit and train TAYs as peer counselors and, to the extent possible, recruit clients who are successfully managing their mental health conditions. Clients will be involved in developing and enforcing house rules in the Congregate Living Facility, and TAYs will provide mutual support through the Supported Education strategy. TAYs participating in Full Service Partnerships will guide development and monitoring of their personal services plans.
8. **Collaboration Strategies**. Strategies proposed for the TSOC Program will be developed through collaboration among county Departments of Mental Health, Social Services, Public Health's Division of Alcohol and Other Drug Programs, and Probation; the State Department of Rehabilitation; Mendocino College; and community-based organizations including rural family resource centers and clinics. Collaboration will leverage funding for the proposed strategies, assist in identifying participants, and ensure provision of a broad spectrum of services.
9. **Cultural and Linguistic Competency**. In selecting applicants for the Congregate Living Facility, the operator will consider the ethnic disparities described in Part II, Section II, which show a disproportionately high number of American Indian youth in foster care and juvenile justice settings. Ethnic

disparities will also be considered when recruiting peer mentors, both in selecting applicants and in providing training in cultural competency issues. The full involvement of representatives of geographic and ethnic communities, including family resource centers, will assure that services are culturally specific to the needs of each community. Cultural competency of services will also be ensured through annual participation of staff and peer counselors in cultural competency training.

10. **Sensitivity to gender issues**. Staff and peer counselors will participate in annual training on sensitivity to sexual orientation and gender issues. Peer mentors will be trained to implement outreach strategies that reach individuals of all sexual orientations. Staff will customize services for clients with different sexual orientations through staff training, non-discrimination policies, and referral to specialized 12-step or other groups. Staff will be trained to respect each client's frame of reference, be nonjudgmental and accepting of each client's cultural, behavioral, and value differences, and adjust strategies in accordance with client characteristics, including sexual orientation. These best-practice methods are critical when working with lesbian, gay, bisexual, and transgender (LGBT) clients.
11. **Individuals residing out-of-county**. All of the proposed strategies will be relevant to the service needs of TAYs who are returning from out-of-county treatment programs. For TAYs who are moved into temporary out-of-county placements during their participation in mental health services, case managers and treatment providers will track and stay involved in treatment and discharge planning.
12. **Unlisted strategies**. All TAY strategies in this proposal are included in the MHSA listing.
13. **Timeline**.

STRATEGY	ACTIVITY	RESP	DATE BY
a. Congregate Living Facility	Identify Congregate Living Facility operator.	MCMHD	Month 2
	Recruit and hire House Manager.	Operator	Month 4
	Develop protocols and procedures.	Operator	Month 4
	Select initial applicants.	Operator	Month 5
	Involve youth in development of house rules.	House Mgr.	On-going
	Provide PSC services.	MCMHD	On-going
	Provide cultural competency, gender sensitivity, and resiliency training.	MCMHD/ Operator	Annually
b. Peer Mentoring Program	Identify Peer Mentoring Program operator.	MCMHD	Month 2
	Recruit and hire peer mentors.	Operator	Month 3
	Provide training in peer support, resiliency, cultural competency, gender sensitivity.	Operator	Month 3
	Begin publicizing program.	Operator	Month 4
	Begin providing mentoring to TAYs.	Operator	Month 4
	Provide mentors with on-going support, supervision, and recognition.	Operator	On-going

STRATEGY	ACTIVITY	RESP	DATE BY
c. Family-Based Support to Rural Communities	Identify partners and develop MOUs.	MCMHD	Month 2
	Recruit or assign Mental Health Clinician.	MCMHD	Month 3
	In collaboration with community partners, develop community schedule.	Clinician	Month 4
	Begin providing strength-based services.	Clinician	Month 4
	Respond to community needs for training.	Clinician	On-going
d. Supported Education	Develop scope of work with college.	MCMHD	Month 2
	Recruit College Coach.	MCMHD	Month 3
	Develop office and group schedule.	Coach	Month 4
	Develop training plan for college staff.	Coach	Month 4
	Begin publicizing and referring TAYs.	Coach	Month 5
	Conduct outreach activities.	Coach	On-going
e. Full Service Partnerships and Personal Service Coordinators	Reassign older adult clients served by PSC.	MCMHD	Month 1
	Assign TAYS to PSC and FSP slots.	MCMHD	Month 1
	Begin providing PSC services.	PSC	Month 2

14. **Budget Requests**. Please see Exhibits 5a, Budget Worksheet and 5b, Staffing Detail Worksheet, together with Budget Narrative, following all Program Work Plans.
15. **Quarterly Progress Report**. Please see Exhibit 6 with estimated population service numbers following Exhibit 5.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County:	Fiscal Year:	Program Work Plan Name:
MENDOCINO	**05/06 – 07/08**	**ADULT SYSTEM OF CARE (ASOC) PROGRAM**
Program Work Plan # 4		Estimated Start Date: **1 MAY 2006**

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Adult System of Care (ASOC) will establish Full Service Partnerships to provide intensive services to three distinct population groups: homeless individuals in Willits (10-12 clients); clients in Ukiah and Willits who are referred by the clinics for chronic mental illnesses (10-12 clients); and clients who are or have been incarcerated (10-12 clients).
Priority Population: *Describe the situational characteristics of the priority population*	The Adult System of Care Program will serve homeless adults, incarcerated adults, and adults with chronic mental illnesses.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
a. North County Wraparound Services for 10-12 homeless individuals.	☒	☐	☐	☐	☐	☒	☐
b. Health Clinic-Based Full Service Partnerships for 10-12 clients with chronic mental and physical health issues in Ukiah and Willits.	☒	☐	☐	☐	☐	☒	☐
c. Forensic Mental Health Program for 10-12 mental health clients who are incarcerated or on supervised release.	☒	☐	☐	☐	☐	☒	☐
d. 7 beds at a Regional Crisis Residential Facility serving both Lake and Mendocino Counties (funded through MediCal reimbursement and One-Time Funds).	☒	☒	☐	☐	☒	☒	☒
e. Start-up costs for 4-bed Single Room Occupancy units with shared kitchen (funded through MHSA One-Time Funds).	☒	☒	☐	☐	☒	☒	☒

1. (EXHIBIT 4)
2. **Detailed Description**. The Adult System of Care (ASOC) will establish Full Service Partnerships to provide intensive services to three distinct population groups: homeless individuals in Willits (10-12 clients); clients in Ukiah and Willits who are referred by the clinics for chronic mental illnesses (10-12 clients); and clients who are or have been incarcerated (10-12 clients). The ASOC will also support 7 beds at a Crisis Residential Facility. Programmatic details for each strategy are described below:

    a. **North County Wraparound Services for homeless individuals.** Under the existing AB 2034 program, wraparound services are provided to 20 individuals in Ukiah and 10 in Fort Bragg. There is a need for similar services in North County communities, and this strategy will provide intensive personalized service coordination for 10-12 additional homeless clients in Willits. A 1.00 FTE Client Services Specialist (CSS) will provide case management, psycho-educational/support groups, linkage to other services, housing and employment referral and advocacy, and anything else needed by the client to improve his/her quality of life. This position will coordinate closely with partner agencies (including Willits Community Services and Little Lake Health Clinic) to identify individuals who qualify. This $50,000 position is funded by MHSA funds (50%) and MediCal reimbursement (50%).

    b. **Health Clinic-Based Full Service Partnerships for 10-12 clients in Ukiah and Willits with chronic mental and physical health issues.** MCMHD will establish a 1.00 FTE Client Services Specialist (CSS) position to be based at Mendocino Community Health Clinic in Ukiah and Little Lake Health Clinic in Willits. This position will provide intensive personalized services to 10-12 clients identified and referred by the health clinics. Services will include case management, linkage to other services, housing and employment referrals and advocacy, and anything else needed by the client to improve his/her quality of life. The CSS will work closely with MCMHD and clinic staff and other agencies to coordinate care. The CSS will divide his/her time between the two clinics depending on the caseload distribution between the two communities. Mendocino Community Health Clinic and Little Lake Health Clinic will provide office space for this MCMHD employee. MHSA funds will cover 56% of this $50,000 position, with the remainder recovered through MediCal reimbursement.

    c. **Forensic Mental Health Program.** MCMHD will establish a 1.00 FTE Forensic Mental Health Coordinator position (filled by a Mental Health Clinician) to provide Full Service Partnerships for 10-12 individuals who have been arrested and incarcerated in the County Jail. Participating individuals will be referred by the Probation Department (if they are participating in the supervised release program) or the jail psychiatrist (prior to their release from incarceration). The Forensic Mental Health Coordinator will provide intensive personalized services for these clients to

support them in managing their care to prevent recidivism. Services will include case management, linkage to other programs including CARE self-help networks, housing and employment referrals and advocacy, establishment or re-establishment of benefits, group counseling, dual diagnosis treatment, and anything else needed by the client to avoid future incarceration. The Forensic Mental Health Coordinator will coordinate care with staff from MCMHD, the Jail, the Court system, and the Departments of Social Services, Probation, and Public Health's Division of Alcohol and Other Drug Programs as a collaborative treatment team. Services for clients who are not in custody will be eligible for MediCal reimbursement; MHSA funding will cover costs that are not eligible for MediCal reimbursement. MCMHD anticipates that MHSA funds will be used for approximately half of this $60,000 position.

d. **Crisis Residential Facility.** Lake and Mendocino County Mental Health Departments have negotiated with Phoenix Programs, Inc. for the development of a 14-bed Regional Crisis Residential Facility that will be open to receive clients in early 2006, providing stays of up to 2 weeks with 24/7 supervision. Since the closure of Mendocino County's Psychiatric Health Facility in 2000, a crisis residential facility has been identified as an urgent need to prevent involuntary hospitalization. The facility is currently in escrow and will provide services for both Mendocino and Lake County, each county utilizing seven beds to provide an alternative to hospitalization for adults (age 18 to 59) experiencing acute psychiatric episodes with or without additional problems such as co-occurring disorders. The facility will be licensed as a Social Rehabilitation Facility by the State Department of Social Services and certified as a Crisis Residential Treatment Facility by the State Department of Mental Health. Phoenix will coordinate closely with the placing county to ensure smooth discharge planning for clients transitioning out of the facility. It is anticipated that this facility will be used by clients with Full Service Partnerships. Costs of the Crisis Residential Facility will be covered through MediCal reimbursement and MHSA One-Time Funds.

e. **Start-up costs for 4-bed Single Room Occupancy units.** MHSA One-Time funds will cover the costs of remodeling four Single Room Occupancy units and a shared kitchen; these rooms will be attached to the Crisis Residential Facility but have a separate entrance. Clients will rent directly from Phoenix, but MCMHD will be able to refer and place clients in these units. All four beds are for Mendocino County clients.

STRATEGIES INCLUDED IN LONG-TERM MHSA PLAN BUT NOT PROPOSED FOR MHSA FUNDING AT THIS TIME

Adult System of Care (ASOC). The need for coordination of adult services through a system of care was identified through the MHSA planning process. MCMHD has developed a strategy to initiate the ASOC without use of MHSA funds by working with existing multi-disciplinary teams that already convene around housing, homelessness, vocational services, etc. For the ASOC,

multi-disciplinary team meetings that include the clinic, substance abuse treatment providers, law enforcement, community-based organizations, etc., will be called as needed to manage specific cases. This strategy will be implemented utilizing existing staff and resources.

Develop partnerships with additional clinics to replicate the Health Clinic-Based Full Service Partnership model that will be piloted through Strategy B above.

3. **Housing and Employment**. Housing will be provided through the four Single Room Occupancy units attached to the Crisis Residential Facility. Although the Personal Services Coordinators will advocate for and refer to housing and employment services, no housing or employment services will be included as direct services in other strategies.
4. **Cost per FSP**. Full Service Partnerships for adults are expected to cost $2,305/Full Service Partnership by Year Three.
5. **Recovery and Resiliency**. The proposed Full Service Partnership strategies will advance recovery goals by involving clients as full participants in assessing their needs and strengths and planning services and linking them with the client-led strategies described in Work Plan #1. The focus on recovery will be continually promoted and reinforced through ongoing monitoring, client satisfaction surveys, and staff training. Evaluation will identify strengths and barriers related to implementation, while baseline data on individual and program outcomes will be collected for outcome evaluation.
6. **Program Expansion**. All of the proposed Full Service Partnership strategies represent an expansion of the Department's intensive services and Full Service Partnerships, although the services to incarcerated clients through the Forensic Mental Health Program (Strategy C) comprise a new venue for such services.
7. **Services Provided by Clients**. Clients will not be providing services but will be full participants in designing their treatment plans and will provide guidance and direction through client focus groups and satisfaction surveys.
8. **Collaboration Strategies**. Through the Adult System of Care, MCMHD partners with the justice system (County Jail, the Probation Department, and the Courts); Mendocino Community Health Clinic and Little Lake Clinic, Willits Community Services, the Departments of Social Services, Probation and Public Health's Division of Alcohol and Other Drug Programs, and other community-based organizations, including the Phoenix Program.
9. **Cultural and Linguistic Competency**. The proposed strategies address racial ethnic disparities described in Part II, Section II by providing services for the American Indian population, which is over-represented in the jail and in the homeless population. Cultural competency will also be ensured through annual participation of MCMHD and partner staff in cultural competency training.
10. **Sensitivity to gender issues**. MCMHD and partner staff will participate in annual training on sensitivity to sexual orientation and gender issues and on customizing services for clients with different sexual orientations. This priority will

also be addressed through non-discrimination policies, referral to specialized 12-step or other groups, and educational presentations. Staff will be trained to respect each client's frame of reference, be nonjudgmental and accepting of each client's cultural, behavioral, and value differences, and adjust strategies in accordance with client characteristics, including sexual orientation. These best-practice methods are critical when working with lesbian, gay, bisexual, and transgender (LGBT) clients.

11. **Individuals residing out-of-county**. Treatment providers will track and stay involved in treatment and discharge planning for all clients who are temporarily placed outside the county. To facilitate the return of those who are in out-of-county placements, appropriate staff will meet with the treatment team to plan and implement necessary preparations for the smooth transition back to the county.

12. **Unlisted strategies**. All of the adult strategies in this program are included in the MHSA listing.

13. **Timeline**.

