



**PREVENTION & EARLY INTERVENTION
COMPONENT
OF THE
THREE-YEAR PROGRAM & EXPENDITURE PLAN
FOR
MENDOCINO COUNTY**

Prevention & Early Intervention Component of the Three-Year Program & Expenditure Plan for Mendocino County

INTRODUCTION

This document is the product of a steadfast and persistent group of individuals from nearly every corner of Mendocino County. They represented American Indians, Latinos, children, adults, youth, and the elderly. They spoke for individuals who have substance abuse issues, are homeless, or incarcerated. They were professionals who deal with mental health issues daily, from sectors such as education, behavioral health, social services, law enforcement, community-based non-profits, and clinics. They were male and female, and of all sexual orientations. They were family members and friends, and some were those who needed and used mental health services themselves. All shared a commitment to addressing mental illness in our community.

Contributors included, of course, the PEI Stakeholders Workgroup listed on pages three through six of Form 2, PEI Community Planning Process. But they also included the many individuals and groups in our county who agreed to talk about their concerns, ideas, and dreams for a mental health system that really works and really helps. They included those who met face to face, and those who phoned, emailed, and completed surveys. We were touched by their stories, amazed at their resourcefulness, and awed by the creative solutions these community members envisioned. It was truly an honor to receive and compile the information they offered so generously. We have done our best to ensure that their input was recorded and incorporated into our thinking as we developed this plan.

Mendocino County's first Three-Year Program & Expenditure Plan is not all that we would like it to be. The available funding falls short of the ideal plan we would like to put into action. We think, though, that we've chosen projects that will have the greatest positive impact on mental illness in our county over the next three years. The projects also address many of the major themes that emerged in the planning process:

- Priority to American Indians and Latinos across the board;
- Inclusion of services for individuals with co-occurring substance and mental health disorders;
- De-stigmatization and education about mental illness so that people seek help early and have a better chance for recovery;
- Catching individuals at critical stages who are "falling through the cracks."
- Providing services countywide, including outlying areas.

This plan calls for four projects over the next three years:

- 1) **Education, De-stigmatization & Peer Support**—community at large and targeted groups
- 2) **Early Onset, Early Intervention: Transition-Age Youth & Young Adults**—Intervention at the first break of a serious psychiatric illness for individuals between age 16 and 25.
- 3) **Prevention: Older Adults**—A coordinated service to prevent depression and suicide among isolated older adults age 60 and above.

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- 4) **Prevention Collaboration Children and Youth Age 0-17**—School-based screening, education and prevention services and community-based family support and education services in the catchment areas of two school districts with high concentrations of American Indian and Latino students.

Each of these projects is detailed in the body of the plan, as are the budgets that align with them. We have focused the largest portion of our PEI funds on Project #2 above. The reason is that this project will provide the best and only chance to stop the deteriorating effects of serious psychiatric illnesses when they most often strike—between the ages of 16 and 25. These illnesses not only destroy individual lives and families, they constitute a huge drain on our community's resources and limit the effectiveness of our mental health system overall. This project can change that picture. Early intervention can truly mean a return to normal functioning and, in some instances, recovery. This project will help both the individuals experiencing the early onset of mental illness and their families to accept and manage their circumstances productively. We expect to be able to provide services to this population in the inland and coastal parts of our county as well as the northern inland areas such as Covelo/Round Valley.

In addition to the details of our projects, this plan includes the data collected over more than a year to inform our community planning process (**Exhibit B**) as well as a chart of our community's assets compiled over several months with the help of the PEI Stakeholder's Work Group and others (**Exhibit C**). Documentation of the focus groups, consultations and survey responses is recorded in **Exhibit D**. Summarized information about strategy ideas that arose from the community planning process is contained in **Exhibit H**.

We hope this Three-Year Program & Expenditure Plan for Prevention and Early Intervention describes clearly the manner in which it was developed, the efforts we propose to improve the mental health of our county, and sound reasoning for selecting these particular efforts for implementation.

Sincerely,

Mary Elliott, Director
HHS Children & Family System of Care,
Mental Health Division

Jill Singleton
PEI Coordinator

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**PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE
PLAN FACE SHEET**

Form No. 1

**MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2009-2010 and 2011-2012**

County Name: Mendocino

Date: 9/09

COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	Project Lead
Name: Mary Elliott	Name: Jill Singleton
Telephone Number: (707) 463-4346	Telephone Number: (707) 467-6016
Fax Number: (707)463-4043	Fax Number: (707)463-4043
E-mail: elliottm@co.mendocino.ca.us	E-mail: singletj@co.mendocino.ca.us
Mailing Address: Mendocino County HHSA, Children & Family System of Care, Mental Health Division, 860 N. Bush Street, Ukiah, CA 95482	

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has 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 the 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 2007-08, 2008-09 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 the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature _____

County Mental Health Director

Date

Executed at _____, California

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Instructions: Please provide a narrative response and any necessary attachments to address the following questions. (Suggested page limit including attachments, 6-10 pages)

County: Mendocino

Date: September 2009

Overview:

Mendocino County's Community Program Planning Process for Prevention and Early Intervention (PEI) funds had its foundations in the development of the Mental Health Services Act (MHSA) Stakeholders Group in October of 2006. Workgroups were developed from the MHSA Stakeholders Group including the Community Services & Supports (CSS) Workgroup, and the Workforce Education & Training (WET) Workgroup that preceded the PEI Workgroup in Mendocino County. Through these bodies, we developed a strong community base and many community connections on which to build for our PEI planning process.

The PEI planning process included the following major elements:

THE PEI STAKEHOLDERS WORKGROUP

Members of this workgroup reflected the diversity of our community as well as its demographic composition. They represented virtually every sector of the community with an interest in mental health and mental illness, and represented these interests with both expertise and passion. Many members also participated on the CSS Workgroup and some were members of the WET workgroup, so that they were familiar with MHSA standards and processes. The composition of the PEI workgroup is shown on pages 5, 6 and 7 below.

- **Data Subcommittee**

The PEI Workgroup included a subcommittee to gather relevant data and create the Community Mental Health Assessment Data Report (**Exhibit B**).

- **Community Assets**

The workgroup developed over time, the Community Assets Chart (**Exhibit C**) as well.

These two documents were an important part of the planning process as they contributed to Workgroup's decisions about priority community health needs and populations.

- **Strategy Subcommittee**

The Workgroup designated a one-time subcommittee to develop strategy ideas to address the priority populations and community health needs that would be the focus of our PEI Plan. This subcommittee is described on pages 10 and 11 below.

FOCUS GROUPS

The PEI planning process included dozens of focus groups across the county. These groups are delineated on pages 13, 14, 15 & 16 below. Their details are documented in **Exhibits D-1 through D-6**. Like the PEI workgroup, the focus groups were representative of the County's demographics and diversity. They included clients and

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family members and representatives of organizations who consulted with and spoke on behalf of the people they serve.

CONSULTATIONS

In addition to meeting with groups, the PEI planning process also included many consultations with individuals with a particular interest or area of expertise. These consultations took place face-to-face, over the telephone and via email over several months. These consultations are listed on page 16 and documented in detail in

Exhibits D-1 through D-6.

SURVEYS

A survey was developed and utilized to capture input from individuals who were unable to attend focus groups or take the time for a more extensive consultation. Details about the surveys are described on pages 16 and 17, and documented in **Exhibit F.**

The PEI workgroup committed to providing both prevention and early intervention services, and recommended four projects for Mendocino County's Prevention and Early Intervention Component of the Three-Year Program & Expenditure Plan:

- Project #1—Education, De-stigmatization & Peer Support for both the community at large and targeted groups.
- Project #2—Early Onset/Early Intervention—Transition Age Youth & Young Adults
- Project #3—Prevention Services—Older Adults
- Project #4—Prevention Collaboration –School-based screening, education and prevention services and community-based family support and education in the catchment areas of two school districts with high concentrations of American Indian & Latino students.

Each of these projects is detailed in the body of this plan, as are the budgets that align with them. We have focused the largest portion of our PEI funds on Project #2. The reason is that this project will provide the best and only chance to stop the deteriorating effects of serious psychiatric illnesses when they most often strike—between the ages of 16 and 25. These illnesses not only destroy individual lives and families, they present a huge drain on our community's resources and limit the effectiveness of our mental health system overall. We believe that Project #2 will change that picture.

Please see the details of our Community Program Planning Process below.

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

- a. The overall Community Program Planning Process
Mendocino County's Mental Health services are part of an integrated Health and Human Services Agency which includes three branches: the Children & Family System of Care Branch, the Adult and Older Adult System of Care Branch, and the Community Health Branch. The overall community program planning process has

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been the shared responsibility of the Director of the Children & Family System of Care and the Adult and Older Adult System of Care.

b. Coordination and management of the Community Program Planning Process

The Mental Health Division of the Children and Family System of Care (CFSOC) took responsibility for the planning and development of the Prevention and Early Intervention (PEI) Plan. The County's MHSA coordinator was initially given responsibility for the community program planning process for PEI.

A Mental Health Services Act (MHSA) Stakeholders Group was established in Mendocino County in October 2006 after the passage of Proposition 63 in November of 2004. Several work groups were developed to address the specific components of the MHSA including the Prevention and Early Intervention Stakeholders Work Group which began meeting on June 9, 2008. This work group was to formulate the planning process for PEI in Mendocino County, review the information collected, and make recommendations to the Mental Health Board and the Director of the Mental Health Division of CFSOC about the PEI Plan. The chart below lists the members of the PEI Stakeholders Work Group and their affiliations:

PEI Stakeholder's Work Group

Name	Organization	Affiliation/Interest
Nancy Adams, MFT	HHSA, AOASOC, Mental Health Division	Older adults
Jane Berry *	Mental Health Board	Consumer family member
Lucia Bianchi	Mendocino County Office of Education (MCOE)	Education
Laurel Bleess	Mental Health Branch, AOASOC, Patient Advocate	Patient rights
Susan Bridge-Mount,	HHSA Adult & Older Adult System of Care	Older adults
Armand Brint	HHSA, Alcohol & Other Drug Programs (AODP)	Substance abuse, co-occurring disorders
Diana Chambers	HHSA, , AOASOC, Mental Health Branch	Adult Mental Health
Javier Chavez	Action Network Family Resource Center	Latino community, community-based services south coast
Carol Ciraulo *	MCOE	Education
Harry Collamore	HHSA, AOASOC, Mental Health Branch	Adult Mental Health
Linda Crocket	Action Network Family Resource Center	Community –based services, Teen Peer Court, south coast
Damon Dickinson	MCOE	Education
Mary Elliott, Director *	HHSA, CFSOC, Mental	Countywide mental health

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Name	Organization	Affiliation/Interest
	Health Branch	services—children, transition-age youth & families
Susan Era, Director	HHSA, AOASOC, Mental Health Branch	Countywide mental health services—adults and older adults
Dennis Fay *	Community Care	Senior citizens and disabled
Wes Forman, Chief *	Mendocino County Probation Department	Juvenile wards and offenders, law enforcement
Jean Franco, PhD	Mendocino Community College	Education
Cathy Frey, Director	Alliance for Rural Community Health (ARCH)	Community clinics, physical and behavioral health
Frank Gonzales, PhD	Consolidated Tribal Health	American Indian community, behavioral health
Lisa Gosselin		Consumer
Zoy Kazan, Deputy Director	HHSA, CFSOC, Mental Health Branch	County-wide mental health services, children, transition-age youth and families
Rachel Kradin *	ARCH	Community clinics, physical and behavioral health
Janet Kukulinsky	Action Network Family Resource Center	Community-based services south coast
Claudia Lavenant, Executive Director	Nuestra Casa Family Resource Center	Latino community
Mary Lou Leonard	HHSA, AOASOC, Adult Social Services	Adults & older Adults
Eileen Lowery	Manzanita Recovery Center	Contractor, mental health recovery services, transition-age youth and adults
Lorelie Manix	Mental Health Board	Consumer family member
Michael McFarland	HHSA, MHSA	MHSA fiscal services
Anne Molgaard, Director	First 5 Mendocino	Children age 0-5 and parents
Vonna Myers	Mental Health Board	Consumer family member
Sonya Nesch	National Alliance on Mental Illness (NAMI)	Mental illness—coast, consumer family member
Susan Wynd Novotny	NAMI	Mental illness—inland Mendocino County,

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Name	Organization	Affiliation/Interest
		consumer family member
Sandra O'Conner	Mental Health Board	Consumer family member
Carol Orton, LCSW	Consolidated Tribal Health	American Indian community, youth in juvenile hall
Raven Price		Consumer, TAY
Catherine Rosoff, MFT	HHSA, MHSA Mendocino Community College	Community College students with mental illness
Frederick Rundlet, Director	Consolidated Tribal Health	American Indians, community health providers, behavioral health
Michele Schott, Director	Laytonville Healthy Start Family Resource Center	Community-based services north Inland Mendocino County
Camille Schraeder, Executive Director	Redwood Children's Services	Organizational contractor, children, youth and transition-age youth
Charlie Selzer	HHSA, AODP	Substance abuse, co-occurring Disorders
Singleton, Jill *	HHSA, CFSOC, Mental Health and Child Welfare Services Divisions	PEI Coordinator
Maya Stuart *	First 5 Mendocino	Children age 0-5, parent education
Lori Sweeney *	HHSA, AOASOC	Older adults countywide
Karin Wandrei, PhD *	Mendocino Youth Project, Redwood Counseling Services	Community-based services, adolescents and transition-age youth and families
Frostie Weber	Round Valley Health Clinic	American Indians in Round Valley
Becky Wilson, Deputy Director	HHSA, CFSOC, Child Welfare Services	Child abuse prevention and intervention, children youth and transition-age youth & families
Roanne Withers, MHSA Coordinator	HHSA, AOASOC	Countywide MHSA services

In July of 2008, several members of the PEI Stakeholders Workgroup attended the PEI Regional Roundtable in Sacramento. Greg Griffin, Liaison from the Oversight and Accountability Commission (OAC) addressed the PEI Stakeholders Workgroup on August 11, 2008, to provide additional information and take questions about PEI. Then, at the PEI Stakeholders Work Group meeting on October 6, 2008, a training about the PEI planning process was provided by Dr. Will Rhett-Mariscal of the California Institute of Mental Health (CIMH). Armed with information from these

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trainings, the Work Group proceeded with the planning process. It defined its guiding principles as follows:

PEI GUIDING PRINCIPLES

- Build on what we have
- Leverage dollars
- Address linkages and maximize resources
- Promote collaboration
- Serve hard-to-reach communities & populations; promote equal access to mental health services
- Address unique strengths and challenges of communities/populations
- Develop programs/strategies that can show positive mental health outcomes
- Avoid duplicating MHSA-funded services

Because the County was entering its third year of the Community Services and Supports Plan, the PEI Stakeholders Workgroup established a subcommittee to collect new data and analyze it as part of the assessment of the community's needs, capacities and strengths for the PEI Plan. Coordination of the Community Mental Health Assessment Data Report was provided by Phyllis Webb, a Sr. Public Health Analyst from the Community Health Branch of the Health and Human Services Agency. The Data Report subcommittee that worked with Mrs. Webb was comprised of the individuals asterisked in the above chart. The resulting Community Mental Health Assessment Data Report is included in this PEI Plan as **Exhibit B**. A summary entitled Findings and Limits of Data is included in this plan as **Exhibit A**.

Like many other counties during 2008/2009, Mendocino County lost staff, reduced hours and consolidated services to address major budget reductions. This and other obstacles delayed the completion of the community planning process for several months. Because we are an HHSA, however, Mendocino County was able to assign ½ FTE Senior Program Manager from Child Welfare Services (another division of the Children & Family System of Care) to assume responsibility for the coordination and management of the community program planning process for PEI under the direction of the Director of the CFSOC Branch. This assignment was made at the end of March 2009, at which time the Sr. Program Manager became the PEI Coordinator.

With the help of Mrs. Webb and the PEI Stakeholders Workgroup, a "map" of our community's assets related to the purpose of Prevention and Early Intervention funds was developed and refined between June and early August of 2009. This document is entitled Community Assets and is included in this plan as **Exhibit C**.

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The Stakeholders Work Group met monthly for at least two hours on the second Monday of each month throughout the planning process. In addition, the Data Report subcommittee met separately for several months on the third Monday of the month starting in October 2008. A calendar of the meeting dates of all the MHSA Work Group meetings has been posted on the County's Mental Health website and has been distributed at the MHSA Stakeholder's meetings. The calendar has also been posted in the Outpatient Lobby of the Mental Health Office. Notices, agendas and relevant documents have been sent each month to anyone who has asked to be included in the PEI Stakeholder's Workgroup. A sign-in sheet has also been included in the MHSA Stakeholders packets for anyone who wants to be added to any of the Stakeholders Workgroups, including PEI.

The PEI Stakeholders workgroup provided guidance and contact information for the new PEI coordinator about how to reach the sectors of the community required in the PEI guidelines, as well as the names of individuals who might offer additional insight and information through "key informant" interviews. The PEI coordinator and the Data Report coordinator provided updates on progress as well as draft documents to the Workgroup at the Stakeholders Workgroup meetings and via email or telephone between meetings.

The PEI Workgroup devoted parts of several meetings to reviewing and discussing the data, the input from focus groups, surveys and consultations, and their own expertise and interests in the prevention of, and early intervention in mental illness. On August 10, 2009, an extended workgroup meeting was held to select priority populations and needs for Mendocino County's PEI Plan. The following Work Group members and other interested community members attended:

- Lisa Gosselin Manzanita Recovery Centers
- Trayce Beards HHSA, AOASOC, MHSA
- Debra Rogers Manzanita Recovery Centers
- Zoy Kazan HHSA, CFSOC Mental Health Deputy Director
- Susan Era HHSA, AOASOC Director
- Alese Jenkins HHSA, CFSOC, CWS
- Dennis Fay Community Care
- Carol Orton, Consolidated Tribal Health
- Mary Elliott HHSA, CFSOC Director
- Lori Sweeney HHSA, AOASOC
- Maya Stuart First 5 Mendocino County
- Wes Forman Chief, Mendocino County Probation
- Frostie Weber Round Valley Indian Health Center
- Leland Pinola Manchester Reservation (South Coast)
- Ruben Reyes Round Valley Reservation
- Karin Wandrei Mendocino Youth Project

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- | | |
|------------------|--|
| • Carole Ciraulo | Mendocino County Office of Education (MCOE) |
| • Phyllis Webb | HHSA, Community Health, Data Group Coordinator |
| • Anne Molgaard | Executive Director, First 5 Mendocino |

At this meeting, the group reviewed its guiding principles and the definitions of prevention and early intervention per the PEI Guidelines published by the California Department of Mental Health. Each member got a copy of the summarized input from focus groups, surveys and interviews, the draft of the Community Assets document, and the Findings and Limitations of Data document. The bulk of the meeting consisted of open discussion about the data, the input from the community and their own experiences and areas of expertise. There was strong interest in addressing both prevention and early intervention issues in our county. To avoid the temptation to advocate for their particular area of concern, each member identified the three key community needs or populations under prevention and under early intervention they considered highest priority. Through this process the overall top priority needs/populations under both the “prevention” category and the “early intervention” category became clear. As a result of this process, the PEI Stakeholder’s Workgroup made the following decisions about its recommendations for the utilization of PEI funds;

- Mendocino County will engage in some type of effort to **de-stigmatize and educate about mental illness and suicide prevention**;
- We will ensure that **American Indians, Latinos, and individuals with co-occurring disorders are given priority** in whatever projects we choose as our focus for PEI funds;
- The priority age groups that will be candidates for **prevention efforts** will be
 - Youth (0-17) in troubled/stressed families
 - Older adults (60+)
- The priority age groups that will be candidates for **early intervention efforts** will be
 - Older adults (60+)
 - Transition-age youth and young adults (16-25)

The group identified a subcommittee to meet before the September PEI Stakeholder’s Workgroup to develop ideas for strategy types that would address the priority groups and needs under “prevention” and “early intervention” with ballpark costs and ideas about leveraging opportunities and the impacts on mental illness in our county. The PEI Coordinator emailed a packet of strategy ideas that arose from focus groups, surveys and interviews (**Exhibits H1-H4**), to the subcommittee prior to the meeting. Subcommittee members were invited to bring to or notify other interested parties about the meeting. The subcommittee meeting took place on August 20, 2009 and was attended by:

- | | |
|------------------|-------------------|
| • Maya Stuart | First 5 Mendocino |
| • Anne Molgaard | First 5 Mendocino |
| • Carole Ciraulo | MCOE |
| • Debbie Rogers | MCOE |

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- Karin Wandrei Mendocino Youth Project
- Lori Sweeney HHSA, AOASOC
- Zoy Kazan HHSA, CFSOC, Mental Health
- Heather Woldemar HHSA, CFSOC, TSOC
- Kate Howe Manzanita Recovery Centers
- Frostie Weber Round Valley Indian Health Center
- Ruben Reyes Round Valley Indian Health Center
- Alain Doegnes Round Valley Indian Health Center
- Sonya Nesch NAMI, Coast
- Jill Temkin HHSA, AOD Programs
- Raven Price Consumer, TAY

The group reviewed and discussed several strategy ideas at the meeting. Participants were encouraged to send any additional ideas to the PEI Coordinator by August 26th. Several common elements came up in many of the ideas that were discussed. For example, many contained an education component (about mental illness), and many contained a peer support component. The PEI coordinator summarized the strategy ideas and calculated ball-park costs based on the information the subcommittee members provided. It was clear that not all the strategy ideas could be funded as presented because they would have exceeded the PEI funding available for the next three years by well over \$100,000 per year. The PEI Coordinator consulted with CIMH and a similar rural county that had completed its PEI planning process, about the best next steps to take to come to conclusions about the PEI Projects to implement in Mendocino County. Their input, and the summary of the costs and strategy ideas were shared with the Director of CFSOC and the HHSA Director. The HHSA Director and the CFSOC Director considered the information and developed the HHSA's recommendation for PEI Projects and funding that honored the community's priorities as well as their feasibility for implementation over the next three years within the limits of the PEI funding. This recommendation was sent to all members of the PEI Stakeholder's Work Group prior to its September meeting. The Workgroup met with the CFSOC Director and discussed the HHSA recommendation on September 14, 2009. Several questions were raised along with a few refinement ideas about one of the strategies. There were no objections. The PEI Coordinator continued from that point to draft the plan as recommended by the Director and reviewed by the PEI Stakeholder's Workgroup.

- c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The PEI Stakeholders Work Group began meeting in June 2008. The Work Group met monthly for at least two hours on the second Monday of each month throughout the planning process. In addition, the Data Report subcommittee met separately for several months on the third Monday of the month starting in October 2008. Meeting dates were predictable and consistent. A calendar of the meeting dates of all the MHSAs Work Group meetings has been posted on the

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County's Mental Health website from the beginning, and has been distributed at the MHSA Stakeholder's meetings. The calendar has also been posted in the Outpatient Lobby of the Mental Health Office. Notices, agendas and relevant documents have been sent at least a week ahead each month to anyone who has asked to be included in the PEI Stakeholder's Workgroup. A sign-in sheet has also been included in the MHSA Stakeholders packets for anyone who wanted to be added to any of the Stakeholders Workgroups.