STRATEGY	ACTIVITY	RESP	DATE
a. North County Wraparound Services	Recruit and hire CSS (consumer). In coordination with partners, enroll participants. Provide services.	MCMHD CSS/CSA	Month 2 Month 3 Month 3 Month 3
b. Health Clinic-Based Full Service Partnerships in Ukiah and Willits	Recruit and hire CSS. Establish on-site presence at clinics. In coordination with partners, enroll participants. Provide services.	MCMHD CSS/CSA CSS/CSA CSS/CSA	Month 2 Month 3 Month 3 Month 3
c. Forensic Mental Health Program	Recruit and hire Forensic Mental Health Coordinator. Establish service schedule. Establish parameters for treatment team. Begin providing services.	MCMHD Coordinator Coordinator Coordinator	Completed Month 1 Month 1 Month 1
d. 7 beds at a Regional Crisis Residential Facility	Finalize contract with Phoenix Program. Establish referral protocols and process. Begin providing services.	MCMHD MCMHD Phoenix	Completed Completed Month 1
e. Start-up costs for 4-bed Single Room Occupancy units	Finalize contract with Phoenix Program. Establish referral protocols and process. Complete remodeling of SRO units and kitchen. Housing available.	MCMHD MCMHD Phoenix Phoenix	Completed Month 3 Month 4 Month 4

14. **Budget Requests**. Please see Exhibits 5a, Budget Worksheet and 5b, Staffing Detail Worksheet, and Budget Narrative, following all Program Work Plans.

15. **Quarterly Progress Report**. Please see Exhibit 6 with estimated population service numbers following Exhibit 5.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County:	Fiscal Year:	Program Work Plan Name:
MENDOCINO	**05/06 – 07/08**	**OLDER ADULT SYSTEM OF CARE (OASOC)**
Program Work Plan # 5		Estimated Start Date: **1 MAY 2006**

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	Mendocino County's Older Adult System of Care (OASOC) was initiated through funds from The California Endowment's Mental Health Initiative in 2001. The program has successfully improved the mental health status of many frail, home-bound older adults but gaps exist in terms of the diversity of clients served and communities reached. The proposed expansion and enhancements to the OASOC will provide a seamless system of services to meet serious unmet mental health needs of older adults. OASOC's core staff and services will continue without additional MHSA funding.
Priority Population: *Describe the situational characteristics*	The OASOC serves mentally ill older adults who need access to mental health services, including older adults in the Hispanic and American Indian communities.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
a. Geriatric Assessment and Treatment to increase OASOC's therapeutic capacity and countywide reach through an additional 1.00 FTE Mental Health Clinician.	☒	☐	☐	☐	☐	☐	☒
b. Intensive Client-Driven Services that increase OASOC's capacity to develop and deliver client-driven services with an additional 1.00 FTE Personal Services Coordinator.	☒	☐	☐	☐	☐	☐	☒
c. Senior Peer Counseling Program expansion through the addition of 10 new senior peer counselors, focusing on recruiting seniors from targeted underserved geographic and cultural communities, including the Hispanic and American Indian communities.	☐	☐	☒	☐	☐	☐	☒
d. Outreach and Engagement to Reduce Ethnic Disparities by recruiting outreach workers at Nuestra Casa and Ukiah's Indian Senior Center.	☐	☐	☒	☐	☐	☐	☒

1. (EXHIBIT 4)
2. **Detailed Description**. The goal of the OASOC is to expand and enhance a multi-agency, multi-faceted system of care for mentally ill older adults throughout Mendocino County, with the vision of having recovery-focused specialized geriatric mental health services available and accessible. The OASOC establishes and nurtures collaborative and cooperative relationships between the public mental health and social services systems and community agencies working to serve older adults and their families. Rather than relying on clinic-based services, the OASOC brings services to mentally ill older adults where they live and spend their time—at home, in senior centers, etc. In keeping with MHSA goals, elements, and outcomes, the OASOC calls for maximum involvement and utilization of older adults in planning, evaluation, and outreach through the training and fielding of older adult peer counselors who may be consumers and also represent the county's culturally diverse communities. The OASOC builds individual, organizational, and community capacity through a planned program of education on geriatric mental health issues, managed by a full time coordinator with guidance from a Core Oversight Team comprising representatives from participating county agencies and non-profit organizations. The Core Oversight Team meets regularly to provide direct program governance and oversight, track program objectives, help plan staff trainings, and ensure continuous program improvement based upon analysis of program data and client surveys. Clinical services will be provided by mental health professionals and coordinated by personal support coordinators. Strategies incorporated in the OASOC expansion are detailed below:
    a. **Geriatric Mental Health Assessment and Treatment Capacity.** MHSA funds will be used to increase OASOC's treatment capacity and countywide reach by adding 1.00 FTE Mental Health Clinician to OASOC's existing 1.00 FTE Clinician, who is based on the coast. This new clinician will use Ukiah as a base to provide a schedule of services in outlying inland communities for a Full Service Partnership caseload of 25 clients, with the goal of reducing misdiagnosis and unnecessary institutionalization. The $68,000 annual cost of this position is offset by MediCal/MediCare reimbursement with a net cost to the MHSA budget of $28,000.
    b. **Intensive Client-Driven Services for Older Adults.** MHSA funding will be used to increase OASOC's capacity to develop and deliver client-driven services by adding 1.00 FTE Personal Services Coordinator to the OASOC's existing 1.00 Personal Services Coordinator who is based in Ukiah. This PSC will be based in Fort Bragg to facilitate comprehensive and integrated service provision to a Full Service Partnership caseload of 25 clients living in Mendocino County's coastal communities. Half of the $85,000 annual cost of this position will be charged to the MHSA budget, with the remainder covered by the Department of Social Services.
    c. **Senior Peer Counseling Program.** The OASOC will expand the county's senior peer counseling program and add a consumer peer counseling

component through the addition of 10 new senior peer counselors (although not all senior peer counselors will be consumers). Recruiting of consumers from targeted underserved geographic and cultural communities, including the Hispanic and American Indian communities, will be incorporated into this program. Through coordination with MHSA partners, this strategy will include training in the recovery model, client-directed self-help therapy, and cultural competency.

d. **Outreach and Engagement to Reduce Ethnic Disparities.** To reduce racial ethnic disparities in services for older adults, the OASOC will contract with the Nuestra Casa Family Resource Center to recruit and train a bilingual outreach worker. It is possible that this position will be filled by an AmeriCorps member at a cost of $8,000 to the MHSA budget. The OASOC will also contract with the Indian Senior Center in Ukiah to recruit and train a bilingual outreach worker for the American Indian community. The Department of Social Services will contract with professional clinicians to provide training and support for these positions and for caregivers in these communities. Nuestra Casa serves more than 3,000 people each year, and the Indian Senior Center provides services to 80 older adults on a daily basis. Mental health education on such topics as depression, anxiety, grief and loss, multigenerational family issues, isolation, etc., will be provided to these seniors, their families, and caregivers. Staff will be provided with in-service training on stress and burnout. The Outreach Workers will also provide advocacy, medication education including help in getting prescription refills, education on Medicare cards and rules, etc.

3. **Housing and Employment**. Neither housing nor employment services are included in the proposal.
4. **Cost per FSP**. Full Service Partnerships for older adults are expected to cost $1,410/Full Service Partnership by Year Three.
5. **Recovery and Resiliency**. The OASOC advances the MHSA goal of recovery through family involvement, peer counseling and support, and community education with the ultimate goal of assisting mentally ill older adults to achieve high quality of life as defined by the consumer in partnership with their natural relationships (family, community, etc.). The focus on recovery will be continually promoted and reinforced through ongoing monitoring, client satisfaction surveys, and psychiatric measures that may include the Sense of Well Being Survey, the Annotated Mini Mental Status Exam, the Geriatric Depression Scale, the Global Assessment of Functioning (GAF), and the Michigan Alcoholism Screening Test-Geriatric version (MAST-G). Evaluation will identify strengths and barriers related to implementation, while baseline data on individual and program outcomes will be collected for outcome evaluation. Specifically, the principles of recovery will be incorporated into all aspects of design through:

- Empowerment of senior peer counselors
- Instilling hope through home-based services that enhance the therapeutic environment and maximize choices for independent living
- Development of problem-solving skills and self-sufficiency through client-driven planning and self-directed care plans
- Client-driven treatment and service plan development

6. **Program Expansion**. As noted previously, the OASOC was established in 2001 with funding from The California Endowment, led by the County Department of Social Services. Since the three-year grant ended in 2004, the Department of Social Services has continued to provide mental health services to older adults in the original communities, although limited resources have reduced the extent of outreach and the number of older adults served. MHSA funding will be used to inaugurate OASOC services in coastal communities, ensuring equal opportunity for older adults throughout the county and increasing and expanding the number of seniors served in outlying communities and underserved racial ethnic groups.
7. **Services Provided by Clients**. In the outreach component, OASOC will recruit and train clients as senior peer counselors (although not all peer counselor will be consumers). Clients and their family members will also be involved in planning the content and style of community education, and will guide the outreach workers in implementation of culturally appropriate outreach strategies.
8. **Collaboration Strategies**. Led by the Department of Social Services, the OASOC is a collaborative body and process whose partners include the Departments of Mental Health and Public Health's Division of Alcohol and Other Drug Programs; Community Care; Nuestra Casa; the Ukiah, Willits, and Fort Bragg Senior Centers; the Ukiah Indian Senior Center; and community clinics throughout the county. As noted above, these partners meet regularly to provide oversight and guidance to the OASOC.
9. **Cultural and Linguistic Competency.** The proposed strategies address the racial ethnic disparities described in Part II, Section II by focusing outreach and engagement on the underserved Hispanic and American Indian communities, and by increasing access to services for older adults in the county's outlying communities. The full involvement of representatives of geographic and ethnic communities will assure that services are culturally specific to the needs of each community; cultural competency of OASOC services will also be ensured through annual participation of OASOC staff and peer counselors in cultural competency training.
10. **Sensitivity to gender issues**. OASOC staff and peer counselors will also participate in annual training on sensitivity to sexual orientation and gender issues. Outreach workers will be trained to implement outreach strategies that reach not only men and women but also individuals of all sexual orientations. OASOC staff will customize services for clients with various sexual orientations through staff training, non-discrimination policies, referral to specialized 12-step or other groups, and educational presentations to meetings of the Pride Alliance

Network. Staff will be trained to respect each client's frame of reference, be nonjudgmental and accepting of each client's cultural, behavioral, and value differences, and adjust strategies in accordance with client characteristics, including sexual orientation.

11. **Individuals residing out-of-county**. Service needs of individuals residing out-of-county will be addressed by the geriatric case managers and treatment providers who will track and stay involved in treatment and discharge planning for all clients who have been temporarily placed outside the county.

12. **Unlisted strategies**. All of the older adult strategies included in this proposal are included in the MHSA listing.

13. **Timeline**.

STRATEGY	ACTIVITY	RESP	DATE
a. Geriatric Assessment and Treatment	Recruit and hire MH Clinician.	MCDSS	Month 3
	In collaboration with partners, develop schedule for outlying communities.	Clinician	Month 4
	Begin providing assessment and treatment.	Clinician	Month 5
b. Intensive Client-Driven Treatment for Older Adults	Recruit and hire Personal Services Coordinator.	MCDSS	Month 3
	Develop schedule for outlying communities.	PSC	Month 4
	Coordinate services with partners.	PSC	On-going
c. Senior Peer Counseling Program	Establish priority communities.	MCDSS	Month 6
	Conduct targeted recruiting.	MCDSS	Month 8
	Begin 15-week training.	MCDSS	Month 9
	Peer counselors begin serving seniors.	Peers	Month 12
	Promote program in community.	MCDSS	On-going
	Provide on-going support and supervision.	MCDSS	On-going
	Provide recognition of peer services.	MCDSS	On-going
d. Outreach and Engagement to Reduce Ethnic Racial Disparities	Through Nuestra Casa, recruit AmeriCorps member as Hispanic outreach worker.	MCDSS	Month 4
	Provide training in peer support, etc.	MCDSS	Month 5
	Develop written outreach plan.	Outreach Worker	Month 6
	Promote program in community and with program partners.	Outreach Worker	Month 6
	Provide on-going support and supervision.	MCDSS	On-going
	Conduct outreach activities.	Outreach Worker	On-going
	Through the Indian Senior Center in Ukiah, recruit American Indian outreach worker.	MCDSS	Month 4
	Provide training in peer support, etc.	MCDSS	Month 5
	Develop written outreach plan.	Outreach Worker	Month 6
	Promote program in community and with program partners.	Outreach Worker	Month 6
	Provide on-going support and supervision.	MCDSS	On-going
	Conduct outreach activities.	Outreach Worker	On-going

14. **Budget Requests**. See Exhibits 5a, Budget Worksheet and 5b, Staffing Detail Worksheet, together with Budget Narrative, following all Program Work Plans.
15. **Quarterly Progress Report**. Please see Exhibit 6 with estimated population service numbers following Exhibit 5.

ONE-TIME FUNDING

The MHSA Guidelines provide counties with the opportunity to access One-Time Funds 1) to extend community program planning activities; 2) to build system improvements for programs and services proposed in the Plan; and 3) for capital purchases, training and education, and intensive outreach. Mendocino County will use MHSA One-Time funding to provide additional supports to the proposed programs and further buttress the mental health care system and MCMHD infrastructure as detailed below. The total One-Time Funding request is $447,600.

- **Family Respite Services ($30,000).** Details of this strategy are included in Work Plan # 2, the Children and Family Services Program. One-Time Funds will be used to match payments to respite providers.
- **Congregate Living Facility Start-up Costs ($27,600).** Details of this strategy are included in Work Plan # 3, the TAY Systems of Care Program.
- **Crisis Residential Facility ($50,000 for remodeling and $200,000 for services to non-MediCal clients).** Details of this strategy are included in Work Plan # 4, the Adult Systems of Care Program.
- **CARE Brochures, Flyers, and Self-Help Educational Materials ($15,000)** will be developed and/or purchased to promote the client-network and community Resource Centers (supports Work Plan #1).
- **Electronic System Integration and "No Wrong Door" through Electronic Charting ($125,000).** MCMHD will use One-Time Funds to purchase *Clinician Workstation*, a supplemental module to the Avatar Practice Management system that will create computer-based medical records. Using *Clinician Workstation* will make client assessments, client-directed care plans, progress notes, and medication logs accessible from any MCMHD office in the county while maintaining full confidentiality and HIPAA compliance. Clinical staff will have access to information without having to retrieve and refer to a paper chart. This is especially critical because MCMHD's three separate clinics, each of which currently maintain their own charts, are geographically dispersed. Information entered into the program will become available as soon as it is input without the risk of being misplaced or misfiled. Clinical supervisors and managers will have the ability to review cases more frequently and provide valuable clinical supervision. Clinician Workstation also allows for the capture of department-specific data that provides the statistical data necessary to plan future services and program revisions.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 1 | Date: 11/29/05

Program Workplan Name: Community Action for Recovery and Education | Page 1 of 1

Type of Funding: 2. System Development | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 425 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 425 | Telephone Number: 707 463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$13,790			$13,790
c. Employee Benefits	$3,022			$3,022
d. Total Personnel Expenditures	$16,812	$0	$0	$16,812
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$49,130			$49,130
6. Total Proposed Program Budget	**$65,942**	**$0**	**$0**	**$65,942**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue	$4,912			$4,912
e. Total New Revenue	$4,912	$0	$0	$4,912
3. Total Revenues	$4,912	$0	$0	$4,912
C. One-Time CSS Funding Expenditures				**$15,000**
D. Total Funding Requirements	**$61,030**	**$0**	**$0**	**$61,030**
E. Percent of Total Funding Requirements for Full Service Partnerships				**42.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 1 | Date: 11/29/05

Program Workplan Name: Community Action for Recovery and Education | Page 1 of 1

Type of Funding: 2. System Development | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 425 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 425 | Telephone Number: 707 463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Client Services Specialist-	*Client Empowerment Advocate*	1.00	1.00	$6,319	$6,319
Client Services Specialist-	*On-call Crisis Response*	6.54	6.54	$1,142	$7,471
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	7.54	7.54		$13,790
C. Total Program Positions		7.54	7.54		$13,790

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 1 | Date: 11/29/05

Program Workplan Name: Community Action for Recovery and Education | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 425 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 425 | Telephone Number: 707 463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$81,119			$81,119
c. Employee Benefits	$17,777			$17,777
d. Total Personnel Expenditures	$98,896	$0	$0	$98,896
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$289,000			$289,000
6. Total Proposed Program Budget	**$387,896**	**$0**	**$0**	**$387,896**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue	$28,896			$28,896
e. Total New Revenue	$28,896	$0	$0	$28,896
3. Total Revenues	$28,896	$0	$0	$28,896
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$359,000**	**$0**	**$0**	**$359,000**
E. Percent of Total Funding Requirements for Full Service Partnerships				**42.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan # 1 | Date: 11/29/05

Program Workplan Name Community Action for Recovery and Education | Page ____ of ____

Type of Funding 2. System Development | Months of Operation 12

Proposed Total Client Capacity of Program/Service: 425 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 425 | Telephone Number: 707 463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Client Services Specialist-	*Client Empowerment Advocate*	1.00	1.00	$37,170	$37,170
Client Services Specialist-	*On-call Crisis Response*	6.54	6.54	$6,720	$43,949
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	7.54	7.54		$81,119
C. Total Program Positions		7.54	7.54		$81,119

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 1 | Date: 11/29/05

Program Workplan Name: Community Action for Recovery and Education | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 425 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 425 | Telephone Number: 707 463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$81,119			$81,119
c. Employee Benefits	$17,777			$17,777
d. Total Personnel Expenditures	$98,896	$0	$0	$98,896
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$289,000			$289,000
6. Total Proposed Program Budget	**$387,896**	**$0**	**$0**	**$387,896**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue	$28,896			$28,896
e. Total New Revenue	$28,896	$0	$0	$28,896
3. Total Revenues	$28,896	$0	$0	$28,896
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$359,000**	**$0**	**$0**	**$359,000**
E. Percent of Total Funding Requirements for Full Service Partnerships				**42.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan # 1 | Date: 11/29/05

Program Workplan Name Community Action for Recovery and Education | Page ____ of ____

Type of Funding 2. System Development | Months of Operation 12

Proposed Total Client Capacity of Program/Service: 425 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 425 | Telephone Number: 707 463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries, Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Client Services Specialist-	*Client Empowerment Advocate*	1.00	1.00	$37,170	$37,170
Client Services Specialist-	*On-call Crisis Response*	6.54	6.54	$6,720	$43,949
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	7.54	7.54		$81,119
C. Total Program Positions		7.54	7.54		$81,119

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 2 | Date: 11/30/05

Program Workplan Name: Children and Families Services Program | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 120 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 120 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$8,384	$8,013		$16,397
c. Employee Benefits	$2,328	$2,834		$5,162
d. Total Personnel Expenditures	$10,711	$10,847	$0	$21,558
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures		$680		$680
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$680	$0	$680
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$21,250			$21,250
6. Total Proposed Program Budget	**$31,961**	**$11,527**	**$0**	**$43,488**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$3,571			$3,571
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds	$3,571			$3,571
d. Other Revenue				$0
e. Total New Revenue	$7,141	$8,637	$0	$7,141
3. Total Revenues	$7,141	$8,637	$0	$15,778
C. One-Time CSS Funding Expenditures				**$30,000**
D. Total Funding Requirements	**$24,820**	**$2,890**	**$0**	**$27,710**
E. Percent of Total Funding Requirements for Full Service Partnerships				**35.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 2 | Date: 11/30/05

Program Workplan Name: Children and Families Services Program | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 120 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 120 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
					$0
Clinician I/II	*Assessment and Therapy for Children Age 0-5*		1.00	$8,384	$8,384
Sr. Program Specialist	Respite Care Coordinator		1.00	$8,013	$8,013
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$16,397
C. Total Program Positions		0.00	2.00		$16,397

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 2 | Date: 11/30/05

Program Workplan Name: Children and Families Services Program | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 120 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 120 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$49,316	$47,136		$96,452
c. Employee Benefits	$13,692	$16,671		$30,363
d. Total Personnel Expenditures	$63,008	$63,807	$0	$126,815
3. Operating Expenditures				
a. Professional Services	$35,000			$35,000
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures		$4,000		$4,000
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$35,000	$4,000	$0	$39,000
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$90,000			$90,000
6. Total Proposed Program Budget	**$188,008**	**$67,807**	**$0**	**$255,815**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$21,004			$21,004
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds	$21,004			$21,004
d. Other Revenue		$50,807		$50,807
e. Total New Revenue	$42,008	$50,807	$0	$92,815
3. Total Revenues	$42,008	$50,807	$0	$92,815
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$146,000**	**$17,000**	**$0**	**$163,000**
E. Percent of Total Funding Requirements for Full Service Partnerships				**35.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 2 | Date: 11/30/05

Program Workplan Name: Children and Families Services Program | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 120 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 120 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
					$0
Clinician I/II	*Assessment and Therapy for Children Age 0-5*		1.00	$49,316	$49,316
Sr. Program Specialist	Respite Care Coordinator		1.00	$47,136	$47,136
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$96,452
C. Total Program Positions		0.00	2.00		$96,452

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 2 | Date: 11/30/04

Program Workplan Name: Children and Families Services Program | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 120 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 120 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$49,316	$47,136		$96,452
c. Employee Benefits	$13,692	$16,671		$30,363
d. Total Personnel Expenditures	$63,008	$63,807	$0	$126,815
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures		$4,000		$4,000
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$4,000	$0	$4,000
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$125,000			$125,000
6. Total Proposed Program Budget	**$188,008**	**$67,807**	**$0**	**$255,815**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$21,004			$21,004
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds	$21,004			$21,004
d. Other Revenue		$50,807		$50,807
e. Total New Revenue	$42,008	$50,807	$0	$92,815
3. Total Revenues	$42,008	$50,807	$0	$92,815
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$146,000**	**$17,000**	**$0**	**$163,000**
E. Percent of Total Funding Requirements for Full Service Partnerships				**35.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 2 | Date: 11/30/04

Program Workplan Name: Children and Families Services Program | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 120 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 120 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
					$0
Clinician I/II	*Assessment and Therapy for Children Age 0-5*		1.00	$49,316	$49,316
Sr. Program Specialist	Respite Care Coordinator		1.00	$47,136	$47,136
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$96,452
C. Total Program Positions		0.00	2.00		$96,452

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 3 | Date: 11/30/05

Program Workplan Name: Transitional Age Youth Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 260 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 8 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 252 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)	$3,672			$3,672
f. Total Support Expenditures	$3,672	$0	$0	$3,672
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)	$6,895			$6,895
b. New Additional Personnel Expenditures (from Staffing Detail)	$15,862			$15,862
c. Employee Benefits	$9,653			$9,653
d. Total Personnel Expenditures	$32,410	$0	$0	$32,410
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$13,688			$13,688
6. Total Proposed Program Budget	**$49,770**	**$0**	**$0**	**$49,770**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)	$8,010			$8,010
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$8,010	$0	$0	$8,010
2. New Revenues				
a. Medi-Cal (FFP only)	$5,241			$5,241
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue	$2,550			$2,550
e. Total New Revenue	$7,791	$0	$0	$7,791
3. Total Revenues	$15,801	$0	$0	$15,801
C. One-Time CSS Funding Expenditures				**$27,600**
D. Total Funding Requirements	**$33,969**	**$0**	**$0**	**$33,969**
E. Percent of Total Funding Requirements for Full Service Partnerships				**56.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 3 | Date: 11/30/05

Program Workplan Name: Transitional Age Youth Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 260 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 8 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 252 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
Clinical Services Associate	TAY Personal Services Coordination		1.00	$6,895	$6,895
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	1.00		$6,895
B. New Additional Positions					
					$0
					$0
Clinical Services Associate	*Personal Service Coordination to Congregate Liviing Facility*		0.50	$6,319	$3,159
					$0
Clinician I/II	Services to rural communities		1.00	$8,469	$8,469
					$0
Clinician I/II	Education Coach at College		0.50	$8,469	$4,234
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$15,862
C. Total Program Positions		0.00	3.00		$22,757

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 3 | Date: 11/30/05

Program Workplan Name: Transitional Age Youth Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 260 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 8 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 252 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)	$21,600			$21,600
f. Total Support Expenditures	$21,600	$0	$0	$21,600
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)	$40,560			$40,560
b. New Additional Personnel Expenditures (from Staffing Detail)	$93,309			$93,309
c. Employee Benefits	$56,780			$56,780
d. Total Personnel Expenditures	$190,649	$0	$0	$190,649
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$80,520			$80,520
6. Total Proposed Program Budget	**$292,769**	**$0**	**$0**	**$292,769**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)	$47,117			$47,117
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$47,117	$0	$0	$47,117
2. New Revenues				
a. Medi-Cal (FFP only)	$30,832			$30,832
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue	$15,000			$15,000
e. Total New Revenue	$45,832	$0	$0	$45,832
3. Total Revenues	$92,949	$0	$0	$92,949
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$199,820**	**$0**	**$0**	**$199,820**
E. Percent of Total Funding Requirements for Full Service Partnerships				**56.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 3 | Date: 11/30/05

Program Workplan Name: Transitional Age Youth Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 260 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 8 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 252 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
Clinical Services Associate	TAY Personal Services Coordination		1.00	$40,560	$40,560
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	1.00		$40,560
B. New Additional Positions					
					$0
					$0
Clinical Services Associate	*Personal Service Coordination to Congregate Liviing Facility*		0.50	$37,170	$18,585
					$0
Clinician I/II	Services to rural communities		1.00	$49,816	$49,816
					$0
Clinician I/II	Education Coach at College		0.50	$49,816	$24,908
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$93,309
C. Total Program Positions		0.00	3.00		$133,869

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 3 | Date: 11/30/05

Program Workplan Name: Transitional Age Youth Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 260 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 8 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 252 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)	$21,600			$21,600
f. Total Support Expenditures	$21,600	$0	$0	$21,600
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)	$40,560			$40,560
b. New Additional Personnel Expenditures (from Staffing Detail)	$93,309			$93,309
c. Employee Benefits	$56,780			$56,780
d. Total Personnel Expenditures	$190,649	$0	$0	$190,649
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$80,520			$80,520
6. Total Proposed Program Budget	**$292,769**	**$0**	**$0**	**$292,769**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)	$47,117			$47,117
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$47,117	$0	$0	$47,117
2. New Revenues				
a. Medi-Cal (FFP only)	$30,832			$30,832
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue	$15,000			$15,000
e. Total New Revenue	$45,832	$0	$0	$45,832
3. Total Revenues	$92,949	$0	$0	$92,949
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$199,820**	**$0**	**$0**	**$199,820**
E. Percent of Total Funding Requirements for Full Service Partnerships				**56.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 3 | Date: 11/30/05

Program Workplan Name: Transitional Age Youth Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 260 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 8 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 252 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
Clinical Services Associate	TAY Personal Services Coordination		1.00	$40,560	$40,560
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	1.00		$40,560
B. New Additional Positions					
					$0
					$0
Clinical Services Associate	*Personal Service Coordination to Congregate Liviing Facility*		0.50	$37,170	$18,585
					$0
Clinician I/II	Services to rural communities		1.00	$49,816	$49,816
					$0
Clinician I/II	Education Coach at College		0.50	$49,816	$24,908
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$93,309
C. Total Program Positions		0.00	3.00		$133,869

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 4 | Date: 11/29/05

Program Workplan Name: Adult Systems of Care | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 36 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 36 | Telephone Number: 707 463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$18,904			$18,904
c. Employee Benefits	$8,436			$8,436
d. Total Personnel Expenditures	$27,341	$0	$0	$27,341
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Total Proposed Program Budget	**$27,341**	**$0**	**$0**	**$27,341**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$13,231			$13,231
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$13,231	$0	$0	$13,231
3. Total Revenues	$13,231	$0	$0	$13,231
C. One-Time CSS Funding Expenditures				**$250,000**
D. Total Funding Requirements	**$14,110**	**$0**	**$0**	**$14,110**
E. Percent of Total Funding Requirements for Full Service Partnerships				

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 4 | Date: 11/29/05

Program Workplan Name: Adult Systems of Care | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 36 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 36 | Telephone Number: 707 463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Client Services Specialist	*FSP to Homeless Clients in North County*	1.00	1.00	$6,011	$6,011
Client Services Specialist	*Health Clinic Liaison*		1.00	$6,011	$6,011
Clinician I/II	Forensic Services Coordinator		1.00	$6,882	$6,882
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	1.00	3.00		$18,904
C. Total Program Positions		1.00	3.00		$18,904

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 4 | Date: 11/29/05

Program Workplan Name: Adult Systems of Care | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 36 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 36 | Telephone Number: 707 463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$111,202			$111,202
c. Employee Benefits	$49,625			$49,625
d. Total Personnel Expenditures	$160,827	$0	$0	$160,827
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Total Proposed Program Budget	**$160,827**	**$0**	**$0**	**$160,827**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$77,827			$77,827
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$77,827	$0	$0	$77,827
3. Total Revenues	$77,827	$0	$0	$77,827
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$83,000**	**$0**	**$0**	**$83,000**
E. Percent of Total Funding Requirements for Full Service Partnerships				