In Mendocino County, we have enjoyed a PEI Stakeholders Work Group that has included representatives from all sectors and regions of the community. The group has been lively, dedicated, and fully engaged throughout the process. Within the requirements and guidelines of the funding, the work group has not only participated in the PEI Planning process, it has structured and defined it, from the development of its guiding principles to supplying statistics and other data, to helping to arrange for focus groups and interviews.

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives (please provide examples):

- a. Included representatives of un-served and/or underserved populations and family members of un-served/underserved populations .

Mendocino County had established contacts with members of un-served or underserved groups and their family members through the MHSA planning process, the development of its Community Services and Supports (CSS) Plan, and through long-standing relationships even prior to these efforts. For example, the County had contracted for mental health services and collaborated on related projects with several community-based organizations such as the Nuestra Casa Family Resource Center (for members of the Latino community), Consolidated Tribal Health and Round Valley Indian Health Center (for the American Indian Community) as well as community clinics and other family resource centers serving outlying areas of our county. We had working relationships with senior centers and organizations serving individuals with disabilities. We made sure to reach out to those same organizations and others to participate on the PEI Stakeholders Work Group. **The roster of PEI Stakeholders Work Group members under 1b above** demonstrates that we were successful in including representatives of the American Indian and Latino communities, representatives from the coast, south coast , and far north inland communities (Laytonville and Round Valley), as well as family members of individuals with mental illness and consumers, and those serving older adults and individuals with disabilities. Some members of the PEI Stakeholders Workgroup were open about their sexual orientation and were instrumental in ensuring that contacts were also made with the Gay, Lesbian, Bi-Sexual and Transgender community as part of our PEI Planning Process.

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As stated in **1b above**, the PEI Stakeholders Work Group was instrumental in defining focus groups that should be conducted as well as individuals with whom to meet for input about priority populations and needs to be addressed through our PEI funds and about strategy ideas. The PEI coordinator followed through on their ideas, conducted those focus groups, and consulted with as many of the suggested individuals as would agree to participate. (**See 2b** below for a listing of the focus groups and consultations conducted and the sectors of the community these represented. Also, detailed documentation of these is included in this plan as **Exhibits D1-D6**). Focus groups and interviews were conducted at the locations and times most convenient to the participants, including evenings, and furlough days. The PEI coordinator traveled to the coast, to Willits in the north inland region of the county and to the Covelo/Round Valley area in the far north, among other areas. The groups and meetings were not held at the Mental Health Division unless they were with staff of the Mental Health Division, or more convenient for participants than other locations. Every effort was made to schedule training/focus group meetings at the regularly scheduled meeting times and locations of these groups to ensure maximum participation. Finally, an information sheet and short survey was developed for those who missed meetings or could not make themselves available for interviews. The survey included the phone number and email address of the PEI Coordinator so that responding would be quick and easy. A sample of the survey is included in this plan as **Exhibit E**. Details about the many responses received through these surveys are included in this plan as **Exhibit F**

- b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.

See **2a above**. The following is a listing of the focus groups and consultations conducted during the planning process, and the sectors of the community these represented:

Focus Group/Consultation Summary

Focus Group Name	Community Sector	Date	Location
Focus Groups			
Adult System of Care (ASOC) Management Team	HHSA staff-- Adults & older adults	May 18, 2009	Ukiah HHSA ASOC Office
Family Resource Center Network	Community-based organizations serving stressed families, American Indians and Latinos	May 26, 2009	Willits Grange
Covelo Building	American Indians	June 2, 2009	Round Valley

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Focus Group Name	Community Sector	Date	Location
Horizons Group			Building Horizons Youth Center
Pride Alliance	Gay, Lesbian, Bi-Sexual & Transgender Community	June 5 (evening)	Maples Restaurant, Ukiah
Mendocino Office of Education (MCOE) Selected Staff	Education, including special education	June 11, 2009	MCOE Ukiah
Pride Alliance	Gay, Lesbian, Bi-Sexual & Transgender Community	June 11 (evening)	Methodist Church Ukiah
Manzanita Recovery Center (Gay, Lesbian, Bisexual, Transgender group)	Gay, Lesbian, Bi-Sexual & Transgender community, including consumers	June 12, 3PM (Friday)	Methodist Church Ukiah
Children & Family System of Care Management Team (CMIST)	HHSA staff-- Children & Families, Child Welfare and Mental Health	June 15, 2009	CWS Ukiah
Mental Health Crisis Staff	HHSA Mental Health Crisis staff.	June 18, 2009 4PM	HHSA Mental Health Ukiah
Youth Project Crisis	Community-based crisis staff serving youth 13-18	June 18, 2009 11 AM	Mendocino Youth Project offices Ukiah
Policy Council on Children & Youth/Child Abuse Prevention Commission (PCCY/CAPC) + Mental Health Organizational Providers	All agencies serving children youth and families in Mendocino County	June 25, 2009	Job Alliance Conference Room Ukiah
Agency Advisory Board	Countywide health care providers	June 24, 2009 9-12 AM	Community Health Conference Room, Ukiah
North Coast Opportunities (NCO) Resource &	Child care providers	June 30, 2009 10:30 AM	NCO Office Ukiah

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Focus Group Name	Community Sector	Date	Location
Referral Meeting			
Coast Interagency Case Management Team (IACMT)	Agencies serving troubled youth and their families on the coast	July 2, 2009 3:30	HHSA office Conference Room, Ft. Bragg
Teen and Transition Age Youth System of Care (TSOC)	Agencies serving youth and young adults countywide	July 6, 1-2:45	Mendocino County Administrative Center Conference Room, Ukiah
Older Adults System of Care (OASOC) Planning Group	Agencies and community members concerned with older adults	July 7, 2009	HHSA ASOC Conference Room Ukiah
Major Crimes Task Force Executive Board Meeting	Law Enforcement	July 9, 2009 10:00AM	Willits Police Department, Willits
Consolidated Tribal Health	American Indians	July 16, 2009 3:30 PM	Consolidated Tribal Health, Behavioral Health Calpella
Nuestra Casa Family Resource Center	Latino Community	July 16, 2009 5PM	Nuestra Casa Family Resource Center Ukiah
Homeless Services Planning Group	Agencies and community members serving homeless individuals countywide	July 20, 2009 1:30	HHSA Big Sur Conference Room Ukiah
Client Council Ukiah	Consumers and their family members	July 22, 2009 2PM	Methodist Church Ukiah
AAA Advisory Council	Agencies and community members concerned with older adults countywide	August 6, 2009 1:00	Redwood Coast Senior Center Ft. Bragg (Coast)
Manzanita Client Groups by Kate Howe	Consumers	July/August 2009	Ukiah
Alliance for Rural	Health Care,	August 14, 2009	ARCH Offices

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Focus Group Name	Community Sector	Date	Location
Community Health (ARCH)	Community Clinics		Ukiah
Consultations			
Alese Jenkins & Tawny Bailey	HHSA Child Welfare, Independent Living Program, THPP and THP+ & Arbor on Main—youth and transition Age youth	6/9/09	Arbor on Main Resource Center Ukiah
HHSA Mental Health Supervisors Support Group	HHSA children's mental health supervisors	6/9/09	Mendocino County Administrative Center Conference Room
Sonya Nesch, NAMI	Family member & mental health services advocate	6/16/09	Email
Cheryl Newman	Adolescent Family Life Program -teen parents	6/18/09	Email
Lynn McGuire	Cal-Learn Program --teen parents	7/2/09	Email
Jackie Herz Associate Behavior Specialist	MCOE/SELPA	8/3/09	Email
Vaughn Pena & Dino Franklin	Pinoleville Vocational Rehabilitation, American Indians and youth in Juvenile Hall	8/7/09	PEI Coordinators Office Ukiah

The PEI Coordinator received **40** survey responses:

- Organizational providers and individual clinicians under contract to the Mental Health Divisions **11**
- HHSA Staff members **1**
- Other professionals in the community such as teachers, community health clinic staff, and staff of community-based organizations and resource centers **9**
- Family members **2**
- Members of the Agency Advisory Board **8**
- Anonymous Respondents **9**

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- c. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate.

See **2a and 2b above**. Two focus groups were conducted that consisted of clients and family members: The **Client Council** meeting on July 22nd and the **GLBT meeting of the Manzanita Recovery Center** on June 12th. In addition, one of the Manzanita Recovery Center group facilitators, Kate Howe, gathered detailed input from clients at two other groups on her own and submitted this to the PEI coordinator. Further, family members were included and provided their passionate input at the PEI Stakeholders Work Group meetings all during the planning process, and submitted their opinions to the PEI coordinator via phone, email and survey responses.

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

- a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:
- Individuals with serious mental illness and/or serious emotional disturbance and/or their families
 - Providers of mental health and/or related services such as physical health care and/or social services
 - Educators and/or representatives of education
 - Representatives of law enforcement
 - Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families

See **1a, 2a and 2b above**. In addition to the contacts with clients and family members and underserved groups described above, focus groups or interviews were held with providers of mental health services, physical health services and social services. These were the **Adult System of Care(ASOC) Management Team** group on May 18, 2009 which includes AOD managers, adult social services managers and adult mental health services managers of the Health and Human Services Agency; the **Children & Family System of Care Managers Integrated Services Team (CMIST)** meeting on June 15, 2009, which also includes AOD services and child welfare services and children's mental health services managers; the meetings with the **Mental Health Crisis Unit** staff on June 18, 2009, the consultation with the **children's mental health services supervisor's support group** on June 9, 2009, and the Youth Project Crisis Services meeting on June 18, 2009; the **Agency Advisory Board** (formerly known as the Mendocino County Public Health Advisory Board) and **Alliance for Rural Community Health (ARCH)** meetings on August 6th and August 14th respectively. In addition, the following multi-agency meetings included providers of social services, behavioral health services and physical health services: The **Policy Council on Children & Youth/Child Abuse Prevention Commission**

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(PCCY/CAPC) meeting on June 25, 2009, **the Coast Interagency Case Management Team** on July 2, 2009, **the Transition System of Care meeting** on July 6, 2009, **the Older Adult System of Care Planning Group** on July 7, 2009, and **the Homeless Services Planning Group** on July 20th. The education community was addressed at the meeting with **Mendocino County Office of Education (MCOE)** staff on June 11, 2009, and the **PCCY/CAPC, TSOC, and IACMT groups** mentioned above also include representatives from the education community. Law Enforcement was included in the focus group held at the **Major Crimes Task Force Executive Board Meeting** on July 9, 2009. This group includes the heads of all the city police departments in Mendocino County, the California Highway Patrol, the County Sheriff's Department, the County Probation Department, the District Attorney's Office and the State Parks Department. Law Enforcement also has a seat on the interagency groups mentioned above at which focus groups were conducted—**PCCY/CAPC, IACMT, TSOC** and also on the **Area Advisory Board, and the Homeless Services Planning Group.**

The above sectors of the community have also been part of the PEI Stakeholder's Work Group since its inception.

Rosters of the PCCY/CAPC, TSOC, Area Advisory Board, and the OASOC and Homeless Services Planning groups are included in the plan as **Exhibits G1–G5**

- b. Training for county staff and stakeholders participating in the Community Program Planning Process.

In July of 2008, several members of the PEI Stakeholders Workgroup attended the PEI Regional Roundtable in Sacramento. Greg Griffin, Liaison from the Oversight and Accountability Commission (OAC) addressed the PEI Stakeholders Workgroup on August 11, 2008, to provide additional information and take questions about PEI. Then, at the PEI Stakeholders Work Group meeting on October 6, 2008, a training about the PEI planning process was provided by Dr. Will Rhett-Mariscal of the California Institute of Mental Health (CIMH).

The PEI Coordinator developed a power point presentation and informational handouts about the purpose of Prevention and Early Intervention funds, definitions of "prevention" vs. "early intervention", and examples of ways these might be utilized per the PEI Guidelines. The PEI Coordinator included these handouts and invited questions and discussion at each focus group and interview.

4. Provide a summary of the effectiveness of the process by addressing the following aspects:

- a. The lessons learned from the CSS process and how these were applied in the PEI process.

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The CSS process taught us to be thorough and discriminating in our collection and interpretation of data. We spent 10 months compiling and analyzing data from a variety of sources in our PEI planning process and utilized an analyst who was not part of the Mental Health Division to do it. This made for a data collection and analysis process that would be as free of bias as we could make it. This person also had a wealth of experience in the field of statistics—including its pitfalls and limits.

The CSS process also taught us to be thorough and open in the way we gathered input from all sectors of the community. We asked open-ended questions and attempted to listen carefully and to clarify any ambiguous information. The CSS plan gave us an array of contacts and groups already steeped in the mental health issues of our community and this made the PEI planning process easier.

We have also learned that it is important to follow up with the groups that have provided their input, to let them know directly the outcome of the process. Their perceptions and ideas have been essential to this plan, and have been incorporated in the four PEI projects Mendocino County is proposing whenever feasible and within the scope and purpose of the funds.

- b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

The success of our outreach efforts is evidenced in the composition of the PEI Stakeholder's workgroup (See **1b above**), the widespread sectors of the community willing to share their ideas about the PEI plan for our county as seen in the list of focus groups and consultations listed in **2b** above, as well as the many survey responses we received. It was also gratifying to see the good representation of interests during the meetings held on August 10th and 20th, when final recommendations were being developed (See **1b**). Finally, we were pleased to have the presence and great ideas of a transition age youth who is a consumer of Mental Health services at both the August 20th subcommittee meeting, and the September 14th PEI Stakeholders Workgroup meeting at which the strategy ideas and HHSA's recommendations were reviewed and discussed. In fact this young person's ideas have been incorporated in PEI Project #2, Early Onset, Early Intervention.

5. Provide the following information about the required county public hearing:

- a. The date of the public hearing:

The public hearing for the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan for Mendocino County took place on

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December 2, 2009. The public hearing for the County's Training Technical Assistance and Capacity-Building Funding Request which is included with the PEI Plan, took place on **December 16, 2009.**

- b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.

The draft of PEI Component of the Three-Year Program and Expenditure Plan was emailed to the entire MHSA Stakeholders Group, the PEI Stakeholders Work Group and all others on the PEI mailing list. The Plan was also posted on our website, of course, from October 29, 2009 through November 30, 2009. Notice of this posting, of how to access the document on the website or in hard copy was also posted in the lobbies of our Mental Health offices in Ukiah, Ft. Bragg and Willits. Hard copies were made available at those locations as well. In addition, hard copies were mailed or delivered directly to locations utilized by mental health clients, and by key constituencies in our county to ensure that it was easily accessible to them. These locations were:

- The Red House Recovery Center in Ft. Bragg
- Manzanita Recovery Center (Ukiah & Willits)
- Building Horizons Youth Group (American Indian organization in Round Valley)
- PRIDE Alliance Ukiah
- The Client Council (Ukiah)
- The AAA Advisory Council (Ft Bragg Senior Center)
- Arbor On Main (Transition-Age Youth Resource Center in Ukiah)
- Pinoleville Pomo Nation Vocational Rehabilitation Program (American Indian service program in Ukiah).

Additional hard or e-mail copies were available on demand.

The draft of the Training, Technical Assistance & Capacity Building Fund Request Form was also emailed to the entire MHSA Stakeholders Group, the PEI Stakeholders Work Group and all others on the PEI mailing list. It was posted on our website from November 16, 2009 through December 15, 2009. Notice of the posting, how to access the document on the website or in hard copy was posted in the lobbies of our Mental Health offices in Ukiah, Ft. Bragg, and Willits. Hard copies were available at those locations as well.

- c. A summary and analysis of any substantive recommendations for revisions.

There were no comments about the draft of the PEI Component of the Three-Year Program and Expenditure Plan at the public hearing, nor were any written comments received during the 30 days prior to the public hearing.

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Likewise, there were no comments about the draft of the Training, Technical Assistance and Capacity Building Funds Request Form at the public hearing, nor were any written comments received during the 30 days prior to the hearing.

d. The estimated number of participants:

There were 20 participants at the public hearing for the PEI Component of the Three-Year Program & Expenditure Plan as follows:

Name	Organization/Affiliation
1. Leslie Jo Feldman	Mental Health Board/Consumer, Family Member
2. Vonna Kindred-Myers	Mental Health Board, Secretary
3. Jane Berry	Mental Health Board, Treasurer
4. Eliste Reeves	Mental Health Board/Consumer, Family Member
5. Guy Grenny	Mental Health Board/Consumer, Family Member
6. Perry G. Joshua Two Feathers Tripp	Mental Health Board/Consumer, Family Member
7. Sandra O'Connor	Mental Health Board/Public Interest
8. Jim Moore	Mental Health Board/Public Interest
9. Valerie Williamson	Mental Health Board/Public Interest
10. John McCowen	Mental Health Board/ County Board of Supervisors
11. Wynd Novotny	NAMI/Consumer, Family Member, PEI Stakeholder's Work Group
12. Raven Price	TAY Consumer/Client Council
13. Lori Sweeney	HHSA Older Adult System of Care, MHSA Stakeholder, PEI Stakeholder's Work Group
14. Laura Welter	Safe Passage Family Resource Center, MHSA Stakeholder, PEI Stakeholders Work Group
15. Maya Stuart	First 5 Mendocino, MHSA Stakeholder, PEI Stakeholders Work Group
16. Carole Orton	Consolidated Tribal Health, PEI Stakeholders Work Group
17. Tracy Burris	Public, Student-Sonoma State University
18. Karen Rizzolo	HHSA, Children & Family System of Care, Mental Health, Administrative Secretary
19. Jill Singleton	HHSA, Children & Family System of Care, Mental Health, PEI Coordinator
20. Mary Elliott	HHSA, Children & Family System of Care & Mental Health Director

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There were also 20 participants at the public hearing for the Training, Technical Assistance and Capacity Building Funding Request Form as follows:

Name	Organization/Affiliation
1. Sandra O'Connor	Mental Health Board/Public Interest
2. Vonna Kindred-Myers	Mental Health Board, Secretary
3. Jane Berry	Mental Health Board, Treasurer
4. Eliste Reeves	Mental Health Board/Consumer, Family Member
5. Valerie Williamson	Mental Health Board/Public Interest
6. Guy Grenny	Mental Health Board/Consumer, Family Member
7. Perry Joshua Two Feathers Tripp	Mental Health Board/Consumer, Family Member
8. Jim Moore	Mental Health Board/Public Interest
9. Leslie Jo Feldman	Mental Health Board/Consumer, Family Member
10. John McCowen	Mental Health Board/ County Board of Supervisors
11. Josephine Silva	Public
12. Kate Howe	Public, Manzanita Recovery Center
13. Wynd Novotny	NAMI/Consumer, Family Member, PEI Stakeholder's Work Group
14. Susan Era	HHSA, Adult & Older Adult System of Care and Social Services Director
15. Mary Elliott	HHSA, Children & Family System of Care & Mental Health Director
16. Karen Rizzolo	HHSA, Children & Family System of Care, Mental Health, Administrative Secretary
17. Diana Chambers	HHSA, Adult & Older Adult System of Care, Mental Health Deputy Director
18. Gayle Harris	HHSA, Mental Health Quality Assurance & Contracts
19. Laurel Bleess	HHSA, Adult System of Care, Mental Health, Patient Advocate
20. Jill Singleton	HHSA, Children & Family System of Care, Mental Health, PEI Coordinator

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Note: County mental health programs will report actual PEI Community Program Planning expenditures separately on the annual MHSA Revenue and Expenditure Report.

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Form No. 3

County: *Mendocino* PEI Project Name: *#1-- Education, De-stigmatization & Peer Support* Date: . 2009/10 - 2011/2012

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Stigma and Discrimination	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Suicide Risk	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

In our PEI planning process, we conducted 30 focus groups and consultations with “key informants”, and received 40 survey responses. (These are documented in **Exhibits D1-D6 and Exhibit F**) After providing a brief training about the purpose, definitions, scope, options for, and limits of PEI funds, we asked simple open-ended questions:

- *If you could target a group or groups of people to receive (prevention or early intervention) services for mental health in our county, what group or groups would that be?*
- *What is your estimate of the number of people in this group or groups?*
- *What are the mental health issues you perceive in them;*
- *Do you know of existing services or programs in our county that address any of their needs now? What are they?;*
- *What kinds of service(s) and program(s) do you think would help them?*

The need to educate the community as well as individuals with mental illness and their families was strongly asserted *in virtually every focus group and discussion conducted during the planning process*. Education and de-stigmatization were, in effect, inseparable topics. Education about the nature of mental illness, the causes and remedies was seen as the best way to de-stigmatize it. Education would enable professionals, early responders, neighbors and friends to recognize signs and symptoms and to respond effectively. It would also act to encourage troubled individuals and/or their families to seek out help, and to accept the need for and efficacy of mental health treatment. Clients of the Mental Health Division and their families said that having examples of individuals with mental illness who have made significant contributions in the world, or have had successful careers and lives, would have gone a long way toward breaking down their denial and resistance to treatment in the early stages of the illness. One parent said, “Education about mental illness is the most important thing. This education has to be made available in every community, every high school...and in many other local groups, and open to the public. Educating people about mental illness so they can recognize it when it occurs could perhaps shorten the time of denial.” Another said, “Both the ill individual and others need to see mental illness in the same way as diabetes. It is an illness that needs to be managed...” A member of a multi-agency group on the coast said, “...on the coast, families wait too long to get services because of the stigma. Everyone will know.”

Many respondents spoke of cultural and generational biases that act as obstacles to obtaining help with mental health issues. They asserted that education efforts would need to be customized to our American Indian and Latino populations

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as well as the older adults in our community. For example, at a meeting with Consolidated Tribal Health, a respondent asserted that the whole Native American community should be educated "...about what mental health is...but in a way they can accept...we need a positive approach." At a focus group at the Nuestra Casa family resource center which serves the Latino community in the Ukiah area, a respondent suggested holding "...educational forums for all ages..." about mental health and mental illness, and advised avoiding the word "therapy".

The need for peer support went hand-in hand with education and de-stigmatization in discussions with clients, family members, professionals and experts in the field. Peer support was described as an effective way to encourage individuals to recognize their illnesses and an essential ingredient in enabling them to manage their conditions ongoing. Peer support was also seen as a great need for the families of those with serious psychiatric illnesses. This concept was reiterated by the crisis workers of the Mental Health Division concerning the clients they deal with, especially those experiencing early onset. Members of the Gay, Lesbian, Bi-sexual & Transgender groups, some of whom were clients of the Mental Health Division, indicated that peers can provide acceptance and a safety net for each other. When asked what would help, other client groups put peer support near the top of their list of remedies second only to de-stigmatization and education. Respondents from the Alliance for Rural Community Health (ARCH) suggested that schools offer peer groups or empowerment groups for kids that address a variety of issues affecting mental and physical health. The staff of the Pinoleville Pomo Nation's Vocational Rehabilitation program talked of their success with "talking circles" they conduct to help youth in juvenile hall address their behavioral and emotional concerns. Those who work with or care for older adults consider contact with peers an essential strategy for both early intervention in, and prevention of mental illness for this age group.

3. PEI Project Description: (attach additional pages, if necessary)

During the discussions of the Stakeholders PEI Workgroup about strategies, most ideas included education, de-stigmatization, and peer support. Therefore this project would interface with other PEI projects Mendocino County is proposing. The call for these services was so widespread, and ideas for their application so varied, that we felt an education, de-stigmatization and peer support strategy merited a focused approach on its own. This project would be provided through a contract or contracts resulting from a Request for Proposals (RFP) or Request for Qualifications (RFQ). Because of this, exact details of the project are as yet undetermined. Mendocino County would solicit for proposals with the goal of securing a sufficient number of providers to ensure that education, de-stigmatization and peer support are available in all regions of the county, reflect the needs of all age groups and underserved populations, and address language and cultural issues appropriately. Proposal would be sought that included the following components:

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Interactive education modules

These modules would provide information about mental health issues of all types and common to all age groups. Information would include the signs and symptoms, red flags and intervention and treatment options. They would utilize video taped or in-person testimonials of individuals who have experienced mental illness to “put a face” to the issues. In addition to providing information, the modules would allow for discussion and a question-and-answer period.

The modules would be designed in a way that would make them replicable *across the county* and usable with a variety of audiences including the spectrum of age groups, the American Indian and Latino populations of our county, the medical community, the education community, law enforcement, mental health providers, public health nurses, social workers, paraprofessionals, parents, and others.

The modules would also include handouts in English and Spanish about the local resources addressing behavioral and emotional health and how to contact them.

Peer Support

This project would facilitate the establishment of support groups as needs surface through the educational sessions, and would also link participants in the interactive education modules to any existing peer support groups as appropriate. Trained peers or paraprofessionals would facilitate the new peer support groups. The focus of the newly established groups would be *ongoing de-stigmatization of mental illness through the support of peers along with encouragement and guidance for seeking and accepting treatment or other services that would contribute to emotional wellbeing.*

Training for Trainers

A key component of this project would be training for trainers about 1) organizing and facilitating the interactive education modules, 2) providing peer support, 3) facilitating peer support groups.

DURATION OF KEY ACTIVITIES

We anticipate that most of the interactive education modules, and training for trainers/facilitators would take place in years two and three, as would the development of peer support groups. Thereafter, community organizations would have the materials and expertise to conduct interactive education modules as needed, and/or these would be incorporated in their ongoing education offerings. We anticipate the selected provider or providers would need to offer only three new interactive education modules per year at most, and update handouts as needed at minimal cost.

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KEY MILESTONES

3 ½ Mos. Prior to Implementation	2 Mos. Prior to Implementation	Implementation Month 1	Month 2	Month 3 & Ongoing	Month 7	Month 12	Month 30
Release RFP	Select provider(s) Develop contract(s)	Notify key organizations & community Develop handouts Refine tracking and reporting methods; before & after tests; peer support participant surveys	Begin inter-active modules & T for T Establish 1 st peer support groups	Continue interactive modules, T for T and peer support groups	1 st report on numbers and demographics served; results of before and after tests; survey results for peer support group participants Meeting with provider(s) to assess progress, outcomes & determine any needed adjustments	2 nd report and meeting with provider(s) to assess progress, outcomes & determine any needed adjustments Follow-up reports and meetings every 6 months thereafter.	Meet with provider(s) to assess ongoing level of service needed.

PEI PROJECT SUMMARY

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Interactive education modules	Individuals:336 Families:265	Individuals:66 Families:52	6
Peer Support	Individuals:150 Families:150	Individuals:30 Families:30	6
Training for Trainers	Individuals:12 Families:N/A	Individuals:12* Families:N/A *Same trainers as Prevention	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals:348 Families:265	Individuals: 66 Families:52	6

5. Linkages to County Mental Health and Providers of Other Needed Services

In proposing to conduct this project, we recognize that it is essential to do more than simply educate the community about mental health. The information is of little help unless resources are available or accessible from every region in the community. The inclusion of peer support groups is one way to make sure this is possible. The handouts that would be included as part of the interactive education modules allow individuals and family members to self-refer for services also. In addition, respondents to the RFP or RFQ for this project would be required to demonstrate in their proposals how they

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would ensure that individuals participating in the interactive education modules and peer support groups are linked, as needed, to the Mental Health Divisions of the Children & Family System of Care (CFSOC) and the Adult and Older Adult System of Care (AOSOC) of Mendocino County's Health & Human Services Agency. They would also be required to address linkages to other providers of mental and behavioral health services as well as parent education classes, social services and other resources. Further, the Mental Health Divisions would work with successful candidates to establish a clear path for referrals and communication as part of their contracts.

Finally, as stated earlier, this project would act as a component of other PEI projects Mendocino County is proposing. In that way, linkages to the Mental Health Divisions are built in.

6. Collaboration and System Enhancements

This project presents our county with a huge opportunity for collaboration. Among the many possible collaborators are:

- Current contractors and organizational providers of the Mental Health Divisions;
- Other divisions in the Health and Human Services Agency;
- Community clinics and health centers;
- The local chapters of the National Alliance on Mental Illness (NAMI)
- Private non-profit community-based organizations such as the eight family resource centers;
- Schools, and community colleges;
- Tribal organizations;
- Senior Centers;
- Churches, granges and service clubs.

All of the above are entities that work with people, and have facilities where people already gather in every region of our community. They are likely locations for interactive educational sessions and peer support groups. Many have staff members who could be trained to facilitate peer support groups or conduct the education modules, or adapt them to programs they already provide.

This project would enhance the mental health system in our county in several ways. First it provides an additional resource through its peer support groups. These are a particularly attractive resource because they are client-driven and recovery oriented in the spirit of the Mental Health Services Act. The project would enhance the system also by

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developing an architecture for mental health intervention and treatment that is similar in each region and understood by the community at large, and by human service providers at all levels. Lastly, it would enhance the system by inviting and encouraging afflicted individuals and their families to take charge of their conditions early, and by mobilizing each community to engage with its members who have, or are at risk of developing mental illness, instead of seeing this as the task of the Mental Health Divisions alone.

7. Intended Outcomes

For Individuals

- Experience less stigma and discrimination;
- Decrease in untreated mental illness and risk of suicide;
- Improve ability to accept one's own mental health needs or those of family members and seek assistance;
- Receive ongoing encouragement and support from peers to accept a mental health condition and learn to manage it;
- Increase knowledge of local and other resources;
- Families and caregivers receive prompt information and assistance with individuals at the early onset of mental illness.

For the System and Project

- All sectors of the community have more *accurate* information about mental illness and suicide, and are more engaged in solutions;
- There is a decrease in untreated mental illness and suicides;
- Community members and clients know how to get help for various mental health issues, whom to contact, and how to make referrals;
- Peer support groups are established in every region and among them are those that focus on culturally appropriate and effective approaches for American Indians and Latinos, older adults, children and their parents, and individuals with co-occurring substance abuse disorders;
- An increase in the number of individuals and families who seek mental health assistance early, and a higher rate of recovery among those served.

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Before and after tests would indicate a decrease in stigmatization of mentally ill individuals and an increase in knowledge about mental illness. These tests would be administered by group facilitators at the interactive educational meetings and at peer support groups. Our manual tracking system and/or an Avatar-generated report would show an increase in the number of referrals from educators, community health providers, other divisions of the Health and Human Services Agency, family resource centers, parents and others. The establishment of peer support groups would be enumerated and monitored through the contracts that result from the RFP/RFQ process. A semi-annual survey of peer support group participants would indicate any changes in their experiences concerning stigma and discrimination as well as their own acceptance of their mental health needs. Suicide data can be obtained from the emergencies rooms of the three hospitals in Mendocino County as well as the Sheriff/Coroner. The prevalence of untreated mental illness would be obtained through surveys with entities serving the homeless in our community, law enforcement, community clinics and branches of the Health and Human Services Agency.

8. Coordination with Other MHSA Components

Since this project includes providing information about local resources to address mental health issues, it would link to the projects included in Mendocino County's Community Services and Supports (CSS) Plan in that way. In addition, this project would be one of the components of the PEI Prevention Project for Older Adults (Project #3) which is an augmentation of Work Plan #5 of the County's CSS Plan. Also, this project could be an element in Project #4 of our PEI Plan.

Mendocino County has not yet developed its plans for Capital Facilities and Technology funds, and so we do not anticipate using these funds for PEI projects. We also do not anticipate using any Workforce Education and Training (WET) Funds for PEI projects. This project, however, could serve as an adjunct to trainings provided to HHS and law enforcement staff who are trained through WET.

9. Additional Comments (optional)

Since the development of Mendocino County's PEI Plan, the California Strategic Plan on Reducing Mental Health Stigma and Discrimination was released. We are pleased to see many similarities between the State's plan and this project. We will draw from, and coordinate with the State's plan as we implement our Education, De-stigmatization & Peer Support project.

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County: Mendocino PEI Project Name: Project #2 Early Onset, Early Intervention: TAY 2009/10 -2011/12

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
C. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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D. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The data we were able to collect in our PEI planning process and the input we received through focus groups, surveys and key informant interviews led us to the decision to utilize a good portion of PEI funds to provide early intervention services for transition age youth and young adults at the early onset of a serious psychiatric illness—and their families. The data cited below are extracted from our **Community Mental Health Assessment Data Report (Exhibit B) pages 29-34.**

In calendar year 2007, of the 282 total acute psychiatric hospitalizations in Mendocino County, approximately 58 (over 20%) were related to the symptoms of a first break, typically in a person between the ages of 16 and 25. As of June, 2008, Mendocino County housed 15 individuals in Institutes of Mental Disease. Of those, 5 (33%) were young adults whose first hospitalization in the previous year was a result of a first break. An analysis of the data collected as part of our PEI planning process revealed the following additional data about transition-age youth and young adults in our county:

- 77 suicide attempts in 2007 and 2008 that were serious enough for an emergency room visit;
- Nearly 100 individuals in this age group were counted among the homeless per the Mendocino County Homeless Census and Survey in 2007
- Of the 120 admissions from this age group into the County's Alcohol and Other Drug Program in 2008, 26 self-reported a mental illness diagnosis and 15 self-reported a mental illness diagnosis with methamphetamine as their drug of choice.

The above statistics are alarming enough in a county with a total population of fewer than 100,000. The situation is even more concerning because of the consensus of local professionals in the fields of medicine, social services, mental health and alcohol and drug abuse prevention, that suicide attempts, co-occurring disorders and the incidence of mental illness among the homeless are under-reported. Documented suicide attempts, co-occurring disorders and mental illness among the homeless in the next age group—adults 26-59—are difficult to compare to those for the transition age population because the adult population is much larger, spanning 33 years instead of nine. However, it is recognized that “the onset of a serious psychiatric illness most often occurs by age 25” (Proposed Guidelines, Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan, September 2007.) This recognition is played out in the diagnoses recorded for these two age groups in our County Mental Health data system in 2008. For the transition age group, the most common diagnoses were for adjustment disorders (21%) and depression (19%), while more than half of the diagnoses were deferred (53%). For the adults aged 26-59, the most common diagnoses were schizophrenia and

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related disorders (30%), depression (24%) and bi-polar disorders (18%). Just 26% of the diagnoses were deferred for this age group. We can surmise that the early onset of many of the serious psychiatric illnesses that were diagnosed in the older age group occurred in the transition age that came before. The term “transition-age” is apt. Those nine or so years are a gateway to an individual’s adult life, in many ways a turning point in the person’s life story. This seems especially true for his or her mental health.

In our PEI planning process, we conducted 30 focus groups and consultations with “key informants”, and received 40 survey responses. (These are documented in **Exhibits D1-D6** and **Exhibit F**) After providing a brief training about the purpose, definitions, scope, options for, and limits of PEI funds, we asked simple open-ended questions:

- *If you could target a group or groups of people to receive (prevention or early intervention) services for mental health in our county, what group or groups would that be?*
- *What is your estimate of the number of people in this group or groups?*
- *What are the mental health issues you perceive in them;*
- *Do you know of existing services or programs in our county that address any of their needs now? What are they?;*
- *What kinds of service(s) and program(s) do you think would help them?*

Responses covered the gamut of age groups and populations. For prevention purposes, of course, great interest was expressed in starting as early as possible. Strategies that focused on parents and school-aged children were especially frequent. However, common themes included the need for better mental health crisis services and post-crisis services, as well as mental health services for people who “fall through the cracks”. When asked about what crisis and post-crisis services meant, respondents were often referring to “out-of-control teens and young adults” they thought might be on the threshold of, or experiencing a first break. When asked about what “falling through the cracks” meant, respondents were often referring to individuals who were not already in the Mental Health system, or who did not qualify for existing programs and services because they did not have MediCal or adequate insurance, or because their behavioral issues crossed Social Services, Mental Health, and Law Enforcement systems and did not fit neatly into any of them. As a result, some individuals and their families go through years of unresolved turmoil with sometimes tragic outcomes. Commonly, these circumstances are present for transition age youth and young adults, also known as TAY.

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Mental Health Crisis workers pointed out that "...there are amazing services for children, but the minute they turn 18, the services dwindle". They stated that at the early onset of mental illness, "clients often don't believe they are mentally ill and are resistant to taking medications because of the side effects and stigma. Families are in denial and fear." The Crisis Workers indicated that when they deal with individuals who have been hospitalized for the first time, it typically isn't really the person's first break, because the client and their families dismiss early symptoms and incidents, and rationalize them in many ways. The Client Council also spoke of the need to address both the young person experiencing the early onset of a psychiatric illness and his or her parents. They pointed to the need for help to be made "immediately available" at the first break or the early signs of a serious mental illness, and vigorously asserted the need for peer support all along the way. Like virtually every other focus group, the Client Council spoke eloquently of the need for education about the signs and symptoms of mental illness for those experiencing it, their parents, and key community members. Among the key community members frequently cited were so-called first responders such as law enforcement personnel. Our focus group with law enforcement revealed much frustration about interactions with individuals who suffer from mental illness and co-occurring disorders. They felt their interventions often entailed futile transports to emergency rooms and multiple subsequent involvement by officers in other jurisdictions. They said that the number of mentally ill individuals in local jails and in prisons is growing for lack of alternatives. This assertion is consistent with the data we were able to gather for our Data Report (**Exhibit B**) which indicates that between 1/5 and 1/4 of the inmates in the Mendocino County jail in any given month are receiving psychiatric medication. Per input from law enforcement, this inappropriately expends law enforcement resources without providing needed assistance to the mentally ill individuals or their families. They asserted that a better crisis response is needed. The Client Council also called for an improved interface between Mental Health and law enforcement as did the Mental Health Crisis Workers, and many other focus groups. Similarly the need to address substance abuse issues along side mental illness was a prevalent response in focus groups, surveys and key informant interviews across the board—and no less so for the transition age population at the early onset of a serious psychiatric illness. Furthermore, our data and our input from groups and individuals across the county indicate that American Indians are over-represented among almost all at-risk populations and indicators compared to their numbers in the population as a whole, and that neither the American Indians in our community nor the Latinos are accessing mental health services at a level we should expect. Finally, one of our "key informants", Diana Chambers, the Deputy Director of Adult Mental Health Services, advised that we placed 50 mental health clients in Institutions of Mental Disease in the year 2007/2008. "The tab for this totaled \$1,506,320," she said. The funding came from realignment dollars which cannot be used to leverage additional dollars that would allow us to provide in-County mental health services, "...so our program loses twice." In 2007/2008, the average cost per adult client placed in high-level residential facilities was \$30,126. At current rates, the average cost per client per year has increased to \$33,266. The costs will continue to increase if we cannot reduce the numbers of clients we must keep in placement. Ms. Chambers went on to state that targeting young

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adults who have experienced the early symptoms of serious mental illness could change this picture: “Young people have behavioral patterns less deeply ingrained than adults, therefore they have more capacity to change them. People who have not experienced institutionalization have not developed the ‘learned helplessness’ and passivity that chronic institutionalization fosters. These attitudes function as serious barriers in recovering and regaining independence.”

Mendocino County has resources to build on for the TAY population. However, at this time they are insufficient to put an end to the human suffering and the drain on both the community and the Mental Health system that will continue without an effective intervention with transition age youth at the early onset of serious psychiatric illnesses. There are no dedicated psychiatric, therapeutic or case management services available to address the unique and complex issues presented by an individual experiencing the onset of serious symptoms of mental illness. There are also no dedicated services available to provide support to the families and loved ones of such individuals who are sharing the traumatic crisis of a first break.

3. PEI Project Description: (attach additional pages, if necessary)

This project will provide a comprehensive constellation of linked services for 10 to 15 individuals aged 16 through 25 who are suffering from the early onset of a serious psychiatric illness and their families. It is founded on two best practice models for first break early intervention recommended by the State: Early Psychosis Prevention and Intervention Centre (EPPIC), Melbourne Australia, and the Early Diagnosis And Preventative Treatment of Psychosis Illness (EDAPT), Sacramento, California. The project will give priority to American Indians, Latinos, and newly incarcerated youth and young adults whose offenses would allow them to be released to partake of the project’s services. The project will also include services to address those transition-age youth and young adults with co-occurring disorders. Services will be available to individuals from all regions of the County. Several of the project’s components will be provided through contracts resulting from a Request for Proposals (RFP) or Request for Qualifications (RFQ), so that exact costs and services are not yet known.

Project Components:

- *Dedicated psychiatry.*

This service would be provided through a contract and may result from a RFP or RFQ, or the expansion of an existing contract. Mendocino County currently contracts with a pediatric psychiatrist who is interested in working with transition-age youth and young adults as well. There is also potential for providing tele-psychiatry through this contract and in collaboration with Yuki Trails Human Services of the Round Valley Indian Health Center that could be utilized for American Indians residing in the remote Round Valley reservation. The pediatric psychiatrist would

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be available to the Ft. Bragg office on the coast via tele-psychiatry as well. In addition we have contracts with two adult psychiatrists based in Ft. Bragg. This service would provide prompt, responsive psychiatric assessment and treatment.

- *Dedicated case management and counseling,*

This service would be provided through ½ FTE Mental Health Rehabilitation Specialist. The rehabilitation specialist will act as a Personal Services Coordinator for each client. Services would include an emphasis on psycho-social development and recovery and would link clients to existing social, vocational and education resources. Services would also include individualized education about the nature of the client's illness and its treatment, help with the reduction of disruption in the client's life, and promotion of well-being and hope.

- *Dedicated family therapy, and education,*

This service would be provided through ½ FTE Mental Health Clinician. The service would include helping the client and the client's loved ones make the adjustment *together*, to the realities and new circumstances occasioned by the client's illness and help them make health-promoting decisions for all family members.

- *Peer support*

This service would be provided utilizing transition-age individuals who are over age 21, and parents of individuals who have serious psychiatric illnesses as volunteers. It may entail an RFP or RFQ for training these peer support facilitators. In the inland part of Mendocino County, peer support would be provided at The Arbor on Main, a resource center specializing in the issues of transition age youth and young adults. Peer support would be developed and provided in natural settings in other regions of the County as well, as determined by the needs of the TAY clients as they are identified for this project. This service would enable clients to receive support and guidance in ways they can accept from peers who have experiences in common with them. The service would also encourage socialization that could help clients maintain a place in "normal" mainstream life. In addition, this project would provide for a peer support person to work with the County's Crisis Unit when transition-age individuals are being served, as available.

- *Alcohol and Other Drug rehabilitation services*

This service would be provided through groups and individual rehabilitation services by Alcohol and Other Drug Treatment staff employed by the County's Community Health Branch, and housed with our Mental Health Divisions.

- *Full Service Partnerships for individuals 18 and older*

We estimate that approximately six of the individuals served through this project will be eligible for Full Service Partnerships through MHS Community Services and Supports. The remaining nine could receive similar services

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through the Family Strengths Program supported by Children's System of Care funds. In both cases, this would involve building a supportive team including Mental Health professionals, family friends and trusted community members to customize "wraparound" services for these clients and their loved ones. This program would include the utilization of MHSA (CSS) "flex funds" as needed for each client to help provide supportive services. This program would not utilize PEI funds.

- *Supported housing*

This program would expand the existing TAY Wellness program which is funded through CSS. It would add supported independent living for six more clients aged 18-24 who are participating in the TAY Early Onset, Early Intervention Project.

- *The development of a new "best practice" screening instrument.*

This program would make use of a brief screening tool currently being developed in our Mental Health Divisions, to be utilized by care providers, school counselors, doctors and other service providers to identify prodromal symptoms of mental illness and suicide risk. The development of this tool would not require PEI funds. The program would include a brief training about the project and about how to use the screening instrument. We anticipate providing training about the project and the instrument as part of the ongoing assignments of the CFSOC Deputy Director and with the addition of Training, Technical Assistance & Capacity Building funds should these be granted to our County. (If granted, the Training, Technical Assistance & Capacity-Building funds would pay for a nationally recognized expert on effective early onset interventions for this age group to kick off the implementation of this important PEI project, and other related costs.)

- *Community outreach & education*

This program would be provided countywide through a contract, as part of PEI Project #1. It would entail workshops that educate the general public, family members, and service providers about the warning signs of mental illness and suicide and what to do. Workshops would include handouts listing local resources and contact numbers. Workshops and handouts would be provided in English and Spanish as needed. Workshops would take place in natural settings such as schools and college campuses, churches and family resource centers for the general public, and at clinics and hospitals, and agency offices for community providers.

DURATION OF KEY ACTIVITIES

- Dedicated psychiatry: Throughout project
- Dedicated case management & counseling: Throughout project
- Dedicated family therapy and education: Throughout project

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- Peer support: Peer support groups would continue throughout the project, but we anticipate that training of peer support facilitators will take place only during the first six months after implementation.
- Alcohol and other drug rehabilitation services: Throughout project
- Full Service Partnerships: Throughout project
- Supported housing: Throughout project
- Best practice screening instrument: Prior to implementation only
- Community outreach & education: First 30 months after implementation

KEY MILESTONES

3 ½ Mos. Prior to Implementation	2 Mos. Prior to Implementation	1 Mo. Prior to Implementation	Month 1	Months 2-6	Month 7	Month 12
RFPs/Qs: Supported Housing & Peer Facilitator Training	Select Providers: Supported Housing & Peer Facilitator training	Invite key community members/staff to kick-off event	Begin accepting referrals	Start peer support groups	Review progress: #s screened, referred & served; hospitalizations and placements	Semi-annual review of progress and results as in Month 7
Develop Screening Instrument and training	Develop contracts	Hold kick-off event	Train peer support facilitators		Meet with partners/contractors and clients/families to assess what's working, what's not and plan any needed adjustments	
Refine referral, tracking and reporting methodology and tools		Conduct training on screening instrument				
Plan kick-off event			Implement all components			

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Dedicated Psychiatry	Individuals: Families:0	Individuals:6 Families:	6
Dedicated Case Management & Counseling	Individuals: Families: 0	Individuals: 6 Families:	6
Dedicated Family Therapy and Education	Individuals:0 Families:0	Individuals:6 Families:6	6
Peer Support	Individuals:0 Families:0	Individuals:6 Families: 6	6
Alcohol & Other Drug Rehabilitation Services	Individuals: Families:	Individuals: 3 Families:0	6
Full Service Partnerships/Family Strengths (Paid through CSS & CSOC, not PEI)	Individuals: Families:	Individuals: 6 Families:6	6
Supported Housing	Individuals: Families	Individuals:6 Families:0	6
Screening Instrument	Individuals: Families:	Individuals:18 Families:	6

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	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		
(Paid through existing contract & in-kind County staff, not PEI)			
Community Outreach & Education—Warning Signs & Response(PEI Project #1)	Individuals: Families:	Individuals: 46 Families: 46	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED (With PEI funds)	Individuals:0 Families:0	Individuals: 6 Families:6 (Does <u>Not</u> include those served through shaded components. These components either do not utilize PEI funds, or are part of another PEI project)	

5. Linkages to County Mental Health and Providers of Other Needed Services

The community outreach and education component and the screening instrument component will both include training to mental health and other service providers about the project in general, about the specific ways to use the screening instrument and/or make referrals to the Early Onset, Early Intervention project. Also, clients who are screened out of the Early Onset, Early Intervention project may still need less intense mental health services that might be provided at local clinics or through contracted or in-house mental health providers or other PEI components. Similarly the clients and their families might benefit from or need the services of other HHS agencies, or community-based organizations. This project would provide information to screened-out clients and their families about alternative services available to them and would facilitate referrals to these services as needed through existing entities such as the Interagency Case Management Team (IACMT), the Multi Provider Screening Team (MPST), and through direct contacts with service providers.