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 4 | Date: 11/29/05

Program Workplan Name: Adult Systems of Care | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 36 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 36 | Telephone Number: 707 463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Client Services Specialist	*FSP to Homeless Clients in North County*	1.00	1.00	$35,360	$35,360
Client Services Specialist	*Health Clinic Liaison*		1.00	$35,360	$35,360
Clinician I/II	Forensic Services Coordinator		1.00	$40,482	$40,482
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	1.00	3.00		$111,202
C. Total Program Positions		1.00	3.00		$111,202

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 4 | Date: 11/29/05

Program Workplan Name: Adult Systems of Care | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 36 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 36 | Telephone Number: 707 463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$111,202			$111,202
c. Employee Benefits	$49,625			$49,625
d. Total Personnel Expenditures	$160,827	$0	$0	$160,827
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Total Proposed Program Budget	**$160,827**	**$0**	**$0**	**$160,827**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$77,827			$77,827
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$77,827	$0	$0	$77,827
3. Total Revenues	$77,827	$0	$0	$77,827
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$83,000**	**$0**	**$0**	**$83,000**
E. Percent of Total Funding Requirements for Full Service Partnerships				

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 4 | Date: 11/29/05

Program Workplan Name: Adult Systems of Care | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 36 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 36 | Telephone Number: 707 463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Client Services Specialist	*FSP to Homeless Clients in North County*	1.00	1.00	$35,360	$35,360
Client Services Specialist	*Health Clinic Liaison*		1.00	$35,360	$35,360
Clinician I/II	Forensic Services Coordinator		1.00	$40,482	$40,482
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	1.00	3.00		$111,202
C. Total Program Positions		1.00	3.00		$111,202

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 5 | Date: 11/29/05

Program Workplan Name: Older Adults System of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 150 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 150 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$8,469	$10,321		$18,790
c. Employee Benefits	$3,133	$4,129		$7,262
d. Total Personnel Expenditures	$11,602	$14,450	$0	$26,052
3. Operating Expenditures				
a. Professional Services		$1,530		$1,530
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$1,530	$0	$1,530
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$2,210			$2,210
6. Total Proposed Program Budget	**$13,812**	**$15,980**	**$0**	**$29,792**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)	$6,842	$7,225		$14,067
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$6,842	$7,225	$0	$14,067
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$0
3. Total Revenues	$6,842	$7,225	$0	$14,067
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$6,970**	**$8,755**	**$0**	**$15,725**
E. Percent of Total Funding Requirements for Full Service Partnerships				**77.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2005-06

Program Workplan #: 5 | Date: 11/29/05

Program Workplan Name: Older Adult Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 2

Proposed Total Client Capacity of Program/Service: 150 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 150 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Clinician I/II	*FSP for Older Adults Inland*		1.00	$8,469	$8,469
Social Worker IV	*FSP for Older Adults Coast*		1.00	$10,321	$10,321
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$18,790
C. Total Program Positions		0.00	2.00		$18,790

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 5 | Date: 11/29/05

Program Workplan Name: Older Adults System of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 150 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 150 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$49,816	$60,714		$110,530
c. Employee Benefits	$18,431	$24,286		$42,717
d. Total Personnel Expenditures	$68,247	$85,000	$0	$153,247
3. Operating Expenditures				
a. Professional Services		$9,000		$9,000
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$9,000	$0	$9,000
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$13,000			$13,000
6. Total Proposed Program Budget	**$81,247**	**$94,000**	**$0**	**$175,247**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)	$40,247	$42,500		$82,747
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$40,247	$42,500	$0	$82,747
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$0
3. Total Revenues	$40,247	$42,500	$0	$82,747
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$41,000**	**$51,500**	**$0**	**$92,500**
E. Percent of Total Funding Requirements for Full Service Partnerships				**77.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2006-07

Program Workplan #: 5 | Date: 11/29/05

Program Workplan Name: Older Adult Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 150 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 150 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Clinician I/II	*FSP for Older Adults Inland*		1.00	$49,816	$49,816
Social Worker IV	*FSP for Older Adults Coast*		1.00	$60,714	$60,714
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$110,530
C. Total Program Positions		0.00	2.00		$110,530

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 5 | Date: 11/29/05

Program Workplan Name: Older Adults System of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 150 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 150 | Telephone Number: 707-463-4334

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$49,816	$60,714		$110,530
c. Employee Benefits	$18,431	$24,286		$42,717
d. Total Personnel Expenditures	$68,247	$85,000	$0	$153,247
3. Operating Expenditures				
a. Professional Services		$9,000		$9,000
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$9,000	$0	$9,000
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$13,000			$13,000
6. Total Proposed Program Budget	**$81,247**	**$94,000**	**$0**	**$175,247**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)		$42,500		$42,500
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$42,500	$0	$42,500
2. New Revenues				
a. Medi-Cal (FFP only)	$40,247			$40,247
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$40,247	$0	$0	$40,247
3. Total Revenues	$40,247	$42,500	$0	$82,747
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$41,000**	**$51,500**	**$0**	**$92,500**
E. Percent of Total Funding Requirements for Full Service Partnerships				**77.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Mendocino | Fiscal Year: 2007-08

Program Workplan #: 5 | Date: 11/29/05

Program Workplan Name: Older Adult Systems of Care | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 150 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Sandi Rizzo

Client Capacity of Program/Service Expanded through MHSA: 150 | Telephone Number: 707-463-4334

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
Clinician I/II	*FSP for Older Adults Inland*		1.00	$49,816	$49,816
Social Worker IV	*FSP for Older Adults Coast*		1.00	$60,714	$60,714
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	2.00		$110,530
C. Total Program Positions		0.00	2.00		$110,530

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5c--Mental Health Services Act Community Services and Supports Administration Budget Worksheet

County(ies): Mendocino Fiscal Year: 2005-06

Date: 11/30/05

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)			
b. MHSA Support Staff			
c. Other Personnel (list below)			
vi.			
vii.			
d. Total FTEs/Salaries	0.00	0.00	
e. Employee Benefits			
f. Total Personnel Expenditures			
2. Operating Expenditures			
a. Professional Services			
b. Travel and Transportation			
c. General Office Expenditures			
d. Rent, Utilities and Equipment			
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			
3. County Allocated Administration			
a. Countywide Administration (A-87)			$541
b. Other Administration (provide description in budget narrative)			$2,890
c. Total County Allocated Administration			$3,431
4. Total Proposed County Administration Budget			**$3,431**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			**$125,000**
D. Total County Administration Funding Requirements			**$128,431**

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and this administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2004-05 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief this administration budget and all related program budgets in all respects are true, correct, and in accordance with the law.

Date: _____ Signature _____

Local Mental Health Director

Executed at _____, California

EXHIBIT 5c--Mental Health Services Act Community Services and Supports Administration Budget Worksheet

County(ies): Mendocino Fiscal Year: 2006-07

Date: 11/30/05

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)			
b. MHSA Support Staff			
c. Other Personnel (list below)			
_____			
_____			
d. Total FTEs/Salaries	0.00		
e. Employee Benefits			
f. Total Personnel Expenditures			
2. Operating Expenditures			
a. Professional Services			
b. Travel and Transportation			
c. General Office Expenditures			
d. Rent, Utilities and Equipment			
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			$0
3. County Allocated Administration			
a. Countywide Administration (A-87)			$3,180
b. Other Administration (provide description in budget narrative)			$17,000
c. Total County Allocated Administration			$20,180
4. Total Proposed County Administration Budget			**$20,180**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			
D. Total County Administration Funding Requirements			**$20,180**

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and this administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2004-05 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief this administration budget and all related program budgets in all respects are true, correct, and in accordance with the law.

Date: _____ Signature _____

Local Mental Health Director

Executed at _____, California

EXHIBIT 5c--Mental Health Services Act Community Services and Supports Administration Budget Worksheet

County(ies): Mendocino Fiscal Year: 2007-08

Date: 11/30/05

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)			
b. MHSA Support Staff			
c. Other Personnel (list below)			
iv.			
v.			
vi.			
vii.			
d. Total FTEs/Salaries			
e. Employee Benefits			
f. Total Personnel Expenditures			
2. Operating Expenditures			
a. Professional Services			
b. Travel and Transportation			
c. General Office Expenditures			
d. Rent, Utilities and Equipment			
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			
3. County Allocated Administration			
a. Countywide Administration (A-87)			$3,180
b. Other Administration (provide description in budget narrative)			$17,000
c. Total County Allocated Administration			$20,180
4. Total Proposed County Administration Budget			**$20,180**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			
D. Total County Administration Funding Requirements			**$20,180**

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and this administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2004-05 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief this administration budget and all related program budgets in all respects are true, correct, and in accordance with the law.

Date: _____ Signature _____

Local Mental Health Director

Executed at _____, California

MHSA BUDGET NARRATIVES

Following please find a narrative that explains the budget for each Program Work Plan. Given our planned date of submittal and the three-month turn-around for approval, all program costs for FY 05-06 represent 2 months of service or 17% of the annual program cost. All one-time expenses have been included in the FY 05-06 budget.

Work Plan #1 – Community Action for Recovery and Education

Personnel Expenditures:

A consumer in the Clinical Services Associate job classification will fill the Client Empowerment Advocate function. We anticipate that this will be approximately a half-time assignment and seemed to be a natural fit to combine with our patients' rights advocacy function that also is no more than a half-time position. The County currently expends $27,000 for patients' rights advocacy and these funds will be put toward this position. Slightly less than half the cost is being requested from MHSA funds.

Expense		Funding	
Salary -	$37,170	$25,000 –	MHSA
Benefits -	$16,726	$28,896 –	Realignment
Total pay -	$53,896	$53,896	

We plan to use trained consumer peer counselors for the Mobile Crisis Response program. The County pays $2.50 per hour for an employee to be on-call. In order to have peer counselors available 5 PM – 8 AM, Monday–Friday and 24 hours on Saturday and Sunday, we will need to pay for 123 hours per week, 6,396 hours per year for full on-call coverage. Law enforcement anticipates that they will require the services of the on-call peer counselor twice per week (6 hours total). Therefore we budgeted 312 hours per year at $15.42/hr, the hourly rate for a Client Services Specialist. Finally, the budget includes 110 hours at $15.42/hr for training, making the total amount $22,496. We plan to implement this program in two geographically distinct communities so the amount requested is $45,000.

Contracted Services:
Mendocino County currently does not have a comprehensive client-based recovery and self-help network. We intend to request proposals from local non-profit organizations to implement a countywide recovery coach program with the goal of providing outreach to consumers and facilitating training and support for emerging client support groups. The budget estimate is built on the equivalent of 3 full-time recovery coaches, although we anticipate there will be many more coaches working part-time. The anticipated cost of this program is $183,000 per year. This contractor would also establish and use trained consumer volunteers to staff a 24-7 warm line ($16,000). Finally, we also plan to seek proposals for the development of up to 3 consumer-run resource centers. The proposal is based on rent and other operating costs plus 1 FTE whose time would be divided between the centers.

Work Plan #2 – Youth and Families Services Program

Personnel Expenditures:

For the 0-5 collaborative program with First Five, we are funding 1.0 FTE Clinician II

Expenditure		Revenue	
Salary:	$49,316	MHSA	$21,000
Benefits	$13,692	MediCal	$21,004
	$63,008	EPSDT	$21,004
			$63,008

We plan to fund a Respite Care Coordinator within our Department of Social Services at the Sr. Program Specialist level (1.0 FTE)

Expenditure		Revenue	
Salary:	$47,136	MHSA	$13,000
Benefits	$16,671	DSS	$50,807
	$63,807		$63,807

Operating Expenditures:

The budget includes $4,000 for general office supplies.

Contracted Services:

While no contract has been negotiated or awarded yet, the intent of this funding is to support a new therapist position at a Latino Service Agency ($45,000) and 0.5 of a Child Psychologist at a Native American Services Agency to increase access to mental health services.

In addition, we propose to contract with 5 new Parent Partners to serve our outlying communities. The estimated amount for the contracts is based on existing contracts. Parent Partners receive an hourly rate and are paid based on actual time up to $7,000 per year.

Work Plan #3 – Transitional Age Youth Systems of Care

Client Support Expenditures:

A flexible funding account available for the residents of the congregate living facility (4 @ $200/month) and other TAY FSPs 4 @ 250/month) to provide for "whatever it takes" to maintain recovery.

Personnel Expenditures:

For the Congregate Living Facility, we are funding 0.5 FTE Clinical Services Associate. The position will be able to draw down MediCal revenue.

Expenditure		Revenue	
Salary:	$18,585	MHSA	$16,000
Benefits	$ 6,876	MediCal	$ 9,461
	$25,461		$25,461

For the Rural Therapeutic Services, we are funding 1.0 FTE Clinician I/II

Expenditure		Revenue	
Salary:	$49,816	MHSA	$51,000
Benefits	$18,431	MediCal	$17,247
	$68,247		$68,247

For the College-based Services, we are funding 0.5 FTE Clinician I/II

Expenditure		Revenue	
Salary:	$24,908	MHSA	$15,000
Benefits	$ 9,216	MediCal	$ 4,124
	$34,124	DOR/College	$15,000
			$34,124

For the additional TAY FSP slots for non MediCal beneficiaries, we are funding 0.25 FTE Clinical Services Associate

Expenditure		Revenue	
Salary:	$10,140	MHSA	$15,700
Benefits	$ 5,560		
	$15,700		
			$34,124

Contracted Services:

We plan to seek proposals from local community-based organizations to operate a congregate living facility for 4 transitional age youth. The requested funding ($53,260) is based on estimated cost of operation. We will also seek a proposal to conduct a peer mentoring program targeting transition age youth and have allocated $27,260 for this program.