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6. Collaboration and System Enhancements

This project itself is an enhancement to our system in that it will provide *a cohesive package of services that did not exist previously*. It will provide these at a critical point in the trajectory of individuals' lives and in the trajectory of serious mental illnesses. If successful, it will change the profile of Mendocino County's mental health services so that more of its resources are used on truly effective, recovery-based, client-driven approaches, and on prevention services. The project would build upon existing relationships and develop new collaborations that promise to enhance current systems in the following specific ways:

- Dedicated psychiatry may be provided by a child psychiatrist with whom the County has an existing contract, or another provider through a RFP or RFQ. Back-up could be provided by another psychiatrist who is a County employee, or under contract. Serendipitously, Yuki Trails Human Services, part of the Round Valley Indian Health Center in a remote area of Mendocino County, has recently obtained tele-psychiatry equipment. This section of the county is home to a relatively large population of American Indians from several tribes. The area and the population are chronically underserved. Collaboration with Yuki Trails Human Services and our contracted psychiatrist would not only allow us to provide dedicated psychiatric services that didn't previously exist for the transition-age youth and young adult population, it would enable us to provide these services to an outlying area of the county and an underserved population.
- Providing dedicated individual case management and counseling as part of a package of services for young people at the early onset of a psychiatric illness, is a huge enhancement to a system that previously was a hit-and-miss proposition at best. It connects these individuals immediately to information and assistance to help them understand and cope with their circumstances in an individualized way. This component will utilize and strengthen collaborations such as those with the community college, the Arbor on Main and other resource centers where clients may avail themselves of classes, get help with utility bills, obtain food, access on-line job search sites and socialize. Several family resource centers offer classes and groups in Spanish—specifically Nuestra Casa in Ukiah, with whom the County has a long-term collaboration as well as contracts to provide mental health and AOD services in Spanish; Nuestra Alianza de Willits in the North inland area of the county; Safe Passage in Ft. Bragg; and Action Network on the South Coast. These sites can help clients referred with the completion and translation of forms and notices, and link them to cultural activities. This component of the Early Onset, Early Intervention project also has the potential for collaboration with such organizations as

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Consolidated Tribal Health, Round Valley Indian Health Center, Pinoleville Vocational Rehabilitation—Youth Transition Partnership and the Building Horizons Youth Program which provide a variety of vocational, educational, health and recreational activities for American Indians that could support recovery.

- Similarly, dedicated family therapy and education, as part of this package, supports the families and loved ones who were previously left alone to face a confounding crisis and to seek out remedies and with little or no guidance. The understanding, support and reinforcement that can be offered by families that are informed and prepared to work with mentally ill loved ones can go a long way toward promoting recovery and independence, and preventing the deterioration and homelessness that are too often the result of psychiatric illnesses. This project provides the potential for closer collaboration with local chapters of the National Alliance on Mental Illness (NAMI), with parents and other loved ones, and with clients in our community to develop the specific education components and supports that will help families. For example, one parent indicated that families and their mentally ill loved ones need communications skills training, and they need to be given examples of people who have led successful lives while living with mental illness as part of their education about mental illness. To avoid the stigma associated with entering Mental Health departments, these services would ideally be offered in natural settings that once again could be provided through collaboration with a variety of community organizations such as clinics and resource centers and schools.
- Community outreach and education along with the development of a new screening instrument both lend themselves to collaboration with community clinics, schools, organizational and individual providers of mental health services, public health services and social services. These organizations are located in nearly every community and have occasion to come in contact with troubled individuals and families. The project calls for training key staff of such organizations to utilize the instrument with clients who come to their attention, and to provide them with a clear path for referrals for further assessment and possible treatment through this project.
- Alcohol and Other Drug Abuse Prevention programs have recently become part of the Mental Health Divisions of both Adult and Older Adult Systems of Care, and Children & Family System of Care within Mendocino County's Health and Human Services Agency. Therefore we expect that collaborating with them to provide assessment and treatment of the substance abuse issues of TAY clients with co-occurring disorders should be seamless. This collaboration also could lead to the refinement of such services for this particular population, and further systems enhancements.
- The peer support component will extend our collaboration with the Arbor on Main in Ukiah and its parent organization, Redwood Children's Services. It may also lead to additional collaborations with entities in our

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coastal and outlying communities that may begin offering peer support through Project #1, and with Manzanita Recovery Services in Willits.

- In our effort to give priority to transition-age youth and young adults who have been incarcerated, and who are experiencing the early onset of a serious psychiatric illness, we hope to strengthen our communication and collaboration with Juvenile Probation, the County Sheriff and other law enforcement entities. This project promises to provide a cohesive service and clear path of referral for mental health services that keep such clients from repeated incarcerations and free up law enforcement personnel to deal with the criminal activities they are trained and equipped to handle.

7. Intended Outcomes

For individuals

Significant and measurable increase in wellness, recovery and hope among participating individuals and their families when having been confronted with a first break;
Measurable decrease in acute psychiatric hospital bed days due to first breaks;
Reduction in placements in long-term, out-of-county locked facilities.

For systems and programs

Earlier referrals to the Mental Health Division from schools, community health centers, physicians, private therapists, organizational providers and parents;
A decrease in acute hospital bed days due to first breaks;
A decrease in placements in out-of-county locked facilities
Evidence of greater collaboration between Probation, Law Enforcement, Education and community health providers.

What will be different and how will we know?

- Our hospital bed data collection process will show a decrease in the number of acute hospital bed days for transition age youth between the ages of 16 and 25;
- Our Avatar system will show a decrease in the numbers of placements in out-of-county locked facilities and board-and-care homes for youth and young adults between the ages of 16 and 25;

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- Our manual tracking system and/or an Avatar-generated report will show an increase in the number of referrals of young people exhibiting prodromal symptoms from Probation, Education, community health providers and parents at earlier ages than previously encountered;
- Before and after tests will indicate a decrease in stigmatization of mentally ill individuals and an increase in knowledge about mental illness. These tests will be administered by group facilitators at psycho-educational meetings and peer support groups offered at schools, community health centers, various branches of the Health and Human Services Agency (HHS), parenting groups, Law Enforcement meetings and so on.
- Trainings will be offered and enumerated for all therapists in the community, for organizational providers under contract to the Mental Health Divisions, for staff of the Mental Health Divisions and all branches of HHS, and other aforementioned sectors of the community to teach them to recognize the prodromal symptoms associated with a first break.

8. Coordination with Other MHSA Components

Through our Community Services and Support (CSS) Plan, groundwork has been laid for mental health services for transition age youth and young adults. Mendocino County implemented a Transition Age Young Adult System of Care (TSOC) built on its Children's System of Care (CSOC) which was established years earlier. The TSOC brings together multiple agencies and service providers for this population to solve problems, coordinate efforts, and create more effective responses through collaboration. The CSS Plan includes serving 24 transition age youth and young adults through Full Service Partnerships (similar to wraparound services) in its TAY Wellness Program or through its Transitional Housing Plus Program. Through these programs, these young adults receive individual therapy and rehabilitation services, as well as services to gain independent living skills, permanent housing, and access to employment, education and career development. Among the priority groups for these services are American Indians and Latinos. The CSS Plan also takes advantage of the County's newly established young adult resource center, The Arbor on Main. This resource center pulls in the services and expertise of multiple community-based organizations, education partners and County agencies and provides active peer support to this age group—including teen and young parents. The CSS Plan also provides for a "clinical coach" at Mendocino Community College who can help transition age youth and young adults who suffer from mental illness re-enter and succeed in the college-level education system, as well as identify and refer students who may need mental health assessments and services.

As stated above, this project will extend these MHSA components to include a focus on the transition-age youth and young adults at the early onset of a serious psychiatric illness. The project will also establish reliable referral and

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communication linkages between these projects and the Early Onset, Early Intervention Project to prevent any service or treatment delays.

Another MHSa component that is part of our CSS Plan includes recovery services through Manzanita Recovery Services and the County's wellness center (Redhouse Recovery Center). These centers provide life skills, job assistance, coping skills, and general support in Ukiah, Willits and Ft Bragg. They help clients build connections with their communities through relationships and the services of other community-based agencies so that they can find their place in the local area and live in a safe and stable environment. Some TAY early onset clients may find these recovery centers a good fit for peer support and for ongoing maintenance of recovery. Therefore, we expect to establish effective collaboration with these MHSa entities to ensure a smooth interface for TAY early onset clients who are at the older end of the TAY spectrum, are aging out of the TAY population, or are simply more comfortable with the peer support and other services offered through these centers.

Mendocino County has not yet developed its plans for Capital Facilities and Technology funds, and so we do not anticipate using these funds for PEI projects. We also do not anticipate using any Workforce Education and Training Funds for PEI projects.

9. Additional Comments (optional)

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County: Mendocino PEI Project Name: Project #3-- Prevention: Older Adults. 2009/10- -2011/12

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The data we were able to gather, the input of focus groups, surveys and key informant interviews, the growing numbers of the older adult population and the potential for leveraging funds led us to select Prevention Services for Older Adults as our third project to fund with PEI dollars. The data cited below are extracted from our **Community Mental Health Assessment Data Report (Exhibit B) pages 41-47.**

Some particularly relevant statistics include the following:

- Between 2000 and 2010, the older adult population in our county will have increased over 30%, and the trend is expected to continue upward with the aging of the baby boomer generation.
- The number of older adults in all three of the major ethnicities in Mendocino County has been growing steadily, but the Latino population is the fastest growing ethnic minority in Mendocino County.
- In 2008, of the individuals in the 60+ age group who were treated through the County's Mental Health Division, over 80% were diagnosed with depression, schizophrenia or bi-polar disorder.
- Though the number of reported suicide attempts for this population is relatively low compared to younger age groups (18 in 2007 and 2008 combined), the suicide attempts are far more "successful", with deaths almost equal to attempts. Furthermore, there is a consensus among professionals working with this population that suicide deaths are vastly under-reported because of concerns about the stigma for the family, insurance eligibility for surviving members, and the dignity of the elder.
- Approximately 10% of the clients receiving case management, psychotherapy and/or Senior Peer Counseling through the County's Older Adult System of Care show some degree of substance abuse or medication misuse.

Focus groups and survey responses related concern about the manifold mental health risks for older adults and the obstacles to their obtaining effective treatment. They spoke of the unique vulnerability of this age group, citing that they have often experienced multiple losses—loss of loved ones, loss of health, loss of personal capacities and capabilities, and loss of income. Several indicated that the cognitive impairments of some older adults cause their mental health issues to be denied or ignored. For example, one respondent said, "A person with dementia can still have treatable clinical depression...but the Alzheimer's or dementia becomes the primary diagnosis precluding mental health services." Isolation was another issue that surfaced frequently in focus groups, interviews and surveys. Mendocino County is a rural community with minimal public transportation. Most services are concentrated in the three major cities of the county--Ukiah, Willits and Ft. Bragg. These cities are separated from

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each other by 45 minutes to an hour and a half by car when weather conditions are favorable. Residents of remote regions of the county can have additional long and treacherous commutes to reach resources. This situation can isolate many of the county's citizens and is especially challenging for older adults who no longer drive, or who cannot afford the price of fuel. Cultural and language barriers can add to the isolation of American Indian and Latino older adults. One respondent said, "I work with older adults with an Axis I mental health diagnoses...Although I think that these prevention services...are needed in all regions of the county, the outlying areas are of a concern due to the obvious lack of available services, transportation etc. Prevention services need to be designed...with a variety of ethnic and cultural differences in mind." Another respondent said of older adults, "Often they are reluctant to participate...and even if they are aware of services, due to isolation, attitude and transportation obstacles, they may not be able to participate." Many respondents indicated that the growing population of Spanish-speaking older adults should be a priority group to receive the benefits of PEI services. Members of the Latino community were especially worried about senior citizens who are newly arrived from Mexico whom they said suffer from adjustment disorders on top of isolation and depression. Indeed, depression and suicide risk for the older adult population were high on the list of concerns expressed in focus groups, interviews and surveys across the board. Finally, substance abuse and misuse came up frequently. One physician stated that older adults are being seen in emergency rooms because they haven't taken their medications, or have taken them inappropriately. "Some have to choose between their food and their medicines. Others forget to take it or fail to order it." Respondents indicated that drug abuse, especially with alcohol, occurs along side mental health issues with many older adults.

When asked what strategies might help address the mental health issues of older adults, a few major themes emerged. Respondents asserted strongly that outreach and in-home services are important tactics. One member of the Area Agency on Aging (AAA) Advisory Council stated, "It is essential that services be available in-home as seniors will not go to Mental Health, even if they are able." She went on to say that the home of an older adult is an "open book". The life situation of the seniors becomes clear in visits to their homes, and the visits often contradict what they might say over the telephone or in an office visit. Another essential ingredient expressed in virtually every forum was the need for education about mental illness along with de-stigmatization. Peer support was also closely aligned with these two issues as means of encouraging anyone experiencing mental illness to accept assistance and achieve lasting recovery. Those who focused on the older adult population reiterated the need for these strategies as well. Lastly, there was strong support for providing outreach, education, peer support and other mental health services in or through the "natural settings" frequented by senior citizens. These include the network of senior centers across the county, local granges and churches, service groups such as Soroptimists, community clinics, and organizations serving the American Indian and Latino members of the county.

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3. PEI Project Description: (attach additional pages, if necessary)

This project would build on and expand existing services included in Mendocino County's Community Services and Supports Plan (CSS), Work Plan 5. Work Plan 5 included the addition of a Mental Health Clinician and a Personal Services Coordinator to ensure that geriatric mental health assessments and treatment, and service coordination for older adults would be available in coastal, inland and outlying communities. It also included additional senior peer counseling services and outreach workers recruited from our two major underserved ethnic groups who comprised the target population for Work Plan 5 —American Indians and Latinos.

This Prevention and Early Intervention project would also give priority to older adults who are American Indians and Latinos, and those who are isolated. The expansion supported by PEI funds would provide prevention, early intervention and ongoing support for seniors at risk of depression and other debilitating Axis I mental health diagnoses. It would provide, across the county, senior peer counseling for an additional 80 older adults (100 total), mental health case management for an additional 50 older adults, and bring direct mental health-related prevention services through senior center outreach to an additional 400 adults and older adults in our community. In addition, it would address the need for education about, and de-stigmatization of mental illness in older adults by providing education and outreach to the community at large, and to physicians, key medical and social services staff and other professionals across the county as well. (Education and outreach activities would take place where seniors live and spend their time, and in numerous other locations as listed in sections 5 and 6 below.) This project would also allow for an additional 4 hours of clinical supervision per week for senior peer counselors. Finally, it would provide a social work assistant to coordinate the services and training of the senior peer counselors and outreach workers, and complete other tasks essential to organizing and evaluating the effectiveness of our services to the older adult population and the project overall.

Project Components

- *Senior Peer Counseling and Outreach Coordination.*

Senior peer counselors make visits weekly to clients of Mendocino County's Older Adult System of Care (OASOC). In doing this, they reduce mental health and suicide risks for these clients in several ways. Senior Peer counselors are trained to recognize mental health and medical misuse or non-use issues, and to utilize a wellness survey and depression scale. Because they too are senior citizens, they share experiences in common with the clients, have insights into their needs and are in a position to develop rapport with them. This "peer support", coupled with knowledge about mental health issues and screening tools, can ensure that the clients are linked to needed mental health treatment and encouraged to accept it. In addition, the weekly visits in and of themselves improve the quality of life for isolated and homebound seniors and therefore act to improve their mental health and reduce the

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chances of a downward spiral that could result in visits to the emergency room, hospitalizations, residential care or suicide. Senior Center outreach workers play a similar role. They conduct depression screenings at local senior centers and in the homes of home-bound clients. Like the senior peer counselors, they refer seniors to the Mental Health Division of the County's Older Adult System of Care for further evaluation and treatment as needed.

This component would provide for the coordination of both the existing Senior Peer Counseling program and senior center outreach services, and would serve as an adjunct to the existing Meals-on-Wheels Suicide Prevention program. It would fund ½ FTE Social Work Assistant to recruit new senior peer counselors, set up their training, engage clients and their family members, track referrals, treatment plan activities and visits, maintain the client database and conduct an annual client satisfaction survey. The social work assistant would also coordinate the completion of depression screenings at senior centers, and the training of senior center outreach workers. The social work assistant would maintain regular contact with senior center outreach workers for training, problem-solving, and to promote expanding outreach activities to additional older adults. This strategy would free up the time of the program supervisor and case managers to provide additional case management and assessment services to existing older adult clients and increase the number of older adults served. The activities of the social work assistant would ensure that all clients of OASOC receive an additional four visits annually to ascertain whether or not any arranged-for services are being provided appropriately and professionally. In addition to improved and expanded services, this component would provide for a more cohesive approach to services to the older adult population and enable the county to evaluate their effectiveness. The social work assistant would be a County employee.

- *Outreach, Education*

This component would include outreach and education to the community in two ways. First, it would provide education to the community at large about mental illness—the various types, how to recognize signs and symptoms, and what to do to get help. Among the mental illnesses addressed would be those common to older adults. The education program would also include information about the services provided to older adults through the Meals-on-Wheels Suicide Prevention Program, and the OASOC, including Senior Peer Counseling and Senior Center Outreach coordination. We anticipate reaching approximately 400 individuals in the community through these sessions with the potential for recruiting additional senior peer counselors and outreach workers as well as receiving additional referrals. These sessions would be conducted in the variety of environments throughout the county as suggested by focus groups and other respondents in our PEI planning process: the network of senior centers across the county, local granges and churches, service groups such as Soroptimists, community clinics, and organizations serving the American Indian and Latino members of the county.

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Second, this component would include at least four educational events annually aimed at physicians, key medical and social services staff and other professionals who come in contact with older adults. These events would provide information and raise awareness about mental illness and suicide risk among senior citizens and the mental health side effects of their medicines among other topics. The Meals-on-Wheels Suicide Prevention Program workers would be among those invited to participate in these training/educational sessions.

The community outreach and education portion of this component will be provided through a contract or contracts resulting from a RFP or RFQ as part of Project #1. The educational events focusing on physicians and other professionals may also be provided through these contracts, may be provided by County staff depending on staffing levels and the results of the RFP/RFQ, or through Training, Technical Assistance and Capacity Building funds should our county receive them.

Additional Clinical Supervision

This component would provide an additional four hours of clinical supervision weekly to senior peer counselors and the social work assistant who coordinates senior peer counseling and senior center outreach services. This will act as ongoing training and quality control of their interventions with older adults, and ensure that the clients are appropriately referred for mental health services.

DURATION OF KEY ACTIVITIES

- Senior Peer Counseling outreach & coordination: Throughout project
- Outreach & Education: We anticipate that most of the outreach and education activities will take place in the first 30 months of this project. Thereafter, community organizations would have the materials and expertise to conduct interactive education modules as needed, and/or these would be incorporated in their ongoing education offerings. We anticipate the selected provider would need to offer only three new interactive education modules per year at most, and update handouts as needed at minimal cost. (See PEI project #1)
- Clinical Supervision: Throughout project

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KEY MILESTONES

3 ½ Mos. Prior to Implementation	2 Mos. Prior to Implementation	Implementation Month 1	Month 2 -6 &ongoing	Month 7	Month 12	Month 30
<p>Community education/outreach RFP released through PEI Project #1</p>	<p>Coordinate with selected provider of community outreach & education for specific outreach/education strategies and timelines for older adults, key organizations and medical professionals who work with older adults.</p> <p>Amend contract with clinician to add hours for clinical supervision.</p> <p>Notify key partners and staff about project details and start date, how it coordinates with community outreach & education.</p>	<p>Schedule recruitment activities for additional Sr. Peer Counselors</p> <p>Establish meeting and training schedule with senior center outreach workers.</p> <p>Schedule additional clinical supervision slots.</p> <p>Train Sr. Peer counselors on assessment tools.</p> <p>Begin community outreach & education.</p>	<p>All components operational</p>	<p>1st report on progress and preliminary outcomes;</p> <p>Meet with contractors, staff, partner organizations and clients to assess what is working, what is not and any needed adjustments</p>	<p>2nd report and semi-annual meetings with contractors, staff, partner organizations and clients to assess progress, outcomes & determine any needed adjustments</p>	<p>Meet with community outreach & education provider to assess ongoing level of service needed.</p>

- Refine data gathering, and evaluation methodologies for Evaluation Project.
- Plan strategies for meeting & trainings with senior center outreach workers and senior peer counselors
- Refine oversight & coordination plan

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Senior Peer Counseling and Outreach Coordination	Individuals:12 Families:	Individuals:0 Families:	6
Outreach & Education (Through PEI Project #1)	Individuals:102 Families:0	Individuals: 0 Families:0	6
Clinical Supervision	Individuals:8 Families:	Individuals:0 Families:0	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals:12 Families:0 Does not include individuals served through shaded program above, which is part of PEI Project #1	Individuals:0 Families:0	6

5. Linkages to County Mental Health and Providers of Other Needed Services

Linking seniors to County Mental Health and providers of other needed services is a big part of the purpose this project is intended to achieve. The social work assistant works hand-in-hand with OASOC clinicians and case managers, while coordinating the activities of senior peer counselors and senior center outreach workers, and tracking referrals and

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services. These tasks and connections will ensure that older adults who qualify for the psychiatric emergency services, specialty case management, and Full Service Partnerships available through the Mental Health Division of OASOC, receive these services in a timely manner. Some older adults who need mental health services would be linked to the many community health clinics that provide both mental health and medical services on a sliding scale, and accept MediCal and other insurances: Hillside Health Center in Ukiah, Little Lake Health Center in Willits, Long Valley Health Center in Laytonville (north inland), and Manchester-Point Arena Satellite Health Clinic for American Indians on the south coast. In addition, the Redwood Coast Health Center provides some behavioral health services for women on the south coast. Consolidated Tribal Health provides behavioral health services as well as medical and social services to American Indians and others in the inland area of the county, and Round Valley Indian Health Center does the same for American Indians in a far north inland region. We expect to be linking regularly with these service providers for this project.

Naturally, this project will also link closely to the Senior Center network in Mendocino County which includes the Round Valley Senior Center, the Indian Senior Center in Ukiah, the Redwood Coast Senior Center in Ft. Bragg, The Anderson Valley Senior Center in Booneville, the South Coast Senior Center in Pt. Arena, and the Ukiah Senior Center. Older adults can obtain a variety of goods and services through these centers, including low cost meals and socialization opportunities. Another close link would be with Community Care of Lake and Mendocino County since this organization provides information assistance to seniors and Multiple-Purpose Senior Services Program (MSSP) services for older adults who qualify for skilled nursing care.

Alcohol and Other Drug (AOD) services have been reduced drastically over the last year because of funding cuts. However, AOD programs have recently been incorporated into the Mental Health Divisions of the Adult and Older Adult Systems of Care as well as Children & Family System of Care (C&FSOC). This has already enhanced our long-standing collaboration with this service provider.

6. Collaboration and System Enhancements

Besides the collaborations noted above with community clinics, health centers, the Senior Center network and Community Care, the outreach and education component of this project lends itself to additional collaborations. Since sessions would be conducted in a variety of environments throughout the county, we will have the opportunity to connect with local granges and churches, service groups such as Soroptimists, and organizations serving the American Indian and Latino members of the county. Furthermore these sessions should establish important links with physicians and other key medical personnel. Outreach and education about the services offered and the nature of mental illness among the elderly

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should strengthen our ongoing collaboration with other branches of the Health and Human Services Agency and other professionals who come in contact with older adults.

This project establishes a coordinating entity for many of the services our community offers to older adults. This, in itself, enhances the system for this population by providing an organizing structure to clarify what services are available and to expedite the provision of those services. Its evaluation and quality control aspects will work toward additional enhancements to the system over time. Finally, the incorporation of outreach and education to professionals and the community will provide vital information about signs and symptoms, and de-stigmatize mental illness so that troubled older adults and those who know, care for, and work with them will seek out help sooner.

7. Intended Outcomes

Individuals

- Decrease in risk factors for depression
- Decrease in isolation
- Increase in social contacts
- Decrease in the number of emergency room visits

System & Program Outcomes

- 12 additional senior peer counselors trained in the first year with emphasis on recognition of suicidality
- At least 50 physicians receive one-on-one visits for training and education on mental health issues among older adults
- The number of visits by case managers, senior peer counselors and/or senior outreach workers to OASOC clients increases
- Strong link established between OASOC outreach coordinator and the senior center outreach workers, evidenced by at least 2 trainings for senior center outreach workers per year, and participation in regular outreach meetings.
- Older adults in the project have a better quality of life as evidenced by the individual outcomes listed above, and are satisfied with the assistance they have received as evidenced by client satisfaction surveys.
- Success will be measured as follows:
 - A database that includes all client assessments (Global Assessment of Functioning--GAF, Mini Mental Status Exam, Sense of Wellbeing, Depression Scale)

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- An additional data base that tracks the number of socialization opportunities since the start of the program, the number of emergency room visits, the number of crisis interventions, and the number of linkages to other services.

8. Coordination with Other MHSA Components

As noted previously, this project provides an enhancement of Work Plan 5 of Mendocino County's CSS Plan and will also coordinate with Project #1 of the PEI plan.

Mendocino County has not yet developed its plans for Capital Facilities and Technology funds, and so we do not anticipate using these funds for PEI projects. We also do not anticipate using any Workforce Education and Training Funds for PEI projects.

9. Additional Comments(optional)

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County: Mendocino PEI Project Name: #4-Prevention Collaboration: Children & Youth
2009/10 -2011/12

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

In the past several years the Mental Health Division of the Children & Family System of Care (CFSOC) Branch of the Health and Human Services Agency along with several community and agency partners have worked to provide services to address the needs of troubled children and their families. Together we have made intensive treatment foster care and related mental health services for children available in our community. We have brought two evidenced based parenting practices here (Parent Child Interactive Therapy and Triple P Parenting) and trained an array of providers so that these practices are widely available. We have established an emergency shelter specifically for troubled children at risk of high level placement or returning to our community from out-of-county group homes. The shelter allows for a thorough mental health assessment of each child before the next placement is selected. Recently, we have opened a group home through which troubled youth and their parents work on behavioral and mental health concerns, and a Multi-dimensional Treatment Foster Care (MTFC) program that has had excellent results with Probation Wards. Our county now has a pediatric psychiatrist. The Mendocino County Office of Education Special Education Local Planning Area (MCOE SELPA), and Alternative Education provide a variety of behavioral health services to preschool and school-aged children, Probation Wards, and youth with substance abuse disorders. We have five Community Health Clinics and several tribal health centers that offer mental health services across the county. However, the data we were able to gather about children, and the input we received from many focus groups and conversations with key informants still pointed to great concerns about the behavioral and emotional health of children in our community. The data cited below are extracted from our **Community Mental Health Assessment Data Report (Exhibit B) pages 6-28**. Some relevant statistics are as follows:

- In calendar years 2007 and 2008, 179 families were referred to Family Mediation when there had been an allegation of domestic violence involving a child under six years old. In those same years, 111 families with children age six to 17 were referred to Family Mediation because of allegations of domestic violence. Several community agencies sponsored a seminar in 2008 that showed the effects of mere *exposure* to violence on the cognitive and emotional development of children. See page 10 of the data report, **Exhibit B**;
- Per the California Healthy Kids Survey for 2005-2007, almost 2/3 of the respondents from Grade 11 in Mendocino County reported alcohol or drug use in the past 30 days and more than 1/3 reported binge drinking within the past 30 days;

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- The school drop out rate for grades 9-12 has increased consistently between 2004/2005 and 2007/2008, and there has been a higher percentage of American Indian and Latino students among the drop-outs in every year during this time;
- An average of 13 mental health cases were open for inmates in Juvenile Hall in 2007, and an average of 8 in 2008. Of the 25-30 juvenile wards in placement on any given month, about 33% are in need of mental health services.
- In 2007 and 2008, 57 children between the ages of 6 and 17 were seen in the three hospital emergency rooms in our county because of suicide attempts.

Respondents to focus groups, surveys and interviews advocated for mental health interventions of many types and at many stages of childhood, and often emphasized that help is needed for the family system as much as for the child. For example, an intern who provides crisis services for youth who are not connected to mental health, child welfare or juvenile probation systems stated that there seems to be "...no family connectedness" for the youth they serve. The Executive Director of the Alliance for Rural Community Health (ARCH) said, "Prevention efforts for youth need to engage troubled parents." Officials of the Mendocino County Office of Education (MCOE) asserted that the troubled children they encounter are often part of "...a whole family system in trouble". Several respondents suggested focusing on teen parents to prevent mental illness in two generations at once.

Respondents frequently cited the role of substance abuse among youth and their families. The Child Care Resource and Referral staff of North Coast Opportunities (NCO) indicated that if they could choose, they would target families that utilize "Exempt" and Family Child Care providers. These are the stressed families affected by poverty, criminal histories and alcohol and drug use, they said. Staff of Consolidated Tribal Health stated that there is a need for outreach to families of youth who have dropped out "...by someone equipped to recognize and address mental health issues and dual diagnosis."

There was much concern expressed in these groups and surveys about children who "fall through the cracks". By this, most meant children who were not eligible for MediCal, or for other programs currently offered by our systems, or whose behavioral issues crossed Social Services, Mental Health, and Law Enforcement systems and did not fit neatly into any of them. Similarly, there was concern for isolated children and families. For example, clinicians, educators and others said they would target children with attendance problems early on. Several felt that children in Junior High and High School who were home schooled or on Independent Study are often doing so because they do not fit in at school. They believed

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that some of these children were not fitting in because of an underlying mental health issue. A manager of mental health services for children in the Mental Health Division of CFSOC suggested that we target children who show early but relatively mild problems in school, as these often develop later into issues that are harder to treat. He indicated that he would like to see prevention services begin with children aged six or seven, or even as early as preschool.

Many respondents from many sectors of the community advocated for school-based prevention services. They reasoned that schools constitute a “natural setting” in which children are already contained and with which parents are willing to engage. One long-time teacher said, “...it sure would be great for a licensed professional to observe students who are at risk, and advise teachers on how to deal with their issues.” A preschool teacher said, “I would love for there to be a service that preschool teachers could make use of that would enable there to be a person to come and observe children with behavior issues in the classroom...Preschool teachers are not taken seriously, nor are we qualified to make a diagnosis.” Along those lines, many educators and others advocated for bringing back the Primary Intervention Program (PIP) which allowed for clinical supervision of paraprofessionals to work with troubled children on school campuses.

Another common theme among respondents was the provision of mental health screening and evaluation of children and youth. One health care provider called for the assessment of every seven-year-old with annual screenings thereafter. Several focus groups suggested utilizing the community health clinics for both screening and treatment services. They pointed out that girls go to the clinics for birth control and lots of children go to clinics for sports exams. These are opportunities to ask children key questions in a non-threatening way. The clinics are equipped to do assessments for depression which can lead to other assessments as needed. Clinics could provide a gateway to peer support groups or empowerment groups at schools, they thought. Therapists at the clinics could provide therapy for the children who need it.

The topic of crisis services came up in many focus groups and conversations as well. In some cases respondents were speaking of crisis services for individuals at the early onset of a psychiatric illness. In other cases, though, the respondents were referring to less severe, but none-the-less serious emotional and behavioral crises, especially among adolescents and teens. They indicated that a fair number of these crises have to do with interpersonal relationships with which the youth are not able to cope. Several cited growing incidences of peer bullying, including cyber-bullying as early as Junior High. Members of the Gay, Lesbian, Bi-Sexual and Transgender community, including some Mental Health clients stated that children as young as nine and ten years old can be in crisis because they are just discovering their sexual orientation, realize they are different from most other children, and usually have no means of getting information or support about it from family or peers. In a focus group of Mental Health clients, respondents suggested a “warm line” that would provide a continuum of interventions from information to intense suicide prevention efforts. At a focus group with the Latino community, respondents called for crisis and suicide prevention services in Spanish, and at a meeting with

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American Indians and others at the Building Horizons Youth Center in Round Valley, respondents said there is a need for 24/7 crisis intervention for people of all ages concerning mental health, domestic violence, financial issues and so on.

Finally, the need for suicide prevention was raised in most focus groups and many surveys and interviews concerning children and youth. Respondents called for information about recognizing symptoms and red flags, and about steps to take on behalf of children who appear to be at risk.

During discussions about strategies for Prevention and Early Intervention for children and youth, a myriad of excellent ideas were raised. The available PEI funding, however, precluded implementation of all of them. Instead, we chose to develop a project which would combine some of the suggested strategy ideas, but focus services on the two major underserved cultural groups, and in two especially needy areas of the community.

3. PEI Project Description: (attach additional pages, if necessary)

Six school districts in our county have high concentrations of Latino or American Indian students. This project would provide prevention services to pre-kindergarten and school-aged children and their parents as appropriate, in the catchment area of two of these school districts. The project would consist of collaboration among two of the school districts having high concentrations of American Indian or Latino students, a local community clinic or other behavioral health provider, and a local community-based organization such as a family resource center (FRC). Most direct services to students would be provided on campus by paraprofessionals, though some students would be referred to a clinic, private nonprofit behavioral health provider or the County's Mental Health Division for more extensive services as needed. Services to parents, children under five or extended family members could be provided on school campuses, but could also be provided in other natural settings conducive to participation by American Indian and Latino families—a FRC, tribal facility, preschool or other community environment. The project would be provided through contracts that result from a RFP. As stated earlier, several school districts in Mendocino County have significant American Indian or Latino populations. In addition to the demographics of the school districts, proposals would be selected based on the viability, potential effectiveness and level of collaboration proposed, among other considerations. For example, an important aspect of any proposal would be a close collaboration between the school and a behavioral health provider and/or community-based organization that can offer culturally appropriate services and services in Spanish as needed. Details of the components sought for this project are as follows:

School/Community-based screening and prevention services

This component would operate in Elementary, Junior High, Middle or High schools in the two selected school districts. Services would focus on children with attendance or behavioral issues of concern that do not yet warrant an Individual

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Education Plan (IEP), children who come to the attention of Care Teams, and other children at risk for school failure. Direct services on campus would be provided one-on-one or in peer groups by paraprofessionals under the supervision of a mental health clinician working at a local community clinic, tribal organization or through another behavioral health provider operating in the community. In the case of schools with high concentrations of Latino students, both the paraprofessionals and the clinician would be expected to speak Spanish at a minimum and would preferably be bi-cultural and from the target community. Similarly, in the case of schools with high concentrations of American Indian students, the preference would be an American Indian clinician and paraprofessionals, but, at minimum, these would be individuals who can be shown to work effectively with the American Indian students and community. The purpose is to ensure that both cultural and language issues are addressed effectively along with oversight of mental health issues that arise among the students served. The clinician would also interface with the school or district psychologist. Specific services would vary by child and age group, but would include:

- Providing general information about and de-stigmatization of mental illness
- Screening, assessing and identifying issues with the students and referring to behavioral health providers if needed;
- Working one-on-one or in groups with students to increase awareness of mental health stressors and build resiliency and protective factors;
- Developing suicide awareness & prevention approaches;
- Fostering tolerance and understanding of diversity, one-on-one or in groups;
- Developing approaches to prevent and respond to bullying, aggression and violence;
- Establishing peer support or student empowerment groups as needed on campus that serve as forums for addressing topics of concern to the students and related to behavioral health (such as substance abuse, cutting, gang violence, relationships with parents and peers; and/or
- referring students to existing peer support groups in the local community.

Community-based family support services

This component would operate in natural settings that encourage the participation of American Indian and Latino families. Such settings might be a community clinic, or a family resource center, a tribal facility, or a school campus. The intention of this component is to enable culturally effective services to be provided to the parents, and to other family members as an inter-generational approach to promoting the behavioral health and academic success of the children participating in the school-based screening and prevention component. Children under age five who are in the catchment area of the selected schools would be included in community-based services as needed. These children would be the siblings of the

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children participating in the school-based component or children screened and referred by other community providers. Specific services would include:

- Outreach and education to increase awareness of mental health issues and reduce stigma and discrimination;
- Screening pre-school-aged siblings of children who are participating in the school-based component;
- Parenting education to teach effective discipline and communication approaches that foster positive relationships between family members and promote the cognitive and emotional health and resiliency of their children;
- Assistance with access to services that would address other issues in the family that affect the school success and emotional health of the children—such as substance abuse, domestic violence, mental health issues of family members, and so on;
- Assistance with access to mental health services for children—including children under age five-- or other family members as needed;
- Opportunities to exchange information about the issues and services on the school campus affecting the children participating in the school-based project, and ways for family members to work effectively with the school to support them.
- Other culturally appropriate services or events that promote the involvement of the Latino and Native American communities in the catchment areas of the selected school districts in the school success of their children and in the mental health of their communities.

We would expect proposals to show how PEI funds would be leveraged with grants, in-kind services and other funding available through the education system, such as funds for suicide prevention through the Jason Flatt Act (California Education Code Section 41533), or funds through the Early Mental Health Initiative.

DURATION OF KEY ACTIVITIES:

We expect all key activities to continue throughout the project.

KEY MILESTONES:

3 ½ Mos. Prior to Implementation	2 Mos. Prior to Implementation	1 Mo. Prior to Implementation	Month 1	Months 2-6	Month 7	Month 12
RFP Released	Select Providers Develop contracts		Implement community-based family support services,	Continue community-based family support services	1 st reports on demographics and numbers screened, referred and	Semi-annual report and meetings as in month 7 to include

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3 ½ Mos. Prior to Implementation	2 Mos. Prior to Implementation	1 Mo. Prior to Implementation	Month 1	Months 2-6	Month 7	Month 12
	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> Notify affected communities about the project </div>		Implement screening and prevention services for children on campus	Continue screening and prevention services for children on campus	served. Meetings with collaborating organizations, participating students and families to assess what's working and what's not and any adjustments needed.	assessment of outcomes.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Prevention Collaboration: Children & Youth			
School/Community-based Screening and Prevention	Individuals: 156 Families:0	Individuals:0 Families:0	6
Community-based Family Support	Individuals: 104 Families: 52	0	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 208 Families:52	Individuals:0 Families:0	6

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5. Linkages to County Mental Health and Providers of Other Needed Services

Proposals for this project would be required to demonstrate how individuals served would be linked with the Mental Health Division of the C&FSOC as needed, and with other needed services in the community. Further, the details of such linkages would be included in contracts with successful candidates, which in turn would include a requirement to track and report them. In Mendocino County, we make use of our Multi-provider Screening Team (MPST), as well. This body meets weekly to review referrals for mental health services and to determine whether or not the client should be served by the Mental Health Division, or one of its contracted providers. This serves as another way to keep track of how well providers of prevention services for youth are linking to the Mental Health Division. Also, the project itself requires important linkages between schools and community-based organizations that provide both behavioral health services and other individual and family support services.

6. Collaboration and System Enhancements

This project has collaboration built in. It calls for decentralized services that take place on school campuses, in community clinics, at family resource centers or other natural settings. By its very nature it would establish and strengthen collaborations with schools, tribal and Latino organizations, and other community-based organizations. As stated earlier, the purpose of the project would be to enhance current efforts to serve the mental health needs of underserved children in our county, especially American Indian and Latino children and their families. An important enhancement would be its potential to reach those children who might otherwise “fall through the cracks” because they do not qualify for traditional Mental Health services and other programs that could address their behavioral health, or because of cultural, language and transportation barriers. As with the Education, De-stigmatization, Peer Support Project (Project #1), this project it would enhance the system by inviting and encouraging young individuals and their families to take charge of their emotional health early, and by mobilizing the American Indian and Latino communities to engage with their young people who are at risk of developing mental illness in ways that honor their culture and heritage.

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7. Intended Outcomes

For individuals

- Children and parents are aware of the causes of all kinds of mental illness and ways to avoid or treat these conditions;
- Children are screened for their risk of mental illness;
- Parents/family members of troubled children and youth seek assistance;
- Parents/family members learn ways to promote the behavioral health and school success of their children;
- Children receive appropriate mental health interventions earlier;
- Children have improved their ability to make healthy choices and develop positive relationships with peers and families;
- Children have developed harm reduction skills and coping strategies;
- Children avoid abusing substances and developing concurrent disorders;

For the System & Program

- More American Indian and Latino children and parents are aware of the causes of all kinds of mental illness and ways to avoid or treat these conditions;
- More families, children and professionals in the selected communities are aware of the sign and symptoms of suicide and how to respond;
- More children are screened for their risk of mental illness and suicide;
- More parents of troubled children and youth seek assistance;
- More children receive appropriate mental health interventions earlier;
- More children have improved their ability to make healthy choices and develop positive relationships with peers and families;
- More children have developed harm reduction skills and coping strategies;
- Fewer children abuse substances, engage in violence and develop concurrent disorders;
- The American Indian and Latino communities in the two target school districts are more engaged in the prevention of mental illness;
- More resources to prevent and address mental health issues are available, accessible, and effective for American Indians and Latinos in the two target school districts.

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Respondents to the RFP would be required to describe how they will measure outcomes for both individuals and programs, including participation rates. Before and after tests would indicate an increase in knowledge about mental illness and suicide prevention. Our manual tracking system and/or an Avatar-generated report would show the number and type of referrals from educators, community health providers, family resource centers, parents and others from the two target school districts. The completion of mental health screenings would be enumerated and monitored through the contracts that result from the RFP process. Suicide data can be obtained from the emergency rooms of the hospitals serving the selected communities as well as the Sheriff/Coroner. The prevalence of substance abuse and co-occurring disorders could be gleaned from AOD statistics and surveys of providers of services concerning these issues and this age group in the two target communities. Similarly, surveys at regular intervals with collaborating organizations and partner agencies would provide evidence about the effectiveness of this project.

8. Coordination with Other MHSA Components

This project would interface with Work Plan 2 of the CSS Plan for Mendocino County which includes

- screenings of children age 0-5,
- wraparound and parent partner services for families of children at risk of placement in high level group homes because of their emotional and behavioral issues,
- bilingual therapy services, and
- out-reach, engagement and counseling services for tribal members at Consolidated Tribal Health in Round Valley.

Care will be taken to avoid screening children under age 5 who have already been screened through Work Plan #2 of Mendocino County's CSS Plan. The Prevention Collaboration Project screenings would increase the number of children screened by expanding this service to school-aged children in the targeted school districts. In addition, some of the children and parents served by the Prevention Collaboration Project for Children and Youth may have conditions and circumstances that warrant the other interventions included in CSS Work Plan #2, and would therefore be referred to those services. However, the Prevention Collaboration Project is meant to avoid the need for those services and would not duplicate them.

Mendocino County has not yet developed its plans for Capital Facilities and Technology funds, and so we do not anticipate using these funds for PEI projects. We also do not anticipate using any Workforce Education and Training Funds for PEI projects.

9. Additional Comments (optional)

Proposed Total Number of Individuals to be served:		FY 08-09	FY 09-10	1742
Total Number of Individuals currently being served:		FY 08-09	FY 09-10	
Total Number of Individuals to be served through PEI Expansion:		FY 08-09	FY 09-10	
Months of Operation:		FY 08-09	FY 09-10	
Total Program/PEI Project Budget				
Proposed Expenses and Revenues		FY09-10	Total	
A. Expenditure				
1. Personnel (list classifications and FTEs)		0	0	
a. Salaries, Wages		0	0	
b. Benefits and Taxes		0	0	
c. Total Personnel Expenditures		0	0	
2. Operating Expenditures		0	0	
c. Total Operating Expenses		0	0	
3. Subcontractors/Professional Services (list/itemize all subcontracts)				
Contract Provide Unknown		17,000	17,000	
a. Total Subcontracts		17,000	17,000	
4. Total Proposed PEI Project Budget		17,000	17,000	
B. Revenues (list/itemize by fund source)				
1. Total Revenue				
5. Total Funding Requested for PEI Project		17,000	17,000	
6. Total In-Kind Contributions				
Funds will be used for the FY09-10, but will come from the FY08-09 Planning Estimate.				

Project 1: Education/De-Stigmatization

Expenditures for this project were extrapolated from information obtained from our local National Alliance on Mental Illness (NAMI) and cost projections developed through the PEI Workgroup, which included organizations currently providing similar services.

A. Expenditures: \$34,000 annually**1. Personnel**

There are no expenses in this category. All personnel will be provided under contract with a provider or providers to be determined.

2. Operating Costs

There are no expenses in this category. All operations will be covered under contract with provider or providers to be determined.