Work Plan #4 – Adult Systems of Care

Personnel Expenditures:

For the North County Wraparound Program, we are funding 1.0 FTE Client Services Specialist (consumer)

Expenditure		Revenue	
Salary:	$35,360	MHSA	$28,000
Benefits	$15,912	MediCal	$23,272
	$51,272		$51,272

For the Health Clinic-Based Program, we are funding 1.0 FTE Client Services Specialist

Expenditure		Revenue	
Salary:	$35,360	MHSA	$25,000
Benefits	$15,912	MediCal	$26,272
	$51,272		$51,272

For the Forensic Mental Health Program, we are funding 1.0 FTE Clinician I/II

Expenditure		Revenue	
Salary:	$40,482	MHSA	$30,000
Benefits	$17,801	MediCal	$28,283
	$58,283		$58,283

Work Plan #5 Older Adults System of Care

Personnel Expenditures:

For the OASOC Clinician (inland), we are funding 1.0 FTE Clinician I/II

Expenditure		Revenue	
Salary:	$49,816	MHSA	$28,000
Benefits	$18,431	MediCal	$40,247
	$68,247		$68,247

For the OASOC Personal Services Coordinator on the Coast, we are partnering with the Department of Social Service to fund 1.0 FTE Social Worker IV

Expenditure		Revenue	
Salary:	$60,714	MHSA	$42,500
Benefits	$24,286	Federal FFP	$42,500
	$85,000		$85,000

The Department of Social Services will also provide support for expanding the number of Senior Peer Counselors with these funds going for training and reimbursement of expenses for volunteers. - $ 9,000

Contracted Services:

While no contracts have been negotiated, the Mental Health Department intends to contract with a Latino Services Agency and a Native American Senior Services Agency for outreach and engagement services. $13,000 has been budgeted to support these efforts.

Administrative Budget Narrative

County Allocated Administration:

The MHSA regulations allow up to 15% for administrative overhead. Due to the need to expand and enhance services, Mendocino County is only asking for a 3% overhead for administration, with $3,130 going for Countywide administration and $17,000 for Departmental overhead related to the administration of MHSA (i.e. data entry, contract administration) and support for the new positions (i.e. office supplies, mileage reimbursement)

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 1**
Program Work Plan Name: **COMMUNITY ACTION FOR RECOVERY AND EDUCATION**
Fiscal Year: **05/06** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults	Seriously & chronically mentally ill adults							1		1	
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 1**
Program Work Plan Name: **COMMUNITY ACTION FOR RECOVERY AND EDUCATION**
Fiscal Year: **06/07** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth	TAY with serious and chronic mental illness							2		2	
Adults	Seriously & chronically mentally ill adults	5		5		5		5		20	
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #:1**
Program Work Plan Name: **COMMUNITY ACTION FOR RECOVERY AND EDUCATION**
Fiscal Year: **07/08** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth	TAY with serious and chronic mental illness							2		2	
Adults	Seriously & chronically mentally ill adults	5		5		5		5		20	
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 2**
Program Work Plan Name: **CHILDREN AND FAMILY SERVICES PROGRAM**
Fiscal Year: **05/06** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Children age 0-5							5		5	
Transition Age Youth											
Adults											
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 2**
Program Work Plan Name: **CHILDREN AND FAMILY SERVICES PROGRAM**
Fiscal Year: **06/07** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Children age 0-5	10		10		10		15		45	
Transition Age Youth											
Adults											
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 2**
Program Work Plan Name: **CHILDREN AND FAMILY SERVICES PROGRAM**
Fiscal Year: **07/08** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Children age 0-5	10		10		10		15		45	
Transition Age Youth											
Adults											
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 3**
Program Work Plan Name: **TRANSITION AGE YOUTH SYSTEM OF CARE**
Fiscal Year: **05/06** *(please complete one per fiscal year)*

	Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	Age Group	Description of Initial Populations	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
	Child/Youth											
	Transition Age Youth	TAY with serious and chronic mental illness							4		4	
	Adults											
	Older Adults											

	System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	Total Number to be served	Services/Strategies	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual

	Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	Total Number to be served	Services/Strategies	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 3**
Program Work Plan Name: **TRANSITION AGE YOUTH SYSTEM OF CARE**
Fiscal Year: **06/07** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth	TAY with serious and chronic mental illness	2		2		3		3		10	
Adults											
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 3**
Program Work Plan Name: **TRANSITION AGE YOUTH SYSTEM OF CARE**
Fiscal Year: **07/08** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth	TAY with serious and chronic mental illness	2		2		3		3		10	
Adults											
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 4**
Program Work Plan Name: **ADULT SYSTEM OF CARE**
Fiscal Year: **05/06** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	Description of Initial Populations	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Child/Youth											
Transition Age Youth											
Adults	Homeless, incarcerated or persons with co-occurring health problems							9		9	
Older Adults											

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	Services/Strategies	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	Services/Strategies	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 4**
Program Work Plan Name: **ADULT SYSTEM OF CARE**
Fiscal Year: **06/07** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults	Homeless, incarcerated or persons with co-occurring health problems	6		7		8		9		30	
Older Adults											

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 4**
Program Work Plan Name: **ADULT SYSTEM OF CARE**
Fiscal Year: **07/08** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults	Homeless, incarcerated or persons with co-occurring health problems	6		7		8		9		30	
Older Adults											

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 5**
Program Work Plan Name: **OLDER ADULT SYSTEM OF CARE**
Fiscal Year: **05/06** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults	Older adults with serious and chronic mental illness							10		10	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 5**
Program Work Plan Name: **OLDER ADULTS SYSTEM OF CARE**
Fiscal Year: **06/07** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults	Older adults with serious and chronic mental illness	10		10		15		15		50	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **MENDOCINO**
Program **WORK PLAN #: 5**
Program Work Plan Name: **OLDER ADULT SYSTEM OF CARE**
Fiscal Year: **07/08** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults	Older adults with serious mental illness	10		10		15		15		50	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

APPENDICES

A. MENTAL HEALTH RECOVERY COALITION SURVEY AND SUMMARY

B. MHSA PLANNING TEAM SURVEY AND SUMMARY

C. LOCALIZED LISTING OF MHSA ESSENTIAL ELEMENTS AND REQUIRED OUTCOMES

D. AGE GROUP PRIORITY LISTINGS

E. MHSA STEERING COMMITTEE ROSTER

F. DOCUMENTATION OF PUBLIC HEARING

G. LISTING OF PRIORITY ISSUES RAISED DURING EARLY PLANNING

H. LISTING OF DATA SOURCES

APPENDIX A

Mental Health Recovery Coalition Questionnaire
Mendocino County July 2005

TO: Clients, Family Members, County Employees, Medical Providers, Criminal Justice System Employees, City Employees, Friends and Others

This Questionnaire* is a means for you to provide input on how mental health resources are used in Mendocino County. The results will be compiled in August and presented to our Supervisors, John Ball, the new CEO, Jennie Vinyard, the Mental Health Services Act (MHSA) Coordinator, and the media.

The intent is to enrich the dialogue about client supports and services, and to augment the current MHSA process.

PLEASE COPY this Questionnaire and give it to people you know who are interested in having a voice and in making changes to the way mental health services are delivered in Mendocino County. Have people give the Questionnaire back to you to mail, or mail it directly ASAP to one of us below. Give us more ideas and your comments using the back of the questionnaire.

Sonya Nesch	Anne Retallick
P.O. Box 309	P.O. Box 537
Comptche, CA 95427	Ukiah, CA 95482
fax 937-5301	fax 462-5861

___Check here if you will be part of our Mental Health Recovery Coalition.

Please circle the group(s) that you identify with in the TO: list at the top of the page. (Family Members, County Employees, etc.)

(These are all optional)

Your Name _____email address_____

Address_____Phone No._____

** Thanks to the Service Employees International Union (SEIU), A Healing Cooperative, the Southeast Colorado Exemplary Rural Mental Health Services Delivery System, CA Mental Health Planning Council, CA Department of Mental Health, various medical providers, and to many others for good ideas about client support and services.*

Mental Health Recovery Coalition Questionnaire 2005

There are 6 categories with a number of items below each. Please rate each item 1 through 5.

1 = Essential
2 = Important
3 = Helpful
4 = Not helpful
5 = Not sure

24/7 Pre-Crisis/Crisis Care and Alternatives to Hospitalization

___ Crisis Hostel with no threshold of symptoms for use

___ Consumer Hostel staffed by professionals and Peer Specialists where people can go any time of day or night for support without having to reach a predetermined threshold of dangerousness or distress. The Peer Specialists work under a consumer Director of Advocacy and also help isolated consumers develop social networks.

___ Mobile Crisis Response Team with cross training of mental health and law enforcement officers

___ Crisis Phone Line countywide with a centralized phone system

Medical Care with Options for Complementary Practitioners

___ Medical Case Managers with Public Health Nurses who work for the Department of Public Health but are based at Department of Mental Health offices

___ Training and on-going seminars by our best local public and private psychiatrists for local medical providers on topics such as "Psychiatry in Primary Care" and "Meeting the Healthcare Needs of People with Mental Illness". Other medical providers already treat more than half of people who suffer from mental illness.

___ Mobile Service Unit to travel to outlying areas to do medication management, medical case management, referrals for general medical care, case management/ personal service coordination, outreach, and groups. The team can include medical providers, case manager/personal services coordinator, human service worker.

___Access to complementary practitioners for clients who choose to augment their medical treatment

Peer Support Networks Countywide

___ Drop In Centers with classes, recreation, and more

___ Self Help Support Groups

___ Peer Counseling

___ Wellness Recovery Plans for health, home, friends, family, job, etc. to improve client quality of life

___ Warm Phone Line countywide with a centralized phone system

Co-Occurring Mental Illness and Substance Use Disorder

___ Integrated and Unified Treatment Programs and Housing for people -- 1 team, 1 plan for 1 person

___ *Double Trouble in Recovery* 12-step group run completely by those who are dually diagnosed

___ Acudetox option to eliminate craving

Criminal Justice System

___ Adequate psychiatric medical treatment, crisis care and recovery support (case management, 12 step, etc.) for people with mental illness in our jail and Juvenile Detention Center

___ Alternatives to jail and Juvenile Detention Center when possible with support to help people avoid future encounters with the criminal justice system

___ Mental Health Court, support and services for those with criminal justice charges

Other

___ Supported Housing--Congregate, Transitional Residential Care, Board and Care, Independent Scattered Site, etc.

___ Supported Education with reasonable accommodation

___ Supported Jobs and Job Training Options

___ Field Case Managers/Personal Service Coordinators who are available 24/7 to consumers, family members, law enforcement or landlords to reduce incidents of hospitalization, incarceration and/or eviction

___ Home Health Care Aides supervised by a mental health worker

___ Community Education and Prevention Forums that are well publicized, countywide, and in collaboration with client groups, NAMI, medical providers, DMH, DPH, DSS, criminal justice system people, counselors, complementary practitioners, etc.

___ Children should have the support and services needed to live with their families and attend local schools, including family education support services

---

Please Add Your Ideas/Comments Here (use the back too)

Thank you for taking the time to fill out this questionnaire

Mental Health Recovery Coalition
P.O. Box 309
Comptche, CA 95427
462-5861 and 937-3339

October 10, 2005

Supervisors
John Ball, CEO
Beth Robey
Jenny Vineyard
Mendocino County
501 Low Gap Road
Ukiah, CA 95482

Dear Supervisors, John, Beth and Jenny:

The Mental Health Recovery Coalition Questionnaire was developed in response to requests from many Mendocino County residents as a method to augment community input regarding mental health needs. We are pleased that 141 people responded to the Questionnaire and that most of these people have firsthand experience of our mental health system. Many of them wrote thoughtful comments for you to consider. The Questionnaire results, narrative and comments of 58 respondents are attached. We are both available to you if you have any questions.

We agree with Dr. Stephen Mayberg, Director of California DMH that the goal of MHSA is to "transform the mental health system" and to build it "around the needs of consumers and families." He further says "How do we start a new system when the old system is falling apart?" The intent of the California DMH is for MHSA money to be available for everyone who needs it, regardless of legal status, voluntary or involuntary. "If you are a person who needs that level of mental health services, you qualify for the service," he says." You should get the services and the Act should pay for those services." There can even be involuntary outpatient treatment, he said, but MHSA money cannot be used for administration of the program. If individuals are diverted from jails or hospitals, money has to be freed up from those programs to develop the administration of an outpatient treatment module.

As family members and advocates for both clients and family members, we believe that everyone with a serious mental illness has the potential to stabilize and often recover with the right combination of support and services. We look forward to a future in Mendocino County where people with severe mental illness are met with the services, compassion and support they deserve to help in their recovery.

Respectfully,

Sonya Nesch MS, MA
Anne Retallick MSN, FNP

Mental Health Recovery Coalition Questionnaire
Mendocino County July 2005

TO: Clients, Family Members, County Employees, Medical Providers, Criminal Justice System Employees, City Employees, Friends and Others

1-Essential 2-Important 3-Helpful 4-Not helpful 5-Not sure
Mark the ideas with 1 through 5.

RANK ORDER OF SUPPORT
N=141

%	No.	
95.7%	135	Adequate psychiatric medical treatment, crisis care and recovery support (case management, 12 step, etc.) for people with mental illness in our jail and Juvenile Detention Center
94.3%	133	Children should have the support and services needed to live with their families and attend local schools, including family education support services
92.2%	130	Alternatives to Jail and Juvenile Detention Center when possible with support to help people avoid future encounters with the criminal justice system.
92.2%	130	Training and on-going seminars by our best local public and private psychiatrists for local medical providers on topics such as "Psychiatry in Primary Care" and "Meeting the Healthcare Needs of People with Mental Illness". *Other medical providers already treat more than half of people who suffer from mental illness.*
92.2%	130	Mobile Service Unit to travel to outlying areas to do medication management, medical case management, referrals for general medical care, case management/ personal service coordination, outreach, and groups. The team can include medical providers, case manager/personal services coordinator, human service worker
92.9%	131	Consumer Hostel staffed by professionals and Peer Specialists where people can go any time of day or night for support without having to reach a predetermined threshold of dangerousness or distress. The Peer Specialists work under a consumer Director of Advocacy and also help isolated consumers develop social networks.
90.8%	128	Mobile Crisis Response Team with cross training of mental health and law enforcement officers
90%	127	Supported Housing--Congregate, Transitional Residential Care, Board and Care, Independent Scattered Site, etc.
90%	127	Supported Jobs and Job Training Options
90%	127	Integrated and Unified Treatment Programs and Housing for people --1 team, 1 plan for 1 person
90%	127	Crisis Phone Line countywide with a centralized phone system
89.4%	126	Wellness Recovery Plans for health, home, friends, family, job, etc. to improve client quality of life
89.4%	126	Drop In Centers with classes, recreation, and more
87.2%	123	Self Help Support Groups
87.2%	123	Peer Counseling
87.2%	123	Supported Education with reasonable accommodation

87.2%	123	Field Case Managers/Personal Service Coordinators who are available 24/7 to consumers, family members, law enforcement or landlords to reduce incidents of hospitalization, incarceration and/or eviction
85.8%	121	Community Education and Prevention Forums that are well publicized countywide, and in collaboration with client groups, NAMI, medical providers, DMH, DPH, DSS, criminal justice system people, counselors, complementary practitioners, etc.
83%	117	Mental Health Court, support and services for those with criminal justice charges
79.4%	112	Home Health Care Aides supervised by a mental health worker
78.7%	111	Warm Phone Line countywide with a centralized phone system
78%	110	Crisis Hostel with no threshold of symptoms for its use
78%	110	Medical Case Managers with Public Health Nurses who work for the Department of Public Health but are based at Department of Mental Health offices
78%	110	*Double Trouble in Recovery* 12-step group run completely by those who are dually diagnosed
76.6%	108	Access to complementary practitioners for clients who choose to augment their medical treatment
62.4%	88	Acudetox option to eliminate craving for drugs and alcohol

There were 141 respondents to this Questionnaire:

52 Medical Providers 36.9%
23 Family 16.3%
20 County Employees 14.2%
18 Friends/Others 12.8%
15 Clients 10.6%
13 Criminal Justice System Employees 9.2%

There are extensive thoughtful comments from 58 people that follow this narrative.