3. Subcontracts/Professional Services

The funds will provide for a contracted vendor or vendors who will provide replicable interactive education modules across the county about mental illnesses, the signs and symptoms, red flags and intervention & treatment options. The modules will be such that they will be effective with all age groups and the American Indian and Latino communities. Vendor(s) will also train trainers to organize and facilitate interactive education modules that can be incorporated in their existing classes, groups and services. Vendor(s) will provide handouts in English and Spanish that list local resources and contacts. Vendor(s) will assist in the development of peer support groups for individuals with mental illness and their family members with the purpose of ongoing education and de-stigmatization about mental illness so that any needed treatment and support will be sought. This project will serve as a bridge between the community and the County Mental Health Branches as well as other mental health resources. The project will work in tandem with Project #3 and Project #4.

B. Revenues: \$0**C. Total 6- Month Funding Requested for Project #1:\$17,000**

We anticipate implementing this project about halfway through FY 2009/2010 so that only about half of the funding can be utilized in that year. In years 2010/2011 and 2011/2012 we expect to fully implement and operate this project at its full cost. In subsequent years costs should be limited to replenishment of supplies and occasional education/de-stigmatization workshops, 3 per year or fewer which we believe we can absorb into our ongoing MHS funding as needed.

Trainers will have already been trained to provide educational groups and most supplies for the education modules will have been purchased or developed and reusable. Peer support groups will have already been established and self-sustaining.

D. Total In Kind Contributions: **\$0**

Provider Name (if known):							
Intended Provider Category	Mental Health Branch						
Proposed Total Number of Individuals to be served:		FY 08-09		FY 09-10	10-15		
Total Number of Individuals currently being served:		FY 08-09		FY 09-10			
Total Number of Individuals to be served through PEI Expansion:		FY 08-09		FY 09-10			
Months of Operation:		FY 08-09		FY 09-10			
Total Program/PEI Project Budget							
Proposed Expenses and Revenues		FY09-10		Total			
A. Expenditure							
1. Personnel (list classifications and FTEs)		0		0			
a. Salaries, Wages		0		0			
Mental Health Clinician II .5 FTE		15,377		15,377			
Rehabilitation Specialist .5 FTEE		12,043		12,043			
				0			
				0			
b. Benefits and Taxes @ 55%		15,080		15,080			
c. Total Personnel Expenditures		42,500		42,500			
2. Operating Expenditures		0		0			
c. Total Operating Expenses		0		0			
3. Subcontractors/Professional Services (list/itemize all subcontracts)							
Contract Provide Unknown		57,000		57,000			
				0			
				0			
				0			
				0			
a. Total Subcontracts		57,000		57,000			
4. Total Proposed PEI Project Budget		99,500		99,500			
B. Revenues (list/itemize by fund source)							
1. Total Revenue							
5. Total Funding Requested for PEI Project		99,500		99,500			
6. Total In-Kind Contributions							
Funds will be used for the FY09-10, but will come from the FY08-09 Planning Estimate.							

Project 2: Early Onset/Early Intervention: Transition-Age Youth & Young Adults
Expenditures for this project were based on current costs for the personnel listed below, from the current supported housing costs in CSS Work Plan #3, from the current cost of contracts with a child psychiatrist which will be expanded for this project, as well as the current cost of Alcohol and Other Drug (AOD) staff who are co-located within the Mental Health Branch. Expenditures for peer support training were extrapolated from information provided by our local National Alliance on Mental Illness (NAMI) and cost projections developed through the PEI Work Group, some members of which are currently providing similar services.

E. Expenditures: \$217,700 annually

1. *Personnel*

Total personnel costs amount to **\$85,000**. This amount is the sum of the salary, taxes and benefits of ½ FTE Clinician II and ½ FTE Rehabilitation Specialist. Taxes and benefits are calculated at a standard rate of 55% in Mendocino County.

2. *Operating Costs \$18,700*

Operating costs are estimated at \$18,700. This cost is calculated at 22% of the salary of the ½ FTE Clinician II and ½ FTE Rehabilitation Specialist above per the County's Chief Fiscal Officer. This percentage includes the portion of facility costs and equipment such as a personal computer and network connections, laser printer, and telephone and County vehicle use and maintenance associated with these positions.

3. *Subcontracts/Professional Services \$114,000*

The funds will provide for the following: 1) expansion of a current contract with a pediatric psychiatrist to provide dedicated psychiatry to the transition-age youth and young adults at the early onset of serious psychiatric illnesses (\$20,000); 2) expansion of contracts with local private clinicians for therapeutic services for youth who are not eligible for Medi-Cal(\$6,000) 3) contract for AOD services for the participating individuals who have co-occurring disorders (\$10,000);4) contract for six additional supported housing beds and related services (\$72,000);5) contract to provide training for transition-age mental health clients and family members to prepare them to provide peer support for youth participating in this project and their families (\$6,000).

F. Revenues: \$72,566
Medi-Cal, EPTSD

G. Total 6-Month Funding Requested for Project #2: 108,850

We anticipate implementing most components of this project in the last six months of FY2009/2010, so that only about half of the projected annual costs would be expended by the end of June 2010. In years 2010/2011, and 2011/2012 we expect to fully implement and operate this project at its full cost, and utilize our Prudent Reserve to fund a third full year.

H. Total In Kind Contributions: **\$0**

			Date:	2/11/2010	
County Name:	Mendocino				
PEI Project Name:	Prevention:Older Adults		Date:	2/11/2010	
Provider Name (if known):					
Intended Provider Category:	Community Based Organization				
Proposed Total Number of Individuals to be served:		FY08-09	FY09-10	33	
Total Number of Individuals currently being served:		FY08-09	FY09-10		
Total Number of Individuals to be served through PEI Expansion:		FY08-09	FY09-10		
Months of Operation:		FY08-09	FY09-10		
Total Program/PEI Project Budget					
	Proposed Expenses and Revenues	FY09-10	Total		
A. Expenditure					
1. Personnel (list classifications and FTEs)					
	a. Salaries, Wages	0	0		
	b. Benefits and Taxes @ 55%	0	0		
	c. Total Personnel Expenditures	0	0		
	2. Operating Expenditures	0	0		
	c. Total Operating Expenses	0	0		
3. Subcontractors/Professional Services (list/itemize all subcontracts)					
Contract Provide Dept. of Social Services					
	Social Worker Asst. .5 FTE	16,120	16,120		
	Clinical Supervisor	3,000	3,000		
	a. Total Subcontracts	19,120	19,120		
	4. Total Proposed PEI Project Budget	19,120	19,120		
B. Revenues (list/itemize by fund source)					
	Federal Title 19	17,100	17,100		
	1. Total Revenue	17,100	17,100		
	5. Total Funding Requested for PEI Project	19,120	19,120		
	6. Total In-Kind Contributions				
Funds will be used for the FY09-10, but will come from the FY08-09 Planning Estimate.					

Project 3: Prevention : Older Adults

This project builds on and expands CSS Plan Work Plan #5. Expenditures for this project were based on current costs included in that Work Plan.

I. Expenditures: \$45,324 annually**1. *Personnel***

Total personnel costs amount to **\$32,240**. This amount is the sum of the salary, taxes and benefits of ½ FTE Social Work Assistant. Taxes and benefits are calculated at a standard rate of 55% in Mendocino County.

2. *Operating Costs* \$7,084

Operating costs are estimated at \$7,084. This cost is calculated at 22% of the salary of the ½ FTE Social Work Assistant above per the County's Chief Fiscal Officer. This percentage includes the portion of facility costs and equipment such as a personal computer and network connections, laser printer, and telephone and County vehicle use and maintenance associated with this position.

3. *Subcontracts/Professional Services* \$6,000

The funds will provide for the expansion of a current contract with a clinician who will provide additional hours of clinical supervision for the Social Work Assistant, case managers and senior peer counselors working in the Mendocino County HHS Adult & Older Adult System of Care in order to expand outreach, suicide prevention and other prevention services to isolated older adults in our county. The project will work in tandem with Project #1 to provide education and de-stigmatization about mental illness to older adults, their families, caregivers, community service and medical providers.

J. Revenues: \$21,302

Federal Title 19 funds.

K. Total 6-Month Funding Requested for Project #3:\$22,662

We anticipate implementing this project during the last six months of FY 2009/2010 so that about half of the annual cost would be utilized in that year. In years 2010/2011 and 2011/2012 we expect to fully implement and operate this project at its full cost, and utilize our Prudent Reserve to fund a third full year.

L. Total In Kind Contributions: \$0

		Date:	2/11/2010	
County Name:	Mendocino			
PEI Project Name:	Prevention Collaboration:Children & Youth			
Provider Name (if known):				
Intended Provider Category:	Community Based Organization			
Proposed Total Number of Individuals to be served:		FY 08-09		FY 09-10
Total Number of Individuals currently being served:		FY 08-09		FY 09-10
Total Number of Individuals to be served through PEI Expansion:		FY 08-09		FY 09-10
Months of Operation:		FY 08-09		FY 09-10
Total Program/PEI Project Budget				
	Proposed Expenses and Revenues	FY09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
		0		0
a. Salaries, Wages				
		0		0
b. Benefits and Taxes				
		0		0
c. Total Personnel Expenditures				
		0		0
2. Operating Expenditures				
		0		0
c. Total Operating Expenses				
		0		0
3. Subcontractors/Professional Services (list/itemize all subcontracts)				
	Contract Provide Unknown	32,028		32,028
a. Total Subcontracts				
		32,028		32,028
4. Total Proposed PEI Project Budget				
		32,028		32,028
B. Revenues (list/itemize by fund source)				
1. Total Revenue				
5. Total Funding Requested for PEI Project				
		32,028		32,028
6. Total In-Kind Contributions				
Funds will be used for the FY09-10, but will come from the FY08-09 Planning Estimate.				

Project 4: Prevention Collaboration: Children & Youth

Expenditures for this project were based on information obtained from the Mendocino County Office of Education, from the California Department of Mental Health Early Mental Health Initiative website, from the Educational Demographics Unit of the California Department of Education, and cost projections developed through the PEI Workgroup, which included organizations currently providing similar services.

M. Expenditures: \$64,056**1. *Personnel***

There are no expenses in this category. All personnel will be provided under contract with a provider or providers to be determined.

2. *Operating Costs*

There are no expenses in this category. All operations will be covered under contract with provider or providers to be determined.

3. *Subcontracts/Professional Services*

The funds will provide for a contractor or contractors who will provide clinical supervision of paraprofessionals who screen and work on campus with children at risk of school failure in two school districts that have high concentrations of American Indian or Latino students. The contractor(s) will also provide culturally effective support services to the families of these children at local community-based organizations such as a tribal facility or family resource center, and will refer children and family members for mental health services as needed. This project will serve as a bridge between schools, community-based organizations, the County Mental Health Branches as well as other mental health providers, and will improve access to mental health services for two underserved cultural groups in our county. The project will work in tandem with Project #1.

N. Revenues: \$0

There is a potential for grant and/or in kind funding from selected providers to match PEI funds but this is undetermined at this time.

O. Total 6- Month Funding Requested for Project #4:\$32,028

We anticipate implementing this project about half-way through FY 2009/2010 so that only a portion of the funding can be utilized in that year. In years 2010/2011 and 2011/2012 we expect to fully implement and operate this project at its full cost, and utilize our Prudent Reserve to fund a third full year. In the interim other matching funds will be sought for EMHI grants and other sources that will be applied for at the two selected school sites if this project is successful.

P. Total In Kind Contributions: **\$0**

PEI Administration Budget Worksheet

Form No. 5

County: Mendocino

Date: 10/2/2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2009-10		Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator		0.20	\$9,002		\$9,002
b. PEI Support Staff					\$0
c. Other Personnel (list all classifications)					\$0
_____					\$0
_____					\$0
_____					\$0
d. Employee Benefits			\$1,107		\$1,107
e. Total Personnel Expenditures			\$10,109	\$0	\$10,109
2. Operating Expenditures					
a. Facility Costs					\$0
b. Other Operating Expenditures			\$1,000		\$1,000
c. Total Operating Expenditures			\$1,000	\$0	\$1,000
3. County Allocated Administration					
a. Total County Administration Cost			\$4,402	\$0	\$4,402
4. Total PEI Funding Request for County Administration Budget			\$15,511	\$0	\$15,511
B. Revenue					
1 Total Revenue			\$0	\$0	\$0
C. Total Funding Requirements			\$15,511	\$0	\$15,511
D. Total In-Kind Contributions			\$0	\$0	\$0

Administration Budget Narrative

A. Expenditures

1. Personnel Expenditures

It is anticipated that the PEI Coordinator will only require to be working on the PEI Program approximately 400 hours during FY2009/10. The efforts by the coordinator will be primarily confined to preparing requests for proposals (RFP) for the contract work identified within the work plans, facilitating stakeholder meetings, and attending PEI Coordinator meetings.

The rate of pay for the coordinator is \$21.64 per hour.

Mendocino County's employee benefit package is estimated at 55% of the base employee salary with the variable being the specific employees choice of medical insurance plans.

2. Operating Expenditures.

Expenses are related to the hosting of stakeholder meetings, travel, and general office and printing supplies.

Meetings may require room rentals and refreshments for attendees.

In an effort to facilitate maximum participation by clients, family members, and other stakeholders travel reimbursement is provided for those traveling from the outlying areas of Mendocino County, where travel distances can be as great as in excess of 100 miles round trip.

The PEI Coordinator and/or stakeholders may attend out of county meetings that may require overnight per diem costs.

3. County Allocated Administration.

The Mendocino County Health & Human Services Agency uses a standard 22% administrative cost against salary and benefits. Supplies and support that are included in these costs are facilities, telephones, computers, utilities, etc.

PEI Funding Request

Form 6

FY 2009/10 Mental Health Services Act Prevention and Early Intervention Funding Request

County: Mendocino

Date: 10/20/2009

PEI Work Plans			FY 09/10 Required MHA Funding	Estimated MHA Funds by Type of Intervention			Estimated MHA Funds by Age Group			
No.	Name			Universal Prevention	Selected/ Indicated Prevention	Early Intervention	Children, Youth, and Their Families	Transition Age Youth	Adult	Older Adult
1.	1	Education, De-Stigmatization & Peer Support	\$17,000	\$14,280		\$2,720	\$3,910	\$2,040	\$7,480	\$3,570
2.	2	Early Onset, Early Intervention	\$99,500			\$99,500		\$99,500		
3.	3	Prevention, Early Intervention	\$19,120		\$19,120					\$19,120
4.	4	Prevention, Children & Youth	\$32,028		\$32,028		\$32,028			
5.										
6.										
7.										
8.										
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23.										
24.										
25.										
26.	Subtotal: Work Plans^{a/}		\$167,648	\$14,280	\$51,148	\$102,220	\$35,938	\$101,540	\$7,480	\$22,690
27.	Plus County Administration		\$15,511							
28.	Plus Optional 10% Operating Reserve		\$4,250							
31.	Total MHA Funds Required for PEI		\$187,409							

^{a/} Majority of funds must be directed towards individuals under age 25--children, youth and their families and transition age youth . Percent of Funds directed towards those under 25 years= 82.00%

County: Mendocino**Date: September 2009**

- Check this box if this is a “very small county” (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name: Project #3—Prevention: Older Adults

1. a. Identify the programs (from Form No. 3 PEI Project Summary), the county will evaluate and report on to the State.

Project #3, Prevention: Older Adults

- **Senior Peer Counseling and Outreach Coordination**
- **Outreach/Education**
- **Additional Clinical Supervision**

1. b. Explain how this PEI project and its programs were selected for local evaluation.

- The project design is relatively simple and therefore easy to track;
- We already have established data collection systems that can measure most of the outcomes for this project, and we have staff in our Older Adult System of Care (OASOC), Social Services Division who are able to include the data collection and analysis for this project with their current duties;
- The project will include a large enough number of participants to ensure that our statistics are meaningful.
- We chose to utilize PEI funds for this project because of the growing numbers of older adults and their vulnerability and potential for isolation in our county. Too many can go unnoticed until they require costly interventions with sad outcomes. We chose to evaluate this project for the same reason—the anticipation that by working with this population pro-actively we can stem the tide of increased costs and improve the quality of life for this segment of our citizenry.

2. What are the expected person/family-level and program/system-level outcomes for each program?

Senior Peer Counseling & Outreach CoordinationIndividual Level Outcomes

- Decrease in risk factors for depression
- Decrease in isolation
- Increase in social activities
- Decrease in number of emergency room visits

System Level Outcomes

- Regular meetings established between the OASOC Outreach Coordinator and senior center outreach workers, with good participation;
- At least two trainings per year conducted with senior center outreach workers that result in increased knowledge, skills or resources for serving their older adult clients;
- Twelve (12) new senior peer counselors are trained in the first year with emphasis on recognition of suicidality;
- The number of home visits with OASOC clients increases;
- Decrease in per cent of suicides among the older adults in our county;
- Improved consistency and follow through on referrals for services.

Outreach and EducationIndividual Level Outcomes

- Attendees of educational meetings have increased awareness and knowledge of signs and symptoms of mental illnesses common to older adults including depression and suicide;
- Attendees have information about what to do to get help and who to contact locally;
- Doctor and other professionals working with older adults are aware of signs and symptoms of mental illness and suicide risk among older adults, and of the side effects of medicines on the mental stability of individuals in this population;
- Older adults and their families have increased awareness and knowledge of the nature of mental illness, and signs and symptoms of mental illnesses common to older adults including depression and suicide;

System-Level Outcomes

- At least 50 physicians receive training/education regarding the mental health issues among older adults including the effects of medicines on their mental stability;
- At least four educational events are conducted annually in “natural settings” across the county;

Increased Clinical SupervisionIndividual Level Outcomes

- Senior peer counselors utilize assessment tools and refer older adults for services appropriately;
- Older adult clients show
 - Decrease in risk factors for depression
 - Decrease in isolation
 - Increase in social activities
 - Decrease in number of emergency room visits

System Level Outcomes

- Overall, more senior peer counselors are utilizing assessment tools and referring older adults for services appropriately;
 - A smaller percentage of older adults show risk factors for depression;
 - A larger percentage of older adults participate in regular social activities;
 - There is improved consistency and follow through on referrals for services.
3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For “other”, provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/DISCRIMINATION
<u>ETHNICITY/ CULTURE</u>							
African American							
Asian Pacific Islander							
Latino	4					34	34
Native American	3					27	27
Caucasian	70					594	594
Other (Indicate if possible)	3					27	27
<u>AGE GROUPS</u>							
Children & Youth (0-17)							
Transition Age Youth (16-25)							
Adult (18-59)						464	464

Older Adult (>60)	80					218	218
TOTAL	80					682	682
Total PEI project estimated unduplicated count of individuals to be served						682	

4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?

The staff of OASOC maintain a database on all assessments conducted with older adults clients. These include the Global Assessment of Functioning (GAF), which measures the client’s physical and mental status; the Mini Mental Status Exam, which screens for suicidality and depression; the Sense of Well-being, which measures the client’s overall perception of his or her quality of life; and the Depression Scale. The GAF would be conducted by the case manager as would the Mini Mental Status Exam. The Sense of Well Being and Depression Scale tools would be used by the senior peer counselors, and case managers working with the older adults, and usually done in their homes. The assessments would be conducted annually with updates every six months. The social work assistant would track these assessments, and produce reports and reminders about their due dates.

In addition, the OASOC staff have developed a detailed database that captures

- the number of social activities since the client started the program
- the number of emergency room visits
- the number of crisis interventions
- the numbers of linkages to other services

All of these can be aggregated over time to determine the system level outcomes that have been achieved (or not).

The number of education/training events and sessions conducted and their locations and audiences would be compiled by the Social Work Assistant who is coordinating these. Sign-in sheets would be used to capture attendance and the composition of the audiences. Similarly, the names of physicians and other professionals with whom training/education sessions are conducted would be tabulated to measure the success of outreach/education efforts. Simple before-and-after tests or questionnaires would be utilized in both large and small group settings to capture their success in increasing information and levels of understanding about mental illness and suicide risks, recognition of symptoms and knowledge of local resources for the older adult populations. This data-gathering method would be used for meetings and trainings with senior center outreach workers as well.

The above data would be collected ongoing as visits with clients occur, and as education/training events and meetings with outreach workers are conducted.

5. How will data be collected and analyzed?

The data would be compiled monthly by the social work assistant and submitted to the account specialist who would track the data on data sheets specific to the program. The account specialist will produce a quarterly report which the OASOC manager and the social work assistant will review quarterly to track changes in client status and progress, as well as trends and changes related to systemic outcomes.

6. How will cultural competency be incorporated into the programs and the evaluation?

Program materials will be translated into Spanish as appropriate. This project would take advantage of existing linkages with the Nuestra Casa Family Resource Center, Consolidated Tribal Health and other organizations to help us explain any assessment tools or surveys in a setting and manner that would put members of the Latino and Native American communities at ease. Whenever possible, client assessments would be conducted in the client's home or other culturally acceptable settings by someone who shares their culture as well as their language.

7. What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?

The nature of the program itself would act to ensure fidelity to the model since it provides one individual who organizes and coordinates its components. This person would meet quarterly with the OASOC manager and review the data so that anomalies or common issues would be identified promptly and could be addressed early. Regular reports would also be presented to the OASOC Planning Committee and its workgroup. These bodies can provide additional insight into differences that arise and whether or not they constitute a serious departure from the model or a productive adaptation.

8. How will the report on the evaluation be disseminated to interested local constituencies?

Reports would be shared with the Mental Health Board, the MHSA Stakeholders Group and the members of the PEI Stakeholders Workgroup annually. In addition, the report would be sent annually to the organizations that serve older adults in Mendocino County.

EXHIBIT A FINDINGS AND LIMITS OF THE DATA

FINDINGS

In reviewing the information contained in this Data Report, some items stood out as particularly concerning or telling. These are mentioned below, by age group if age seemed significant, and by topic for issues that could not be broken down by age, or that seemed to cross ages.

Age 0-5

- **Over half** of the children who were served through County Mental Health in 2008 were diagnosed with **Adjustment Disorders**.
- In 2007 and 2008, **179 families** were referred to Family Mediation when there had been an allegation of **domestic violence** involving a child under 6 years old.

Age 6-17

- **Over ¼** of the children who were served through County Mental Health in 2008 were diagnosed with **Adjustment Disorders** or **Oppositional Defiant Disorder**.
- In 2007 and 2008, **57** children in this age bracket were seen in the three hospital emergency rooms in our county because of **suicide attempts**.
- In 2007, **87%** of the children who had been **in foster care for at least two years** and had experienced **more than two placements** were in this age bracket.
- Per the California Healthy Kids Survey for 2005-2007, almost 2/3 of the respondents in Grade 11 in Mendocino County reported alcohol or drug use in the past 30 days, and **more than 1/3 reported binge drinking within the past 30 days** (five or more drinks in a row within two hours).
- In 2007/2008, **111 families** with children in this age bracket were referred to Family Mediation when there had been allegations of **domestic violence**.
- The school **drop-out rate for grades 9-12 has increased** consistently from 2004-05 to 2007-08, and there has been a **higher percentage of American Indian and Latino students** among the drop-outs in every year during this time.
- The average daily population in Juvenile Hall varied in 2007 and 2008 from 34 to 41. **An average of 13 mental health cases** were open for **inmates in Juvenile Hall in 2007** and an **average of 8 in 2008**. On average, **25-30 juvenile wards** are **in placement** on any given month. Of those, **about 33% are in need of mental health services**, and 33% have a formal IEP.
- The California Healthy Kids Survey revealed that **1/3 of 9th and 11th graders and 2/5 of continuation/community school students** who responded to the survey **felt sad or hopeless in the past 12 months**.