Jail Medical Care

Two of the top three highest ranked services are concerned with jail psychiatric medical treatment. 95.7% of the people want better psychiatric medical treatment at the jail and 92.2% want alternatives to the Jail and Juvenile Detention Center when possible. People at the jail also want this as expressed in the recent Mental Health Board Report (June 2005). In this report, Dr. Rosoff estimates that about one third (88 people or more) of inmates are on psychotropic medication. Dr. Rosoff says we need an in-patient care facility, another nurse at the jail, case management, discharge planning, and a dedicated area within the jail to provide specialized mental health care. Currently, people who are psychotic or suicidal are kept in safety cells, isolation cells, and lockdown cells. Captain Tim Pearce says the jail needs another nurse on site to deliver medications and to have a nurse on the weekend. He also says a PHF Unit is desperately needed and the Bridge Program (case management, help with housing, etc.). Leila Lamun, R.N. at the jail wants another nurse, a secretary and the Bridge Program. She sees from 20 to 50 people/day. When she first started at the jail, she was seeing about 10 people/day and could spend 45 minutes or so with them. As of March 2004 when jail psychiatric care was cut in half, there has been another suicide, a woman gouged her eye out, another inmate self-mutilated their genitals, and psychotic and suicidal inmates can be kept in isolation cells for months. These

are people who need hospitalization. Some inmates have to wait 6 to 8 months to be moved to Napa State Hospital. Also eliminated is the Conditional Release Outpatient Program which provided strong case management support for people in transition from State Hospital/Prison to the community.

Children

The second highest ranked response was for children to get the support and services they need in order to live with their family and attend local schools. Children facing mental illness need early intervention by a psychiatrist or primary care physician. In some cases, medication support under a psychiatrist or primary care physician may help prevent the multiple failures so many children with mental illness face. Outreach, training and support for their families is essential.

Training for Local Medical Providers

Ranked fourth in importance was Training and On-Going Seminars by our best local public and private psychiatrists for local medical providers on topics such as "Psychiatry in Primary Care" and "Meeting the Healthcare Needs of People with Mental Illness". Many primary care medical providers (MDs, FNPs, PAs) already provide more than half the care for people who suffer from mental illness. Mark Kline M.D. and John Garrett M.D. are both interested in providing this training. Counselors and Therapists have also expressed an interest in and need for this training.

Mobile Service Unit

Ranked fifth was a Mobile Service Unit available for South Coast, Anderson Valley, Laytonville, etc. with a medical provider, case manager, human service worker. It would be helpful to add a medical case manager from DPH to assess and help manage the diabetes, high blood pressure, respiratory ailments, and other medical problems faced by clients.

Crisis Care

Adequate Crisis Care is high on everyone's list. The respondents expressed a critical need for a 24/7 site for people who are psychotic/suicidal/ relapsing to obtain help before becoming a danger to self or others. A Mobile Crisis Response Team with cross training of mental health and law enforcement officers was identified as important. Many respondents identified a need for a local inpatient psychiatric unit. All Criminal Justice System Employees who commented asked for more 24/7 Crisis Care. In addition, 17 of the 27 medical providers who wrote in comments identified this need.

Peer/Consumer/Client Support Services

There was extensive support for a Consumer Hostel. This would include Peer Specialists working under a Consumer Director of Advocacy. In addition the following support and services were identified as important: Supported Housing of all kinds, Supported Jobs and Job Training, Wellness Recovery Plans, Drop In Centers, Self Help Groups, Peer Counseling, Supported Education, Home Health Care Aides supervised by a Mental Health Worker, a Warm Line, and Integrated Dual Diagnosis Programs with housing and 12 step groups.

Mental Health Recovery Coalition Questionnaire Comments

MEDICAL PROVIDER COMMENTS

We truly need a 24/7 365 day Crisis Center that can evaluate and treat psychiatric emergencies. The ER doesn't cut it.

We need an inpatient psychiatric unit so people are NOT hospitalized out of the county away from their families, or are put in jail.

We need inpatient psychiatric care in Mendocino County to serve more than just the involuntary acute cases. We need voluntary beds to prevent need for 5150. Willits Hospital would be an ideal location. We need 24/7 psychiatric on-call coverage for crises!! available to MD's, and other mental health professionals including MCMH staff!

We need a Crisis Unit 24/7.

Need Crisis Triage Center and Inpatient Unit in Mendocino County. need alternative treatment unit with higher level of care than social worker and crisis worker. Also need safe supportive place to de-stress, diffuse crisis and triage to next step for care (peer support, family support, medication adjustment, admit to crisis residential, admit to hospital). Need more active recovered clients to do Peer Counseling. Need Respite Housing.

Concentrate on the most effective prevention based model to avoid 5l50's and placements -- thereby saving money that could be used elsewhere

Nurse/MH Case Management of top 20 users/high money maintenance clients. THINK UPSTREAM

Reviving the 23 hour crisis unit would make a dramatic difference

We need a 23 hour crisis unit

A 23 hour crisis center to hold patients who will need inpatient psychiatric care is essential as the emergency department at UVMC does not have the capacity/manpower to staff this function and remain a viable, effective emergency care center.

We really need inpatient services and a way to get our patients seen by a psychiatrist.

The county needs a short-term psychiatric facility again. Especially because so many folks end up housed at the jail.

The few dollars we have need to be spent on the most vital services. In my opinion the greatest need is an in-County locked psychiatric facility that can work with outpatient personnel to provide better and more humane care to the seriously/chronically mentally ill.

We urgently need appropriate crisis care: 1. What's going on in the jail is unconscionable. 2. Strapping people down on a gurney in ER while a weirdo stares at them for hours and hours and hours, is anti-therapeutic, even medieval. Couldn't they at least have a bed?

We have a desperate need for a 24-hour crisis unit and for mental health workers to do outreach at Plowshares, etc.

Basic essentials: 1. Health Insurance (MediCal, etc.) to cover cost of long-term therapy (i.e., CMSP for mental health services). 2. Adequate Staffing - enough clinicians to provide

therapeutic services (without long waiting lists and ridiculous caseloads and low salaries). 3. Inpatient Services in county.

A Day Treatment Program for people with chronic problems. Not use Cognitive Behavioral Therapy Program. Need Special Vocational Rehabilitation Program.

Training and on-going seminars by our best local public and private psychiatrist for local medical providers and include mental health practitioners/counselors!

County needs a secure lock-up for mental health clients with acute symptoms. The hospital is unsafe - no protection if violence erupts. The jail as it now exists may be too threatening. However, they have the strength to protect client and staff! Could there be a mental health area at the jail to hold clients until a plan is arranged?

Sheltered employment needed.

We do not have a strong enough (large) population of long recovering dual diagnosed folks in our 12-step communities in this county.

Need sheltered jobshop where mental health clients can meet/work for community projects (sandwich making for soup kitchen, playing music with/for k-3 kids in schools under supervision.

Offer CEUs for the Community Education and Prevention Forums.

Any support system that networks law, medical, CDP programs, mental health, schools and families that work together to establish the well-being of families and communities are important and essential in raising the overall health of our county. How do we track people?

Housing and daily outpatient counseling are at the top of my list.

Day Treatment Programs throughout the county for people with Schizophrenia and Schizoaffective Disorder, even if for just a few hours a day, several times a week.

There needs to be a program that talks with parents about Mental Illness as it relates to bonding between parent and child.

CRIMINAL JUSTICE SYSTEM EMPLOYEE COMMENTS

Most important from the DAs perspective are Crisis Care, Dual Diagnosis Treatment and Law Enforcement/Jail Support and alternatives to incarceration

Need Crisis Workers who do not rescind every Law Enforcement 5150 and release subjects back into community without treatment.

We need a local PHF Unit or staff who will make transport to a PHF facility a priority. Transport to a PHF Facility should not be seen as a burden. Quit letting people who are 5150'd by Law Enforcement go instead of detaining them for 72 hour hold. Current staff more frequently than not, release victims who end up right back in situations that often lead to incarceration instead of help.

There needs to be adequate Care Providers and Crisis Workers who are qualified by training, school, and experience to appropriately treat the person who needs help. I do not feel that all Care Providers/Crisis Workers currently fill their positions and are a benefit to the persons that they are serving.

Mobile Crisis Response Teams with cross training of mental health and law enforcement officers must be countywide. Clients need assistance with making appointments and being prepared to present all that the appointment requires (e.g., Social Security Administration to appeal SSI decisions, housing appointments, appointments at DSS or with the Court).

It is my opinion that too many patients are left by themselves in living situations and follow-up is not conducted in an effective manner. There needs to be more intervention in regard to substance abuse, including marijuana, Marijuana is still illegal in the United States, contrary to what the Sheriff or District Attorney may suggest. There needs to be more adequate supervision of Care Providers and Crisis Workers. Patients cannot be treated appropriately by individuals who should be deemed patients themselves.

NOTE: The following italicized comments were made by one person but the author's paragraphs were left in for easier reading.
I believe that everyone (Sheriff's, Police, and Hospital staff) would all agree that something needs to be improved in the mental health services that are offered in the Fort Bragg area and surrounding areas.

I have personally sat with people/victims inside the hospital who were in need of mental health services and had mental health workers refuse to aid the individual because they believe that they are only acting in an abnormal fashion because they are "coming down off of drugs." Just because someone is coming off of a high from drugs is not an acceptable excuse for the Crisis Worker's behavior. What would it take for the person to be "5150'd"? Would it take them to harm themselves or others and be arrested when Mental Health could have intervened and assisted in finding somewhere for the patient to go for help? As the law stands, we as law enforcement officers cannot make an arrest of someone due to the fact that they are coming down off of drugs. If they are not actively under the influence of a controlled substance then they are not breaking the law. We as law enforcement officers continually come across individuals who are angry/hostile because they are coming off of a drug binge and we have no resources available to get these hostile people off of the street.

I have actually walked outside of a hospital room and overheard the patient ask the Mental Health Worker how he/she could not go to Saint Helena Mental Facility, and heard the Mental Health Worker reply by telling the patient that they would need to stop pretending that they were mentally ill. The Mental Health Worker actually told the patient that they would need to calm down with the police around and stop talking nonsense.

I have had a Mental Health Worker tell me that because the person is not suicidal and does not have the capability to harm others, that the patient does not meet the criteria for a 72 hour detention for mental evaluation hold. This leaves the officers in a predicament. It would be nice to have a place that accepted people who need help mentally but do not meet the Mental Health's "criteria" for 5150.

We are in dire need of mental health workers who take their job seriously with the intention of helping the mental health victims.

Remember that in order to detain someone on a 72 hour detention for evaluation that the person only needs to be Gravely Disabled. A Gravely Disabled person includes a person that is mentally ill and unable to take care of themselves. Respectfully submitted

COUNTY EMPLOYEE COMMENTS

The feedback that I get from clients in our offices indicates hesitancy to use mental health office services for the following reasons: 1. Reception at their office not responsive to their needs (communication levels not good). 2. Unavailability of qualified staff to make a proper assessment of the client's needs in a timely manner. 3. Feeling prevalent that they are not being heard or helped.

Would be nice to see more support for medication monitoring for those MH patients who end up in jail especially for doing street drugs to self medicate. Must be a weird reality to be around hardened criminals in a strange mental state.

"Home health care aides supervised by mental health worker" might be a good idea if "mental health worker" was more specific: the person supervising needs to have training in both mental health and in supervision. The needs that I see that most need addressing are medical/mental health treatment for incarcerated persons and youths and alternatives to incarceration, and also supportive housing.

Need more services directed to parents with mental health issues that affect parenting.

Refer for inpatient treatment (diagnosis). Without the correct diagnosis, recovery and treatment cannot be determined. The Mobile Crisis Response Team is a great idea. When disaster happens (fire, abuse, etc.), having someone there is a great help to those in need. The person does not need to be from mental health. A community volunteer can talk to and help guide the person.

Any groups, facilities etc. need to be manned by professionals equipped to deal with those individuals with mental

health issues. Medication should be a last resort after other interventions. Make MH services available, but not enforced.

FAMILY COMMENTS

A society that does nothing to help people with mental illness find ways to stay out of jail will pay huge social costs beyond dollar cost to governments and community services.

The number 1 need is for 24/7 Crisis Care with beds and doctors/nurses who can provide medical treatment to stop a relapse and try to avoid hospitalization. We need a local inpatient psychiatric unit. People in crisis who are in the Juvenile Detention Center or Jail must also have access to this or similar crisis care.

Please consider seriously these clients supports and services. It is a nightmare to try to help an ill loved one without them.

Why does our MH Department make a person reach a life or death situation before they can be hospitalized and then placed in long-term hospitalization? There were no steps taken to prevent our family member from reaching such a hopeless level of life. The entire mental health issue is upside down with only a fraction of people being cared for and this is in large part due to families that care. Clients without family support appear to be fair game for a life of 5150, jail, and self-destruction. We are very lucky our family member is still alive and receiving help.

Resource clearinghouse where all existing programs and services can be easily accessed by anyone. I still think we need to audit the DMH's annual budget to see how they are

(mis)spending money. In presenting this, the BOS, CEO, etc. need to know what the DMH does not provide, even on their considerable budget.

Much of this county is not served at all by Mental Health.

Supported Housing - home for several clients with a case worker that will check in and help with medication compliance, substance abuse compliance and livability issues (food, clean clothes etc.). Peer Support and Social Activities (things to do that don't involve drugs).