EXHIBIT A FINDINGS AND LIMITS OF THE DATA

Age 18-25

- Forty per cent (**40%**) of the individuals in this age group who were treated through County Mental Health in 2007 were diagnosed with **Adjustment Disorders or Depression**.
- In 2007, of the 282 total **acute psychiatric hospitalizations** in Mendocino County, **58 (over 20%)** were related to the symptoms of **first onset**, typically in a person aged 16-25. As of June 2008, Mendocino County housed five young adults in Institutions of Mental Disease whose first hospitalization had occurred in the last year as a result of first onset. These **young adults comprised about 33% of the individuals the County housed in these institutions**.
- Per the County Alcohol and Other Drug Program, of the 120 admissions in 2008 from this age group, **26 self-reported a mental illness diagnosis as well**. Fifteen (**15**) self-reported a mental illness diagnosis with **methamphetamine as their drug of choice**.
- According to a survey conducted at Mendocino College in 2004 about drinking habits, 403 students were surveyed from the “under 26” age group, and **33% of them reported being binge drinkers** (five or more drinks of alcohol within two hours).
- The number of **foster youth who “age out”** or emancipate from the foster care system after having been **in care more than three years** has **trended upward** from 1999 through 2007.
- **Nearly 100** individuals between the ages of 18 and 30 were counted among the **homeless** in the Mendocino County Homeless Census and Survey of 2007.
- The Ukiah Valley Medical Center Emergency Room, the Mendocino Coast District Hospital, and Howard Memorial Hospital in Willits reported **77 suicide attempts** in this age group in 2007 and 2008.

Age 26-59

- Of the individuals in this age group who were treated through County Mental Health in 2008, **almost ¾** were diagnosed with **Bi-Polar Disorder, Schizophrenia or Depression**.
- The Ukiah Valley Medical Center Emergency Room, the Mendocino Coast District Hospital, and Howard Memorial Hospital in Willits reported **171 suicide attempts** in this age group in 2007 and 2008.
- Of the 402 individuals admitted by the County’s Alcohol and Other Drugs Program in 2008, **147 (36%) self-reported a mental illness diagnosis as well**. Almost **100** self-reported a **mental illness diagnosis with methamphetamine as their drug of choice**.

EXHIBIT A FINDINGS AND LIMITS OF THE DATA

Age 60+ _____

- Of the individuals in this age group who were treated through County Mental Health in 2008, **over 80%** were diagnosed with **Depression, Schizophrenia, or Bi-Polar Disorder**.
- Between 2000 and 2010, the older adult **population will have increased over 30%**.
- Although the number of suicide deaths in younger age groups is considerably small compared to the number of suicide attempts, between 2002 and 2006, the **number of suicide attempts was almost equal to the number of suicide deaths in the older adult population**.
- **Approximately 10%** of all of the clients receiving case management, psychotherapy and/or Senior Peer Counseling through the County's Older Adult System of Care present with **some degree of substance abuse or medication misuse**.

Across Ages _____

- **American Indians are over-represented** among almost all the at-risk populations and indicators in our county compared to their numbers in the population as a whole.
- **Between 1/5 and 1/4 of the inmates** in the Mendocino County jail in any given month are **receiving psychiatric medication**.
- According to the 2007 Mendocino County Homeless Census and Survey, **35%** of respondents reported experiencing **some form of mental illness**.

DATA LIMITATIONS

Several obstacles arose in our efforts to gather reliable, meaningful data:

- Age groups often didn't match up among the available data sources. This made comparing issues and numbers by age difficult.
- Many of the entities providing data for this report could not break out the information by age group at all.
- Automated data collection systems were frequently inadequate, inconsistently utilized, or non-existent, so that extracting information that might inform our conclusions was problematic.
- Mental health diagnoses change over time, and clients may have several diagnoses. In addition, there were a good number of clients without a diagnosis among those served by County Mental Health at a given point in time. Therefore we do not feel secure about the data we used to cite the most common mental health issues in our community.
- Finally, many of our data sources provided information by ethnicity. While this information can help us zero in on under-served ethnic populations, it

EXHIBIT A
FINDINGS AND LIMITS OF THE DATA

also makes us uneasy. There is no true, consistent measure of poverty, and data sources use a variety of them. The Prevention and Early Intervention Work Group members share a conviction that poverty has a larger role to play than ethnicity in the stressors that contribute mental health issues, and the obstacles that prevent individuals experiencing mental illness from gaining access to interventions and resources.

EXHIBIT B

**MENDOCINO COUNTY
Health & Human Services Agency**

**MHSA PREVENTION AND
EARLY INTERVENTION
Community Mental Health
Assessment Data Report**

July, 2009

EXHIBIT B
Community Mental Health Assessment Data Report

Acknowledgments

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Mendocino County
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Community Mental Health Assessment Data Report

Mendocino County
MHSA Prevention and Early Intervention
Community Mental Health Assessment, 2009

Introduction

The purpose of this report is to compile a needs assessment in the form of a snapshot of local and relevant information about mental health issues in Mendocino County. It has helped guide those involved in the Prevention and Early Intervention (PEI) planning process who have added depth and meaning to the data by gathering additional information from local stakeholders around the county. This report will also provide a baseline for monitoring, over time, the long-term effectiveness of local Mental Health Services Act (MHSA) PEI efforts.

The PEI focus is to engage individuals prior to the development of serious mental illness or at the very early onset of such a condition. Prevention and early intervention activities focus on alleviating the need for extended mental health treatment and the more serious consequences of untreated mental health conditions by reducing risk factors and stressors with low-intensity approaches.

This data report is by no means a comprehensive report on the multitude of complex factors that influence a person's or a community's mental well-being. Nor is it a complete picture of the outcomes resulting from untreated mental illness. Rather, it reports local data as is available at this time on factors strongly correlated with the lack of mental well-being and indicators that have been known to be precursors of mental illness. It also includes measures of population-based and often self-reported mental health status. An appendix at the end of the document briefly describes each source of local data and how the information is collected. There are many mental health issues for which we don't have local measurements or were unable to get adequate information. Over time and with more adequate resources, we hope to build a better base of local knowledge about some of these problems and assets.

We would like to acknowledge an issue that was brought up in the work group: race/ethnicity may not be as appropriate a sub-grouping as poverty level in many of these data sets. However, race/ethnicity still remains the demographic data that is most available to us. We have included a discussion of the strong connection between race/ethnicity and poverty in Mendocino County that was made by the California Center for Rural Policy (see page 12).

This project was a collaborative effort of Mendocino County Health and Human Services Agency Branches of Adult and Older Adult System of Care, Children and Family System of Care and Community Health Services, members of the PEI work group and others who also have a "stake" in the mental health of their clients and families.

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Community Mental Health Assessment Data Report

707-472-2776

707-467-6016

Mendocino County
MHSa Prevention and Early Intervention
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CHILDREN AGES 0-5

POPULATION

The 2007 population of children ages 0-5 in Mendocino County is estimated to have grown about 5% since 2003. The racial diversity in children 0-5 has changed little over these 5 years with White and Hispanic races accounting for over 80% of all children ages 0-5.

Mendocino County Estimated Population for Ages 0-5 by Race/Ethnicity

	2003		2004		2005		2006		2007	
White, non-Hispanic	3379	53.2%	3291	52%	3278	51%	3385	52%	3444	51%
Hispanic	2105	33.2%	2179	34%	2220	35%	2303	35%	2360	35%
Native American	375	5.9%	379	6%	354	6%	358	5%	391	6%
Other Races (Asian, Black, Pac. Islander)	74	1.2%	60	0.9%	54	0.8%	52	0.8%	63	0.9%
Multirace	414	6.5%	465	7.3%	501	7.8%	473	7.2%	446	6.7%
TOTAL, ages 0-5	6347		6374		6407		6571		6704	

Source: California Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050.

MENTAL HEALTH ISSUES

Very young children can have mental health issues that interfere with the way they interact with others, learn and develop as healthy individuals. Diagnosing and treating these issues at an early age significantly increases the likelihood of successful treatment and long-term positive effects.

County Mental Health Services

Mendocino County Mental Health Department accepts clients needing mental health services who have Medi-Cal or Medicare through county staff and contracted services provided by local services providers and agencies. The following numbers are based on clients ages 0-5 served in a year through this countywide service provision.

Children ages 0-5 served by Mendocino County Mental Health Department in 2008

Race/Ethnicity, Ages 0-5	# CLIENTS ADMITTED AT MCDMH IN 2008	% OF CLIENTS ADMITTED AT MCDMH IN 2008
White/non-Hispanic	15	15%
Hispanic	5	5%

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Community Mental Health Assessment Data Report

Native American	5	5%
Other Races (Asian,Black,Pac.Islander)	3	3%
Multirace		
Unknown	69*	71%*
TOTAL, Ages 0-5	97	

*Unknown race numbers are high due to lack of data collected on race/ethnicity.

Children ages 0-5 served by Mendocino County Department of Mental Health in 2008 by language spoken at home:

Language Spoken at Home, Ages 0-5	# CLIENTS SERVED AT MCDMH IN 2008	% OF TOTAL
English	65	67%
Spanish	7	7%
Other Language	25*	26%
TOTAL, Ages 0-5	97	

*Other (or unknown) language numbers are high due to lack of data collected on language spoken.

Children ages 0-5 served by Mendocino County Department of Mental Health in 2008 by Diagnosis at Admission:

Diagnoses, Ages 0-5	# DIAGNOSES AT MCDMH IN 2008	% OF TOTAL
Adjustment Disorders	18	51%
Attention Deficit Disorder	2	
Anxiety Disorders	4	
Conduct Disorders	5	
Oppositional Defiant Disorder	4	
Posttraumatic Stress Disorder	2	
TOTAL DIAGNOSES, Ages 0-5	35	
Diagnosis Deferred or Left Blank	34	49%
TOTAL, Ages 0-5	69	

NOTE: CLIENTS MAY BE DUPLICATED AS THEY HAVE MORE THAN 1 DIAGNOSIS

Health Clinics Mental Health Services

Consolidated Tribal Health Project (CTHP)

- 2 mental health clients ages 0-5 were seen in 2008; both were American Indian with Adjustment Disorders. No clinician was available to see young children at CTHP in 2008.
- The small numbers reflect the fact that no clinician was available to see young children at CTHP in 2008.

Round Valley Tribal Health Project (RVTHP)

- No mental health clients ages 0-5 were seen in 2008.

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Community Mental Health Assessment Data Report

Alliance for Rural Community Health (ARCH) Health Centers

The Alliance for Rural Community Health (ARCH) is a organization whose mission is to support the network of six federally qualified community health centers throughout Mendocino County, including: Anderson Valley Health Center (AVHC), Long Valley Health Center (LVHC), Mendocino Coast Clinics (MCC), Mendocino Community Health Clinics (Ukiah and Willits) (MCHC), Potter Valley Community Health Center (PVCHC), and Redwood Coast Medical Services (Pt. Arena and Gualala) (RCMS). Four of the six health centers act as the sole provider of care for their respective communities: Anderson Valley, Long Valley (Laytonville), Potter Valley, and Gualala/Pt. Arena.

**Percent of Total & (Number) of Mental Health Clients
in 2007 with Diagnosed Condition**

CLINIC DIAGNOSTIC CATEGORY	Mendocino Community Health Clinics (3 sites)	Mendocino Coast Clinics	Redwood Coast Medical Services (2 sites)	Long Valley Health Clinic
Depression/Mood Disorders	47% (1219)	70% (597)	61% (119)	40% (52)
Anxiety Disorders and PTSD	43% (1116)	27% (231)	34% (65)	43% (46)
Attention Deficit/ Disruptive Behavior Disorders	9% (242)	2% (20)	5% (10)	8% (8)
TOTAL # MH CLIENTS	2,577	848	194	106

- ARCH was unable to break down Mental Health clients by age group, but most children seen would be diagnosed with attention deficit or behavior disorders; a total of 280 clients from all clinics had these diagnoses.
- While only four of the six health centers collected data on the specific mental health diagnoses described above, in 2008, AVHC and PVCHC provided a combined total of 521 mental health visits.

EXPOSURE TO TRAUMA

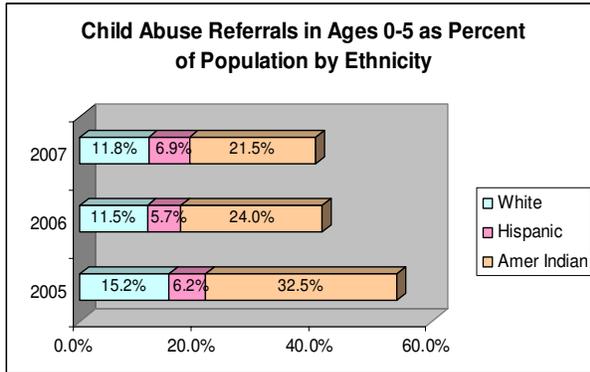
Child Abuse and Neglect

Children abused and neglected often lose the opportunity to grow up in stable and loving families that promote emotional health. Abuse and neglect can accompany a host of other factors detrimental to a child’s cognitive, social and emotional development. It is estimated by criminal justice professionals that more than 60% of domestic violence incidents involve child abuse.

Allegations of neglect or abuse that come to the attention of Child Protective Services are captured in the form of child abuse referrals. Child abuse typically takes place in the

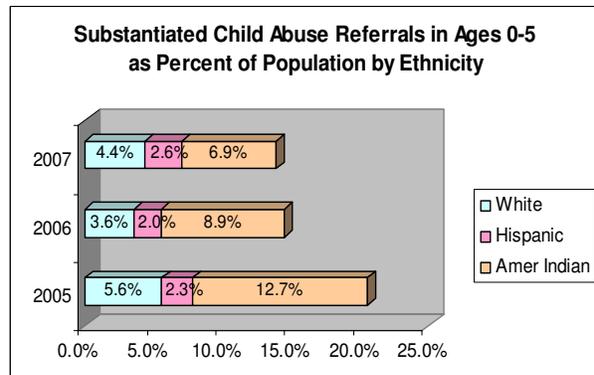
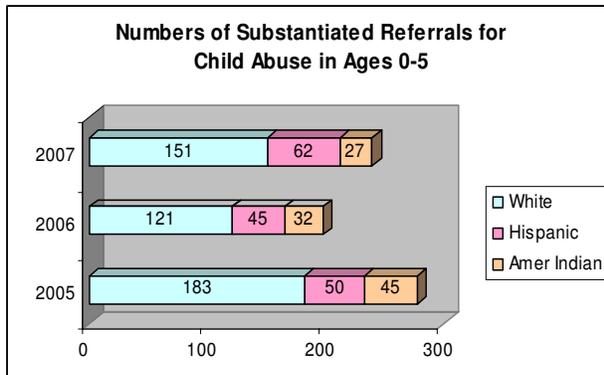
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child's home and most often is committed by adults responsible for the care of the child. In 2007, a total of 682 children were reported to the Mendocino County Family and Children's Services Division for suspected child abuse or neglect, down 15% from 2005. Looking at these referrals by race/ethnicity for Ages 0-5 reveals the following:



- The largest number of children 0-5 comes from the White population in all 3 years.
- The largest percent of the 0-5 population comes from the Native American population.

Of these children reported for possible abuse or neglect in 2007, 246 (36%) were substantiated, which was the same as in 2005. The race/ethnicity breakdown pattern is similar to the graphs above.



Source: CWS/CMS Dynamic Report System, California Department of Social Services / University of California at Berkeley collaboration, http://cssr.berkeley.edu/ucb_childwelfare

Domestic Violence

Living with domestic violence can be extremely damaging for a child. Recent research has shown that witnessing domestic violence can affect brain and emotional development and have long-term impacts on children's lives.

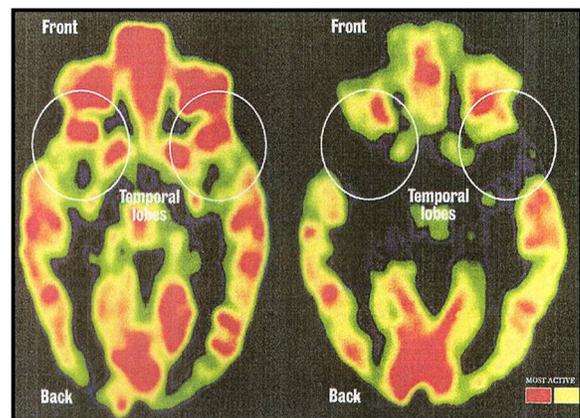
Families are referred to Family Mediation from Family Court when there are issues of custody and visitation of minor children in cases of dissolution, parentage (non-married parents), and requests for modifications of custody and visitation orders. Families are also referred to Family Mediation when one parent files for a domestic violence restraining order and there are minor children of the relationship.

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The following table indicates the number of children under 6 who have been possible witnesses to domestic violence in their family and whose family was referred to Family Mediation from Family Court:

Number of Families	2007	2008
In Family Court referred to Family Mediation.	242	275
Referred to Family Mediation alleging that there had been domestic violence.	140	153
Referred to Family Mediation where at least one parent applied for a domestic violence restraining order	58	73
Referred to Family Mediation alleging that there had been domestic violence with children under 6.	84	95

The effects of abuse and neglect on children are well-documented. Now through medical imaging of the brain, the damage can actually be pictured. This MRI (picture of brain activity) shows the effects of extreme deprivation. The picture on the left is of a healthy, well cared for child; the one on the right is of a child who has been severely neglected. *Courtesy of the Center for Educational Enhancement and Development.*



Foster Care (“Out-of-Home”)

Foster care is 24 hour, day-to-day care for children outside of their usual homes and families. There can be a variety of reasons for a child to live “out-of-home”, and a variety of placement settings. In January 2007, about 300 children were in out-of-home placement under the care of the Department of Social Services.

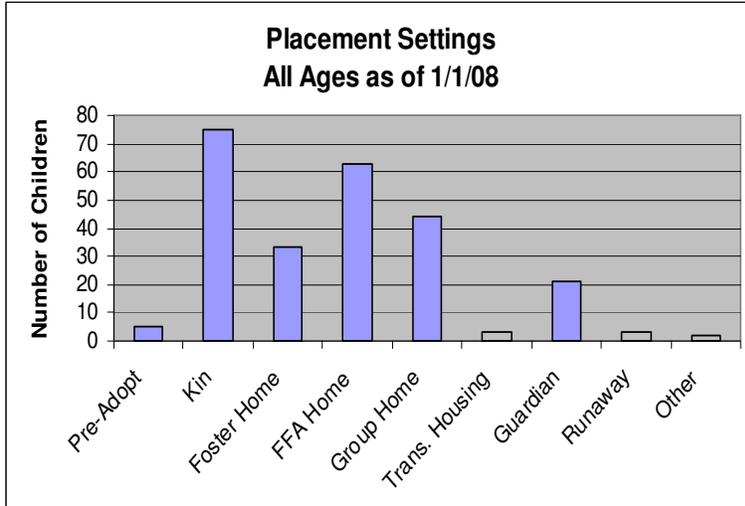
The most common reasons for removal for Child Welfare-supervised foster children are severe and general neglect, physical abuse, and sexual abuse. In Mendocino County most foster children are placed in out-of-home care because of neglect. In the period of January 1 through December 31, 2007,

- 145 children entered Child Welfare Services-supervised foster care.
- 128 of them were removed from their homes because of neglect (88%).
- 53 of the 145 children who entered foster care during that time were between the ages of zero and five years old.
- 50 of the 53 children in that age group were removed from their homes because of neglect (94%).

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The major ethnic groups in Mendocino County are White, Hispanic and Native American. Of the children between the ages of zero and five years old who were removed from their homes because of neglect during the period of January 1 and December 31, 2007,

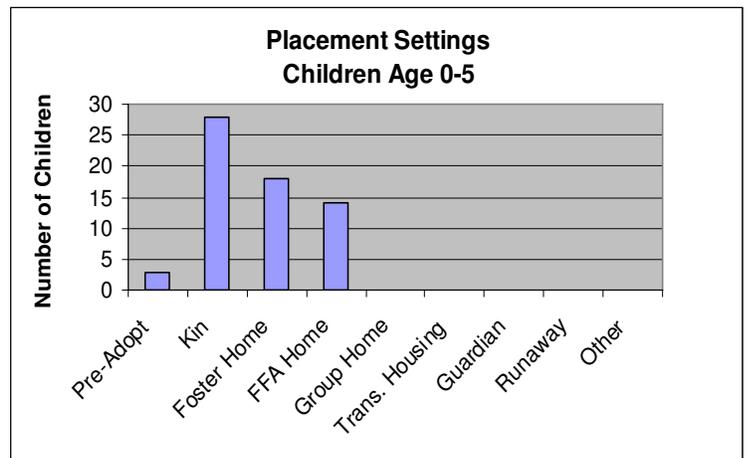
- 29 children were white (58%),
- 11 were Hispanic (22%) and
- 9 were Native American (18%).



Children may be placed with relatives, non-related extended family members, or guardians. They may also be placed in county or state-licensed foster homes, in homes certified by foster family agencies (FFAs), in group homes or institutional care facilities. On January 1, 2008, the most common placement settings for Mendocino County Child-Welfare-supervised foster children, all ages, were homes of relatives (36%), homes

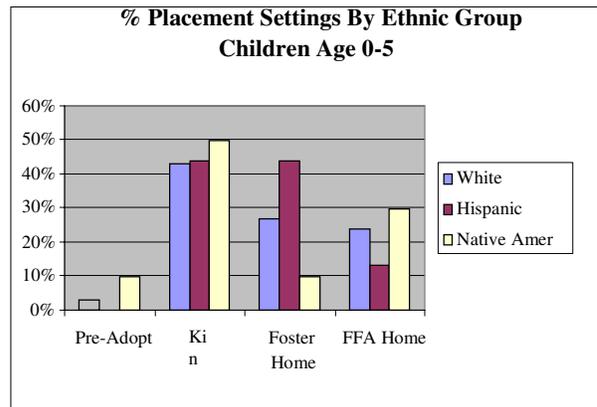
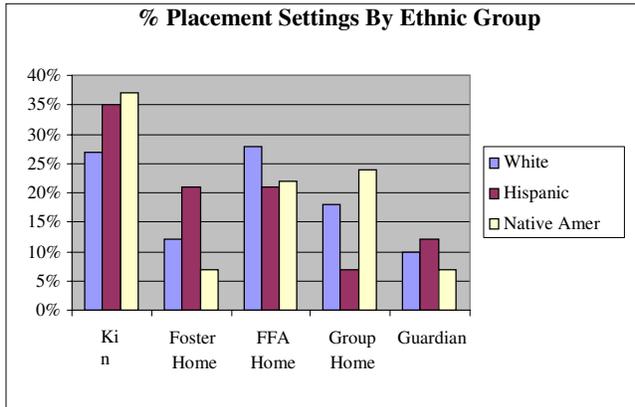
certified by FFAs (27%), group homes (15%), and county-licensed foster homes (13%).