There should be more focus on the group housing issue, more peer counseling and group therapy.

Friendly non-invasive Supported Housing -- Homes that 3 or more clients could live in with a case worker that visits every morning and night. The case worker would 1. Administer medication. 2. Monitor food availability. 3. Question clients re: how they're feeling (sleep, dreams, positive symptoms), appointments, work schedule, diet, concerns or problems. 4. Check for compliance with no alcohol/substances as well as require random drug testing to help clients remain alcohol and substance free. 5. Inform residents of activity options for the day/night. *Master/Individual Calendars* - an inter/intra coordinated master calendar for MCMH appointments, classes (daily living, expression, skill building), community events, Mendocino College, and client generated ideas. *Peer Support and Social Activities* - with a goal of staying well, esteemed, focused, wanted and valued. *Library* - books, movies, clothes, household items, things clients say they need.

I see a division of skills and body of information between Psychiatry on one hand and therapy/counseling on the other. I think information from cutting edge therapy developments in PTSS, communications skills, cognitive behavior approaches to issues etc. would be very helpful for day to day.

FRIEND COMMENTS

Please consider all co-occurring disorders (developmental disabilities, etc.) in all phases of services and supports.

I have felt, for over 15 years that Mendocino Co. has one of the worst Mental Health Agencies around. I had a lot of hope when Kristi Kelley was hired and not because of her, but now, things are worse than ever. I can't believe this County can't figure something out for a population who needs us so much!

It is absolutely imperative that we provide services to the rural areas of the County. We need folks who can assist families when there is a meltdown and get help to them fast.

Need transportation for clients to get to services. Need a buddy (sponsor) for 1 on 1 contact 24/7.

CLIENT COMMENTS

Mental health support in school and education system (i.e., university, state, private). Supportive and educated counselors with prior experience with mental illness and the traits to help in making decisions in school and to support kids with some of the tougher issues in classes. Peer counseling.

For me personally, I am interested in Peer Support Groups but think the most help I need is in better insurance/less co-payments etc.

I think the Red House should be open from 9 AM to 8 PM 7 days per week. The Hospitality House is run improperly and a person needs to be able to lock the door to his/her room. I was robbed while sleeping there. Safe shelter is needed. Hire someone to come in once a week to thoroughly clean the Red House. County can afford that!!!

Need a 24 hour/7 day a week Drop In, like the Ukiah Crisis Center used to be where I spent 4 nights and 5 days. Mental health problems and drug use problems should be reclassified as medical problems and people should get medical treatment. Right now we have a Mental Health emergency in our nation. Thousands of people are being jailed, suicides, accidents, killings by family members and by the police. One million users of mental health with drug problems that can be addressed by this New Arm of Mental Health, just put these ideas to the test. In other words, let's remake the laws, and attitudes of old, for a brave new world of tomorrow. Open up the prisons, 1 million prisoners released on drug charges and 1 million openings for the real criminals, psychopaths and the like, real criminals.

APPENDIX B

MHSA PLANNING TEAM SURVEY

Thanks to Proposition 63, the Mental Health Services Act, we have the opportunity to enhance and improve mental health services in Mendocino County. Please take a few minutes to complete this survey and mail it back in the envelope provided. YOUR VOICE MATTERS! For more information on how you can get involved in the MHSA planning process, please call one of our outreach workers at 468-3368, 459-___, or check our website at www.co.mendocino.ca.us./mh/prop63.

Date_____ Location_____

I am: □ 16-24 □ 25-34 □ 35-59 □ 60+

I am a □ Female □ Male

I am a □ Consumer □ Family Member

I am: □ Heterosexual □ Gay/Lesbian □ Bisexual □ Transgender

What is your ethnicity? (Optional) Please check all that apply:

□ Amer. Indian/Alaska Native □ Asian
□ Black/African American □ Mexican/Hispanics/Latino
□ Native Hawaiian/Pacific Islander □ White/Caucasian
□ Other_____

1. What would help you or your family member most to live a quality life in your community?

2. What community mental health services and supports would you like to see developed or expanded?

3. Have you encountered any difficulties in getting mental health services in your Community? □ YES □ NO
   If YES, please describe, including what would have helped you in this situation?

4. What changes would make mental health services more welcoming and helpful to you?

5. What are the most important things a mental health program can do to respect your culture/lifestyle?

6. What specific new or additional mental health services would you like to see in Mendocino County?

7. In your experience with Mendocino County Mental Health, what current services, programs, or practices were most helpful? Please explain:

   What current services, programs, or practices were not helpful? Please explain:

8. What services programs or practices were helpful but are no longer available? Please explain:

9. Have you have experienced hospitalization related to a mental health issue?
   □ YES □ NO If YES, what services or supports would have helped you avoid going into the hospital?

10. Are you or have you ever been homeless?
    □ YES □ NO If YES, what services did you receive while homeless?

    What services would have helped you?

11. Have you spent time in jail in relation to a mental health issue?
    □ YES □ NO If YES, what services did you receive in jail?

    What services would have helped you?

12. Are you familiar with the recovery model?
    □ Yes □ No

13. Have you met someone who has recovered from a mental illness like yours?
    □ Yes □ No

14. If there were a Client Drop In Center, what would you like it to offer?

15. If you are a family member, what would be helpful to you?

16. What needs do you have that are not being adequately addressed? (please check all that apply to you and describe what you need.)
    - ❑ Affordable Housing
    - ❑ Transportation
    - ❑ Therapy
    - ❑ Psychiatric Medication
    - ❑ Substance abuse service
    - ❑ Physical healthcare
    - ❑ Social activities/ recreation
    - ❑ Education
    - ❑ Employment
    - ❑ Other_____

Please add any other comments you have:

MHSA Survey: Summary of Priorities

Surveys were done by outreach workers and through a mailing to all clients who had received services in the past year. Listed below are the top choices broken down by specific population/location. There were over 570 surveys completed.

Top priorities for High School Students (34):

- 24 hour crisis center (23)
- Drop in center with peer counseling (25)
- After school activities (21)
- Sports (21)

Additional Comments:
Confidentiality and being non-judgmental and an open, quiet, friendly atmosphere
The person should not be looking in my eyes or asking too many questions. I need to be the one looking into the other person's eyes
No suits! Someone average I can relate to
Someone my age that I could relate to

Top priorities for College Students (61):

- 24 hour crisis center (37)
- Drop in center (32)
- Peer counseling (25)
- After school activities (25)

Additional Comments:
A warm, homelike, comfortable environment
No eye contact
Someone who has been there done that

UKIAH

Top priorities in Ukiah for age 16-24 (11):

- Affordable Housing (7)
- Employment (6)
- Social Activities/Recreation (5)

Additional Comments:
Family Strengths program should go past 18
Crisis staff need more training, should be compassionate
Have both cultural **AND** lifestyle diversity in staff
A better description of "Mental Illness", pamphlets you can understand
A client run business would be nice

Top priorities in Ukiah for age 25-34 (22):

- Affordable Housing (9)
- Transportation (7)
- Social Activities/Recreation (6)

Additional Comments;
Yoga, acupuncture, food and drinks, etc.
Tools for dealing with family members
Treat me as an individual, treat me as an equal, be NON-BIASED, be more open minded
Way to find out what resources are available
MH needs to offer services to the average citizen
I don't like change

Top priorities in Ukiah for age 35-59 (88):

- Affordable Housing (43)
- Social Activities/Recreation (36)
- Therapy (29)

Additional Comments:
System works ok…sadly, it's under funded
More outings with transportation provided
Stop putting out surveys and spend the money instead of talking it to death
Where do we go when we get turned away because of no insurance
Recognize healthy bohemianism
Resource list
Accept me for me, don't assume anything

Top priorities in Ukiah for age 60+ (12):

- Affordable Housing (5)
- Transportation (5)
- Social Activities/Recreation (4)

Additional Comments:
Need accommodations for smokers
More funding from government would be helpful
Affordable senior activities
Counseling, not just meds
Contact person for family
Get rid of the stigma of MH

Top Priorities for Inmates in Mendocino County Jail (19):

- Medication while in jail (12)
- Crisis Residential (9)
- Peer Counseling (6)

Additional Comments:
Better, healthier food and correct meds on time in jail
Increase library (jail)

More/better understanding of MH by community
I need better social skills, support system
More personal connections, activities and food at MH
Housing and counseling would help

Fort Bragg Survey Priorities

Top Priorities in Fort Bragg for Age 16-24 (4)

- Therapy (3)
- Employment (2)
- Affordable (2)
- Case Management (2)

Additional Comments:
Need anger management classes
Accept me for who I am
Teen related stuff

Top Priorities in Fort Bragg for Age 25-34 (7)

- Social Activities/Recreation (4)
- Transportation (4)
- Employment (3)

Additional Comments:
Need more groups at Red House
Practical help/Behavior Modification
Monetary help

Top Priorities in Fort Bragg for Age 35-59 (26)

- Affordable Housing (11)
- Counseling (9)
- Social Activities/Recreation (9)

Additional Comments:
Don't let Voc/Rehab push you
Improve what already have

Top Priorities in Fort Bragg for Age 60+ (6)

- Transportation (3)
- Other (3)
- Therapy (2)

Additional Comments:
Bus need's expanded hours
Healthy food
Homeless services

Willits Survey Priorities

Top Priorities in Willits for Age 16-24 (16)

- Social Activities/Recreation (8)
- Affordable Housing (7)
- Employment (6)

Additional Comments:
Peer Support needed
Support groups for rape victims, substance abuse and weight issues
Don't judge me
Can't get services because Mom makes to much money

Top Priorities in Willits for Age 25-34 (34)

- Affordable Housing (16)
- Transportation (15)
- Employment (13)
- Social Activities/Recreation (12)

Additional Comments:
Need more jobs
More food stamps and cash aid
Place to get food and take showers, a homeless Shelter
Be respectful not judgmental
Drop in center, peer support and services on weekends

Top Priorities in Willits for Age 35-59 (109)

- Affordable Housing (38)
- Social Activities (38)
- Transportation (36)
- Therapy (28)
- Employment (28)

Additional Comments:
Staff should be nicer and more caring
I'm sleeping under the bridge
More counseling
Activities for kids and adults
Easy way to find resources
Someone to talk to
Food
Understand illiteracy

Top Priorities in Willits for Age 60+ (19)

- Drop in Center (8)
- Counseling (5)
- Able to stay in community (5)
- On call Dr./home visits (5)
- Social Activities/Recreation (4)

Additional Comments:
Staff that understands Senior issues
Friendly, welcoming peer center
More outreach
Be treated with respect and dignity
Transportation
A new car and a new body

APPENDIX C

LOCALIZATION OF MHSA ESSENTIAL ELEMENTS AND REQUIRED OUTCOMES

CHILDREN, YOUTH, AND FAMILIES

ESSENTIAL ELEMENTS

1. Cultural competence:
- Small town personal touch with quality relation ships
- Ongoing relationships that include having fun, doing stuff

2. Community collaboration
- Collaborative partnering and a supportive team that includes informal family know-how and formal supports that can anticipate stress points in plan
- Community-based variety of ways to reach young people sooner
- Outreach structured enough to look like support and human enough to be supportive

3. Client/family centered and driven - voluntary
- In crisis the whole family explores issues/solutions and find real resolution

4. Focus on Wellness: recovery and resilience
- Willingness of provider to work with ALL aspects of a person's situation
- Multiple opportunities for success
- Is held accountable for anti-social behavior in a way that promotes growth/resp

5. Integrated service experience
- Open-ended services that continue as child develops and grows past age "boundaries"
- Resources for uninsured and (privately insured kids), work the system so they qualify
- Peer support for family and child

REQUIRED OUTCOMES

1. Meaningful Use of Time & Capabilities
- Can take advantage of educational opportunities
- Has a track record of success at something

2. Safe and Adequate Housing including:
- Safe living environments with family (for children and youth)
- Reduction in homelessness
- In-county residential where family stays involved
- Youth stays in own home/community

3. A Network of Supportive Relationships
- Both child and family have supportive relatives and/or peers
- Child is listened to as an individual and included in planning
- School age children with working parents are nurtured, get basic needs met

4. Timely Access to Needed Help including in times of crisis
- Referrals to relevant services/information/education for special needs kids.

5. Reduction in incarceration in jails and juvenile halls

6. Reduction in involuntary services including institutionalization
- Local solutions that use family strengths to develop family plan

TRANSITION AGE YOUTH

ESSENTIAL ELEMENTS

1. Cultural competence:
- Being with others your own age
- Being with other clients
- There is a gift and strength in "how I'm different" that contributes and leads to goals

2. Community collaboration
- Persistently linking relationships from "wherever" that are meaningful and connected to each other in the service of the individual
- Client/family centered and driven - voluntary
- Individual attention; TAY seen as individual with own unique goals/desires
- Key is a unique individual who "takes it on", keeps at it, weathers storm, is anchor

3. Focus on Wellness: recovery and resilience
- Advocacy that translates "being different" into strengths and "can do" leading to participation/recovery
- Confidence, engagement and opportunities for success
- Is held accountable for anti-social behavior in a manner that promotes moral growth/responsibility

4. Integrated service experience
- Cooperation/ coordination among agencies and individuals to keep TAY on track toward personal goals
- Seamless personal service coordination & family involvement in transitions between age groups and eligibility

REQUIRED OUTCOMES

1. Meaningful Use of Time & Capabilities
- Results in a job, school, personally meaningful activities
- Self-advocacy is a goal modeled by helpers
- Has own goals, stemming from appreciative view of "how I'm different"
- Has a spectrum of specific job and interpersonal skills –including self advocacy
- Has a sense of interdependence is a world that is "getting bigger"

2. Safe and Adequate Housing including:
- Safe living environments
- Reduction in homelessness
- A safe and supportive place to go: may not be home or school
- A small communal TAY living environment to learn/teach life skills
- Supportive crisis residential that acknowledges TAY developmental realities
- Stable, supported formal and informal housing (think Melrose Place)

3. A Network of Supportive Relationships
- Has one to one relationships in which TAY seen as individual with own goals
- Is heard/understood as an individual by someone who can make things happen
- Feels and is seen as part of community, integrated into own age group
- Has a sense of interdependence- "I give help as well as get it"

4. Timely Access to Needed Help including in times of crisis

- Gets support wherever they're at on recovery continuum
- Treatment is available within the judicial/law enforcement system
- Service in outlying areas including transportation

5. Reduction in incarceration in jails and juvenile halls

- Spectrum of consequences for illegal behavior/wrongdoing that is part of recovery, seen through individual lens and is part of education about human consequences- learned through restorative means

6. Reduction in involuntary services including institutionalization

ADULTS

ESSENTIAL ELEMENTS

1. Cultural competence:
- Cultural competence about mental illness and client culture

2. Community collaboration
- Full community integration: neighbors accept them

3. Client/family centered and driven voluntary
- Belief in the individual by giving opportunities to do what they're good at
- Focus on goals, not rules. Take action that works, protocols come second
- Focus on service first, not $ (look to ER model)
- Look at person and their strengths not "the population"-
- One to one relationship-driven- an approach--human, individualized, supportive
- Focus on what's meaningful to client
- "Personal services coordination" is culturally competent, "Case management" is not

4. Focus on Wellness, recovery and resilience
- Food- it reduces stress and enables thinking
- Flexibility at work- reduces stress

5. Integrated service experience
- Clients improve when services are accessible and integrated
- Different agencies rally around and contribute with peer and licensed help
- Personal services coordination (aka case management) is critical

REQUIRED OUTCOMES

1. Meaningful Use of Time & Capabilities including such things as:
- Employment, vocational training, education, social and community activities
- Trained client leaders

2. Safe and Adequate Housing including:
- Safe living environments with family (for children and youth)
- Reduction in homelessness
- Basics for living enhances other outcomes

3. A Network of Supportive Relationships
- A framework for developing a supportive network
- Organized around similar issues
- No matter where you are in system, there are trained clients there to help

4. Timely Access to Needed Help including in times of crisis
- Timely regionally centered access to supports/services
- Resources in each community (including Covelo, Gualala)
- Preventive maintenance and access to personal service coordinator
- Trauma services for PTSD women, veterans

5. Reduction in incarceration in jails and juvenile halls

6. Reduction in involuntary services including institutionalization
- Client self-determination

OLDER ADULTS

ESSENTIAL ELEMENTS

1. Cultural competence
- It feels personal, some ONE who knows you, to talk to in your language
- Someone to share stories with who understands your culture
- A place to go to be with people where you're comfortable
- Use of term "personal service coordination" instead of "case management"
- "I'm not a case and don't manage me"
- Same array of treatment choices available for OA as for other age groups

2. Community collaboration
- Personal, collaborative and creative care shared by agencies

3. Client/family centered and driven - voluntary

4. Focus on Wellness, recovery and resilience
- Viewed as whole person with a lot of strengths and needs
- Focus on keeping older adults healthy- before problems arise

5. Integrated service experience
- Services go to where older adults are
- Persistence & advocacy until diagnosis and meds are correct

REQUIRED OUTCOMES

1. Meaningful Use of Time & Capabilities
- Has a place to go to be with people
- Has links to and engages in interesting/productive activities
- Access to transportation, activities in outlying areas

2. Safe and Adequate Housing
- Safe living environments
- Gets 24/7 "are you ok? " check ins.
- Reduction in homelessness

3. A Network of Supportive Relationships
- OAs needs and special circumstances known and understood by communities
- Gets help in a language/setting that feels comfortable/familiar
- OAs and grandparents get strengths-based support/empowerment

4. Timely Access to Needed Help including in times of crisis
- Receives appropriate, self-directed treatments and interventions that
- Is the provider right for individual (not the ER)
- Reveal and use client's strengths
- Are facilitated by providers and family members
- Services that go to where OA's are
- Persistent advocacy & follow through until diagnosis and meds are correct

5. Reduction in incarceration in jails and juvenile halls

6. Reduction in involuntary service
- Maintain quality of life via support for independence & preferred life style

APPENDIX D

AGE GROUP PRIORITY LISTINGS

CHILDREN, YOUTH, AND FAMILIES

1. Crisis Response

- 24 hour warm line offers support, resource advice, and can respond or access crisis services
- Mobile intervention: services attached with a resource specialist who can provide personal service coordination (aka case management) in every community centered at community center, health centers- where people go.
- Expanded access to crisis service in outlying areas: mobile team, warm/crisis line. MH peer and professional, law enforcement/family
- Family system crisis response on coast: by having a dedicated clinician at Ft. Bragg clinic for assessment and follow up

2. Parents/Peer Support

- Youth peer mentors
- Parent/peer partners in outlying areas (at Family Resource centers)
- Expand parent partners to cover crisis, family education in outlying areas
- Expand Parent Partners to FRC-connected MH services
- Specialty respite services, a partnership agreement of parent-provider for respite and peer support

3. Increased Access for Un-served and Under-served Youth/Families

- Fund for unfunded families NOT included in “10% org. provider mandate”
- Expanding wrap-around program to become county-wide service
- 0-5 clinician to work with Early Mental Health Initiative and First Five. This person will provide assessment and treatment in areas of the county where none exist
- Early identification and assessment that’s school based and in outlying areas, too
- Timely access to needed help in communities and schools, especially for youth without MediCal in outlying areas

TRANSITION AGE YOUTH

1. Supported education program at community college with integrated services

2. Expand TAY MH personal service coordinators: more in Ukiah, outlying

3. Job Coaches: expand Y.E.T.

4. Specialized activities, groups, etc. for TAY at Clubhouse(s)

5. Local Crisis Residential

6. Supportive small group living home for TAY only

ADULTS

1. Array of housing stock

2. 24-7 Crisis Residential/Shelter with Peer Support

3. Client-Centered/Operated Regional "Club Houses"

- Regional Club House (client-operated) model
- Client-centered club house model -includes peer and licensed helpers
- Club House model with dual diagnosis track and housing advocate
- Education for individuals to create their own support

4. Mobile regional response/crisis team(s) by peers/family members

5. Establish Interagency Adult Systems of Care

- Interagency Adult Case Management Team
- Interagency Personal Service Coordination Team

6. Supported Education

7. Dual Diagnosis (added at second meeting)

OLDER ADULTS

1. Increase # of Peer Counselors

- Peer counselor at each senior center
- Outreach/engagement to seniors through Nuestra Casa and Indian Senior Health
- Peer supportive services and client-run services including peer counseling and support
- Productive activities for seniors
- Transportation to services for OA's in outlying areas

2. Reestablish OASOC (Older Adult Systems of Care) Teams

- Home based mobile services to reach Older adults
- Crisis-response by familiar person; education for first responders/alert system
- Integrated assessment teams that look comprehensively at mental health/ social / substance abuse
- OASOC clinician in Ft. Bragg, Willits, Ukiah
- Compassionate and personal client-centered care, with focus on collaboration

3. Education of Geriatric Issues

- Providers, family and caregivers trained in geriatric assessment/issues

4. 24/7 crisis and/or warm phone line

5. Outreach and Engagement to Seniors

- Must be coastal, north inland, Ukiah and to ethnic minorities

6. Peer Counseling and Therapeutic Services where seniors go and live

- Must be non-stigmatizing and preserve confidentiality.

APPENDIX E

IN ORIGINAL PLAN

	NAME	AFFILIATION	REPRESENTING	ALTERNATE
1.	Marita Bakewell	(Willits Outreach Worker, Legacy House)	Consumer Self Help Committee	
2.	Mary Carley	(Self-Help Peer Counselor, Ft. Bragg)	Consumer – M.H. Board	
3.	Leigh DeLap	(former MH Board member, Willits)	Consumer	
4.	Susan Era	(Deputy Dir. – Social Services)	Older Adults Committee	Susan Bridge Mount
5.	Karin Wandrei	(Mendo Co. Youth Project, PCCY**)	Community member	
6.	Eileen Lowery	(NAMI, Willits)	Family Member- M.H. Board	
7.	Michael Mabanglo	(Mendo. Comm. Health Clinic)	Medical Services Committee	
8.	Kevin Murphy	(AHC*, CA Network of MH Clients)	Consumer	
9.	Wynd Novotny	(NAMI, Wishing Wellness, MCPHAB***)	Family Member- M.H. Board	Fred Sly
10.	Noel O'Neill	(Youth & Family Mgr-MH Dept)	Transition Age Youth Committee	
11.	Dina Ortiz	(MH Adult Svc- Willits, SEIU, Latina, Nat. Am.)	Housing Committee	Mary Lou Leonard
12.	Eva Pate	(Ft. Bragg Outreach Worker)	Consumer	
13.	Tim Pearce	(Jail Commander)	Jail Diversion Committee	Hugo Boecx
14.	Julie Price	(NAMI)	Vocation/Education Committee	Monique Hart
15.	Anne Retallick	(NAMI, medical professional)	Crisis Services Committee	Louise Osejo
16.	Camille Schraeder	(Redwood Children's Services, PCCY**)	Children and Families Committee	Mary Elliott
17.	Eliste Reeves	(Covelo, Native American)	Family Member- M.H. Board	
18.	Trent Taylor	(Ukiah Police Department)	Law Enforcement Committee	Peter Sears
19.	Vanessa Vachon	(Ford Street Project)	Adult Committee	Michael McGee
20.	Roanne Withers	(Ft. Bragg Homeless Advocate)	Mental Health Board	
21.	Lynette Woolfolk	(Patient's Rights Advocate)	Client/Family Advocacy Committee	Claudine Williams
		ADDED THROUGH PUBLIC PLANNING PROCESS		
22.	Joe Barnett	(MH Homeless Services Program)	Dual Diagnosis Committee	Art Davidson
23.	Carmen Price	(Outreach Worker, College Student)	Consumer – Transition Age Youth	
24.	Moises Soria	(Nuestra Casa)	Latino	Vicki Patterson
25.	Frank Tuttle	(Consolidated Tribal Health)	Native American	Frank Gonzalez
26.	Michele Schott	(Laytonville Healthy Start, MCPHAB***)	Laytonville	Lucy Andrews
27.	Seana Dildine	(Round Valley Unified School Dist, Native Am.)	Covelo	James Russ
28.	Javier Chavez	(Action Network, Latino)	South Coast, Latino	

*AHC=A Healing Cooperative **PCCY=Policy Council on Children and Youth ***MCPHAB=Mendocino County Public Health Advisory Board

APPENDIX F

DOCUMENTATION OF PUBLIC HEARING TO BE HELD ON JANUARY 18, 2006 WILL BE INSERTED HERE

APPENDIX G

Mental Health Forum Identified Priorities
October 25, 2004
Todd Grove Clubhouse

Youth Unmet Needs:

- Expand all services for all children in communities
  - Wraparound
  - Therapist in each school and preschool
  - Bilingual services
  - Services for gay & lesbian youth
- Creative financing
  - Leverage EPSDT funds to provide additional services
- Community center/resource center models
- Public education
  - Reduce stigma
  - Suicide prevention
- Childcare for kids exposed to mental illness at home
- More parent advocates
- Universal health care
- Dual diagnosis services
- Genetic counseling for parents and support services for prenatal care

Transitional Youth Needs:

- Establishment of a therapeutic community through a safe house or resource center model
  - Dual diagnosis services
  - Supportive housing
  - Comprehensive life skills
  - Comprehensive job skills and employment opportunities
  - Family advocates, possible use of Court Appointed Special Advocates
  - Street outreach
  - Self-help, empowerment, strength based programs
- Organized protocol to enhance integration of services
- Residential treatment for transitional age youth

Adult Unmet Needs:

- County wide self-help – consumer-run network
- Accessible, supportive, and appropriate housing
- More comprehensive crisis services
  - Mobile response unit
  - Beds available 24/7 staffed with nurses and psychiatrist on call
  - In-County inpatient care
- Dual diagnosis programs
- More comprehensive services for medically indigent individuals and CMSP beneficiaries

Adult Unmet Needs Continued:

- Vocational/employment training
  - Consumer-run businesses
- Transportation
- Programs
  - Support for transitional (acute, non-chronic) clients
  - Art & Music
  - Support groups for family members
  - Suicide survivor group
- Mobile outreach to consumers
- Education
  - Providers
  - Mental Health staff
  - Public Awareness
  - Consumer and families
- Ongoing small grant program for innovative projects
- Enhanced diagnostic services

Older Adult Unmet Needs:

- Professional, high level expertise in geriatric mental health
  - Psychiatrist on coast
- Interagency vision (MSSP, AODP, Public Health, Area on Aging, Social Services, Senior Centers and Mental Health)
  - Identify players, start from assets, no need to reinvent the wheel
  - Integration/collaboration/one-stop system
- Training in geriatrics for various types of service providers
- Peer counseling/self advocacy/empowerment
- Services for working poor
- Bring services to where seniors are
  - Transportation
  - Outreach workers

APPENDIX H

DATA SOURCES USED IN MENDOCINO COUNTY PLAN

DATA	SOURCES
Foster Care Populations	Mendocino County Children's System of Care Mendocino County Department of Social Services
Health Insurance Coverage	California Department of Health Services UCLA Center for Health Policy Research (2003). California Health Interview Survey
Homeless Populations	Mendocino County Homeless Census and Survey (2005). Applied Survey Research, Watsonville CA. Fischer PJ, Breakey WR (1991). The Epidemiology of alcohol, drug, and mental disorders among homeless persons. American Psychologist: 46:1115-1125.
Hunger and Food Insecurity	UCLA Center for Health Policy Research (2003). California Health Interview Survey California Food Policy Advocates (2003). Touched by Hunger: A County-by-County Report on Hunger and Food Insecurity in California.
Incarcerated Populations	Jail Commander, Mendocino County Detention Center Superintendent, Mendocino County Juvenile Hall Teplin LA, et al (2002). Psychiatric disorders in youth in juvenile detention. Archives of General Psychiatry: 59:12.
Mental Health Services and Utilization	Mendocino County Health Clinics, Inc. Consolidated Tribal Health Project, Inc. Mendocino County Department of Social Services Mendocino County Mental Health Department
Myths About Mental Illness	Anthony, W.A., Cohen, M., Farkas, M, & Gagne, C. (2002). Psychiatric Rehabilitation, 2nd edition. Boston: Boston University Center for Psychiatric Rehabilitation.
Older Adults Populations	Area Agency on Aging Mendocino County Department of Social Services
Population Data (demographics and socio-economic indicators)	United States Census (2000) California Department of Finance
Prevalence Data on Mental Illnesses	California Department of Mental Health (http://www.dmh.ca.gov/sada/SDA-Prevalence_rates.asp) UCLA Center for Health Policy Research (2003). California Health Interview Survey
Student Demographics	Dataquest, California Department of Education
Student Drop-Out Rates	Dataquest, California Department of Education
Student Assets and Substance Abuse	California Healthy Kids Survey
Suicide	Mendocino County Community Health Status Report (2004). Mendocino County Department of Public Health.