The placement settings most commonly utilized in our county on that date varied, however, by age group. Most of the children between the ages of 0-5 years old were placed with relatives (44%), but the next highest percentage of children in this age group were placed in County-licensed foster homes (28%), followed by FFA homes (22%).



On January 1, 2008, the percentage of all children in various placement settings varied by ethnic group and age. The charts below show the distribution by ethnic group for all ages, and the distribution by ethnic group for the 0-5 age group:

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FAMILY STRESSORS

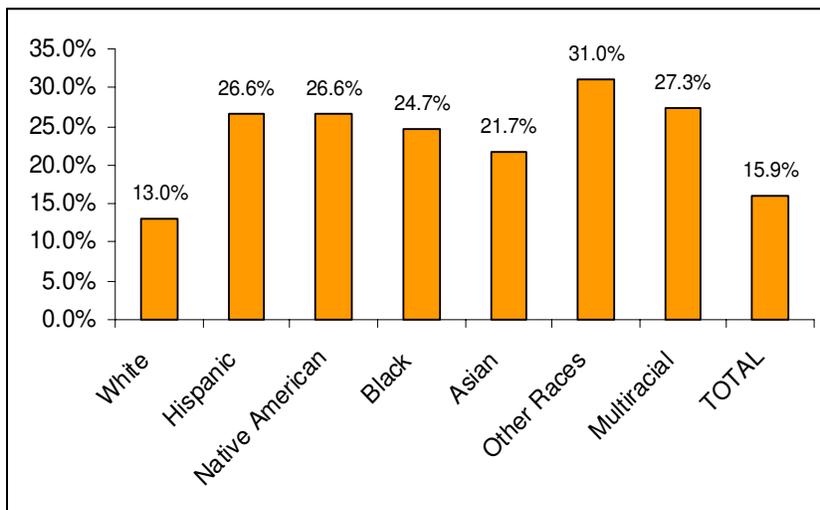
Many adults in our modern society have difficulty in providing for their families and live with intense stress like working 2 jobs to make ends meet, living in a single-parent household, living in poverty or going without enough food to eat. Stress can cause emotional problems that may lead to poor parenting skills that can have significant negative effects on developing children.

Poverty

Some of the ethnic disparity seen in the tables on foster care can be attributed as well to living below the federal poverty level and can prevent many families and individuals from accessing needed services and support.

Percent of Population below the Federal Poverty Level In Mendocino County within Race/Ethnicity, Census 2000

Even though this breakdown is for 2000, it provides some indication of the



connection between race and poverty:

- The White population has the lowest % of poverty (13%), but the highest numbers.
- Both Hispanic and Native American populations have more than twice the % of poverty than White.
- Other race and

Multiracial also show high poverty rates.

According to the U.S. Census Bureau, 2005-2007 American Community Survey, in Mendocino County,

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- an estimated 20.5% of families with children 0-17 years of age live at the poverty level, or about 1 in 5 families with children live in poverty,
- an estimated 26% of families with children 0-4 years of age live at the poverty level or about 1 in 4 families
- These updated poverty rates are not available for race/ethnicity breakdowns

According to the California Center for Rural Policy at Humboldt State University in their report "Rural Poverty and the Health Impacts: A Look at Poverty in the Redwood Coast Region",

- Poverty rates are higher in the Redwood Coast Region than in the U.S. and California particularly for children and families headed by single women with children and the American Indian and Hispanic populations.
- Physical and social isolation can also occur in rural areas making access to health care, social services, food and work more difficult.

Responses to the Rural Health Information Survey (RHIS), conducted in the fall of 2006 in Humboldt, Del Norte, Mendocino and Trinity counties by CCRP, revealed that

- Respondents living in poverty were 4.1 times more likely to report feeling sad or depressed most or all of the time compared to respondents living at or above 300% poverty. As the socioeconomic status of the respondent improves the likelihood of experiencing sadness or depression decreases.
- Almost 40% of respondents living in poverty reported that were unable to get needed health care (including mental health) in the year prior to the survey, or 5.2 times higher than respondents living at or above 300%.

According to the California Department of Social Services, 12.6% of the Mendocino County population were recipients of public assistance programs in 2007.

Food Insecurity

According to the California Health Interview Survey (CHIS) 2007, in Mendocino County

- an estimated 38% of residents were unable to afford enough food, and
- 19% were currently receiving food stamps.

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Mendocino County
MHSa Prevention and Early Intervention
Community Mental Health Assessment, 2009

CHILDREN AGES 6-17

POPULATION

The 2007 population of children & youth ages 6-17 in Mendocino County is estimated to have decreased about 10% since 2003. The racial diversity has changed somewhat in these 5 years with number of White children & youth 6-17 decreasing from 61% to 57% and numbers of Hispanic children and youth 6-17 increasing from 27% to 31%.

Mendocino County Estimated Population for Ages 6-17 by Race/Ethnicity

	2003		2004		2005		2006		2007	
White, non-Hispanic	9340	61.3%	8998	60.3%	8618	59.3%	8204	58.2%	7919	57.0%
Hispanic	4103	26.9%	4141	27.8%	4188	28.8%	4209	29.9%	4298	30.9%
Amer Indian	1081	7.1%	1114	7.5%	1104	7.6%	1088	7.7%	1077	7.8%
Other Races (Asian,Black, Pac.Islander)	1186	7.8%	1221	8.2%	1213	8.3%	1198	8.5%	1181	8.5%
Multirace	463	3.0%	430	2.9%	393	2.7%	372	2.6%	399	2.9%
TOTAL, ages 6-17	15229		14922		14533		14097		13895	

Source: California Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050.

LANGUAGE SPOKEN AT HOME

Language barriers between clients and providers can prevent access to critical services such as employment, transportation, medical and social services. Examining the language spoken at home by the county population helps providers of mental health services to offer language-appropriate services to the community.

According to the U.S. Census Bureau, American FactFinder, among the almost 16,000 people in Mendocino County who speak a language other than English at home, 28.4% are children and youth 5-17 years of age.

MENTAL HEALTH ISSUES

Children and teens can have mental health issues that interfere with the way they interact with others, learn and develop as healthy individuals. Diagnosing and treating children has become part of the fabric of family and school life.

County Mental Health Services

Mendocino County Mental Health Department accepts clients needing mental health services who have Medi-Cal or Medicare through county staff and contracted services provided by local services providers and agencies. The following numbers are based on clients ages 6-17 served in a year through this countywide service provision.

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Clients ages 6-17 served by Mendocino County Mental Health Department in 2008

Race/Ethnicity, Ages 6-17	# CLIENTS ADMITTED AT MCDMH IN 2008	% OF CLIENTS ADMITTED AT MCDMH IN 2008
White/non-Hispanic	194	22%
Hispanic	56	6%
Native American	35	4%
Other Races (Asian,Black,Pac.Islander)	25	3%
Multirace		
Unknown	577*	65%*
TOTAL, Ages 6-17	887	

*Unknown race numbers are high due to lack of data collected on race/ethnicity.

Clients ages 6-17 served by Mendocino County Department of Mental Health in 2008 by language spoken at home:

Language Spoken at Home, Ages 6-17	# CLIENTS SERVED AT MCDMH IN 2008	% OF TOTAL
English	658	74%
Spanish	35	4%
Other Language	194*	22%
TOTAL, Ages 6-17	887	

*Other (or unknown) language numbers are high due to lack of data collected on language spoken.

Clients ages 6-17 served by Mendocino County Department of Mental Health in 2008 by Diagnosis at Admission:

Diagnoses, Ages 6-17	# DIAGNOSES AT MCDMH IN 2008	% OF TOTAL
Adjustment Disorders	110	17%
Attention Deficit Disorder	60	
Anxiety Disorders	65	
Bipolar Disorders	15	
Conduct Disorders	80	9%
Depression	51	
Dysthymic Disorder	50	
Mood Disorders (NOS)	18	
Oppositional Defiant Disorder	84	13%
Posttraumatic Stress Disorder	75	8%
Reactive Attachment Disorder	21	
Other Psychotic disorders (NOS)	3	
TOTAL DIAGNOSES, ages 6-17	632	
Diagnosis Deferred or Left Blank	295	32%

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TOTAL, Ages 6-17	927
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NOTE: CLIENTS MAY BE DUPLICATED AS THEY HAVE MORE THAN 1 DIAGNOSIS.

Clinic Mental Health Services

Consolidated Tribal Health Project (CTHP)

- 52 mental health clients ages 6-17 were seen in 2008; more than 50% were American Indian.
- 67% were diagnosed with adjustment disorders and 21% with anxiety or PTSD.

Round Valley Tribal Health Project (RVTHP)

- 25 mental health clients ages 6-17 were seen in 2008; 36% were American Indian.
- 64% were diagnosed with adjustment disorders; 32% with impulse control disorders and 44% with alcohol abuse.

Alliance for Rural Community Health (ARCH) Health Centers

The Alliance for Rural Community Health (ARCH) is a organization whose mission is to support the network of six federally qualified community health centers throughout Mendocino County, including: Anderson Valley Health Center (AVHC), Long Valley Health Center (LVHC), Mendocino Coast Clinics (MCC), Mendocino Community Health Clinics (Ukiah and Willits) (MCHC), Potter Valley Community Health Center (PVCHC), and Redwood Coast Medical Services (Pt. Arena and Gualala) (RCMS). Four of the six health centers act as the sole provider of care for their respective communities: Anderson Valley, Long Valley (Laytonville), Potter Valley, and Gualala/Pt. Arena.

**Percent of Total & (Number) of Mental Health Clients
in 2007 with Diagnosed Condition**

CLINIC DIAGNOSTIC CATEGORY	Mendocino Community Health Clinics (3 sites)	Mendocino Coast Clinics	Redwood Coast Medical Services (2 sites)	Long Valley Health Clinic
Depression/Mood Disorders	47% (1219)	70% (597)	61% (119)	40% (52)
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TOTAL # MH CLIENTS	2,577	848	194	106

- ARCH was unable to break down Mental Health clients by age group, but most children seen would be diagnosed with attention deficit or behavior disorders; a total of 280 clients from all clinics had these diagnoses.
- While only four of the six health centers collected data on the specific mental health diagnoses described above, in 2008, AVHC and PVCHC provided a combined total of 521 mental health visits.

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County School-based Services

The Mendocino County Special Education Local Plan Area (SELPA) is made up of 12 school districts and the County Office of Education. These entities work together to assure that all individuals with disabilities receive a free appropriate public education in the least restrictive environment. One of the special factors that the team is required to consider is the behavior of the student. If the student's behavior interferes with his/her learning or the learning of others, the team must consider strategies and supports to address the student's behavior. Students identified with "Emotional Disturbance" exhibit one or more specific characteristics which adversely affects educational performance, and services are provided to that student through SELPA.

According to the Mendocino County Office of Education SELPA, as of 12/1/08, 212 children between 6 and 18 ages of age had been identified with Emotional Disturbance in the Mendocino County School system and received interventions by staff. This number is almost 2% of the school (K-12) population (13,304 in 08-09) and presents many challenges to school special education staff, students, teachers and parents.

Feelings of Hopelessness

The 2005-2007 compiled responses from the California Healthy Kids survey revealed the following about assets and risks in 7th, 9th and 11th graders and Continuation/Community students:

Mendocino County Student Respondents	Grade 7	Grade 9	Grade 11	Continuation /Community
Felt Sad or Hopeless, Past 12 months	28%	32%	32%	40%
Ever seriously consider suicide? *	17%	15%	14%	

Source: California Healthy Kids Survey, 2005-2007, Module A and * 2004-2006, Module C.

Suicide

Between 2002 and 2006 the California Department of Public Health, EPIC Branch reports that there were a total of 4 suicide deaths and 24 hospitalized suicide attempts among children and teens ages 10-17 in Mendocino County. According to the Mendocino County Child Death Review Team Report, between 2007 and 2008 there were no teen suicides.

In 2007 and 2008 combined, Ukiah Valley Medical Center Emergency Room reported that there were 43 attempted suicide injuries in ages 6-17 seen in the ER. About 6% of these were admitted to the hospital. Mendocino Coast District Hospital reported 4 attempted suicides seen in the ER and Howard Memorial Hospital reported 10 attempted suicides in the ER in ages 6-17 for these 2 years.

SUBSTANCE ABUSE ISSUES

Alcohol and Drug Use

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The 2005-2007 compiled responses from the California Healthy Kids Survey revealed the following about 7th, 9th and 11th grades and Continuation/ Community schools alcohol and drug use and attitudes about use:

Mendocino County Student Respondents	Grade 7	Grade 9	Grade 11	Continuation/ Community
Any AOD Use, Past 30 Days	22%	43%	61%	85%
Alcohol Use, Past 30 Days	18%	40%	56%	78%
Perceived Harm of Frequent Alcohol Use	71%	62%	65%	49%
Binge (Episodic Heavy) Drinking, Past 30 Days*	7%	25%	38%	60%
Marijuana Use, Past 30 Days	7%	19%	29%	55%
Perceived Harm of Frequent Marijuana Use	78%	64%	54%	34%
Cigarette Use, Past 30 Days	5%	10%	20%	55%
Perceived Harm of Frequent Cigarette Use	87%	84%	87%	77%

Source: California Healthy Kids Survey, 2005-2007

*Binge Drinking is using five or more drinks of alcohol in a row within a couple of hours.

SCHOOL FAILURE

Dropouts

The high school drop-out rate can indicate possible mental health issues as well as a host of other issues such as physical and emotional safety, resistance to authority and boredom. A comparison of Mendocino County 9-12th graders for school year 2003-04 through school year 2006-07 shows an increase for all students and for students of all races. There was a higher percent of both Hispanic and Native American students than White, non-Hispanic students who dropped out of high school for all years.

1-year Drop-out Rates* for	2004-05	2005-06	2006-07	2007-08
All 9-12 th grade students	1.9%	1.9%	3.7%	4.9%
White, non-Hispanic students	1.7%	1.8%	3.2%	3.2%
Hispanic students	2.2%	2.1%	4.2%	3.8%
Native American students	3.9%	2.8%	5.3%	8.3%

Source: California Department of Education, Data Quest, www.cde.gov/dataquest/

* 1-year drop-out rate = (# Gr.9-12 drop-outs)/(Gr. 9-12 enrollment)*100

This table points out that

- dropouts appear to be on the increase and
- the populations most at risk of school failure in Mendocino County are the Hispanic and Native American students who represent a smaller percent of the school population but a larger percent of the dropout population.

Suspensions and Expulsions

Truancy rates are calculated from the number of students with unexcused absence or tardy on 3 or more days. In the 2007-08 school year, Mendocino had a truancy rate of 32.7% compared to California with a rate of 25.8%. Mendocino has been higher than the State for the past 3 years.

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Suspensions and expulsions are disciplinary actions imposed for prohibited conduct committed by a student. An expulsion is when a student is permanently removed from a school system, whereas a suspension can mean the student is suspended from school activities for a period of time. Both can indicate possible mental health problems, family trouble and/or alcohol and drug abuse in the teen's life. The Department of Education reports these numbers annually.

School Year	2007-2008	2006-2007	2005-2006
Expulsions	57	45	51
Suspensions	2,932	2,334	2,425

Source: California Department of Education, Data Quest, www.cde.gov/dataquest/

INVOLVEMENT WITH JUVENILE PROBATION

The Juvenile Division is responsible for both court and supervision services for Juvenile Court. These services include intake investigations at Juvenile Hall, preparation of jurisdiction and disposition reports, community supervision, out-of-home placement and monitoring, and home supervision. Modifying delinquent behavior by early intervention and holding youth accountable for their actions, aids in preventing costly foster and group home placements. This unit has a specialized Gang Intervention caseload and performs juvenile traffic hearings.

By statute, all juvenile criminal offenders are referred to the probation department for an investigation of the circumstances that led to the arrest and to decide the most appropriate intervention strategy. Depending on the type of crime, seriousness of the offense and the sophistication of the offender, intervention options range from a mere counsel and close to a direct file in the adult court of justice.

Probation receives between 600 and 700 referrals annually. Misdemeanor crimes have been on the decline. Although felony crimes in 2006 are less the 2003, they have been on the rise since 2005.

Juvenile Arrests

Juvenile (Ages 10-17) Misdemeanors						
	2003	2004	2005	2006	2007	2003 to 2007 % Change
TOTAL	715	564	473	446	445	-37.8%
Assault & Battery	183	130	139	119	93	-49.2%
% of Total	25.6%	23.0%	29.4%	26.7%	20.9%	
Marijuana	132	107	64	45	60	-54.5%
% of Total	18.5%	19.0%	13.5%	10.1%	13.5%	
Other Drugs	22	14	16	16	13	-40.9%
% of Total	3.1%	2.5%	3.4%	3.6%	2.9%	
Alcohol-related	110	96	71	70	60	-45.5%
% of Total	15.4%	17.0%	15.0%	15.7%	13.5%	

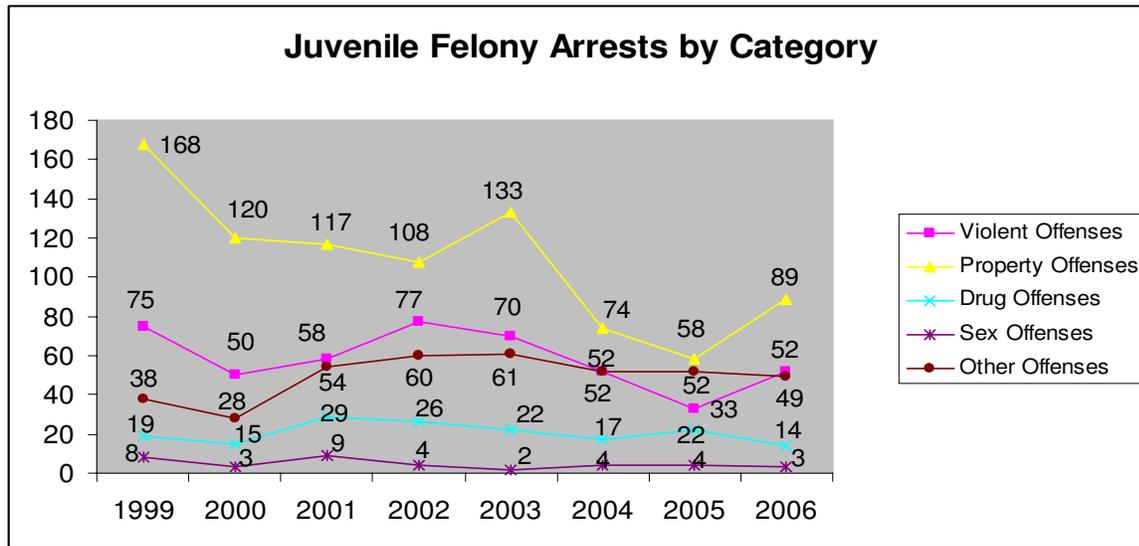
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It can be seen from this table that numbers of juvenile misdemeanor arrests decreased between 2003 and 2007 in all areas reported here. Especially marked is the 55% decrease in marijuana arrests which may be attributed to a relaxing of law enforcement for marijuana use.

Juvenile (Ages 10-17) Felonies						
	2003	2004	2005	2006	2007	2002 to 2007 % Change
TOTAL	288	199	169	207	194	-32.6%
Assault	65	47	30	45	43	-33.8%
% of Total	22.6%	23.6%	17.8%	21.7%	22.2%	
Property Offenses	133	74	58	89	78	-41.4%
% of Total	46.2%	37.2%	34.3%	43.0%	40.2%	
Drug Offenses	22	17	22	14	16	-27.3%
% of Total	7.6%	8.5%	13.0%	6.8%	8.2%	

Source: California Department of Justice, <http://ag.ca.gov/cjsc/datatabs.php>

Juvenile felony arrests decreased as well between 2003 and 2007. Especially marked is the 34% decrease in assault arrests and 41% decrease in property offense arrests.



Note: the numbers are relatively small and any decrease is affected by small changes in the numbers.

Source: California Department of Justice, <http://ag.ca.gov/cjsc/datatabs.php>

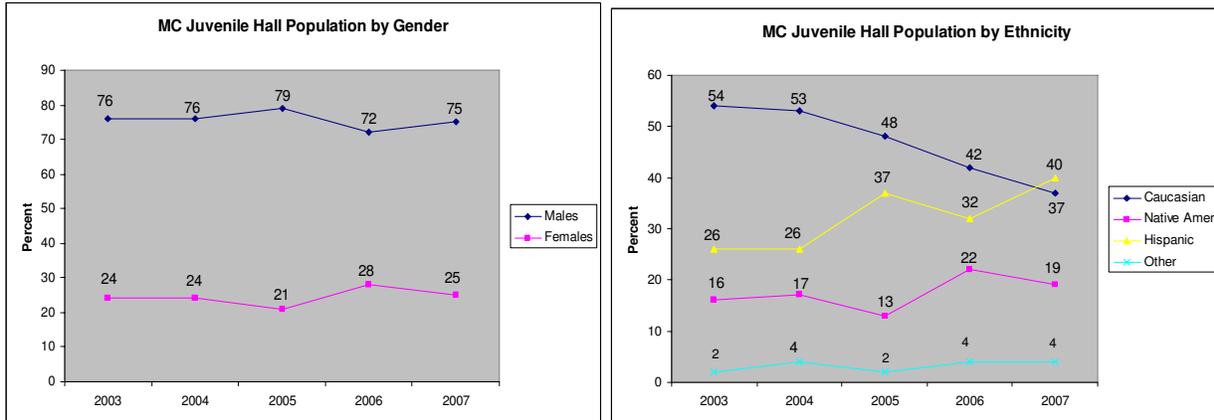
Juvenile Hall

Juveniles being booked into the juvenile hall often show signs of mental illness. Unfortunately this number has continued to grow over the past several years. To compound the problem, most juvenile halls are not staffed appropriately to deal with the

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rising number. Mendocino County Juvenile Hall is currently staffed with a mental health clinician for 20 hours each week.

The Average Daily Population of Juvenile Hall in 2007 varied between a low of 34 in January to a high of 40 in August and in 2008 varied between a low of 35 in August to a high of 41 in April. The following graphs show the breakdown by gender and ethnicity:



Source: Mendocino County Department of Probation, Juvenile Division

The Juvenile Hall population had the following characteristics:

- almost 3/4ths were males between 2003 and 2007
- Over 50% were White in 2003 and 2004 which decreased until 2007 when the 40% were Hispanic and 37% were White.
- In 2007, an average of 13 mental health cases were open. In 2008, the average had dropped to 8 open mental health cases.
- In 2007, an average of 2.5 minors were receiving psychotropic medications. In 2008, the average was 2 minors receiving psychotropic medications.
- A great number of the juvenile offenders referred to probation are at risk of entering foster care. On the average, 25 to 30 juvenile wards are in placement on any given month. Of those in placement, approximately 33% are in need of mental health services and 33% have a formal IEP (based on data collected in April 2009).

EXPOSURE TO TRAUMA

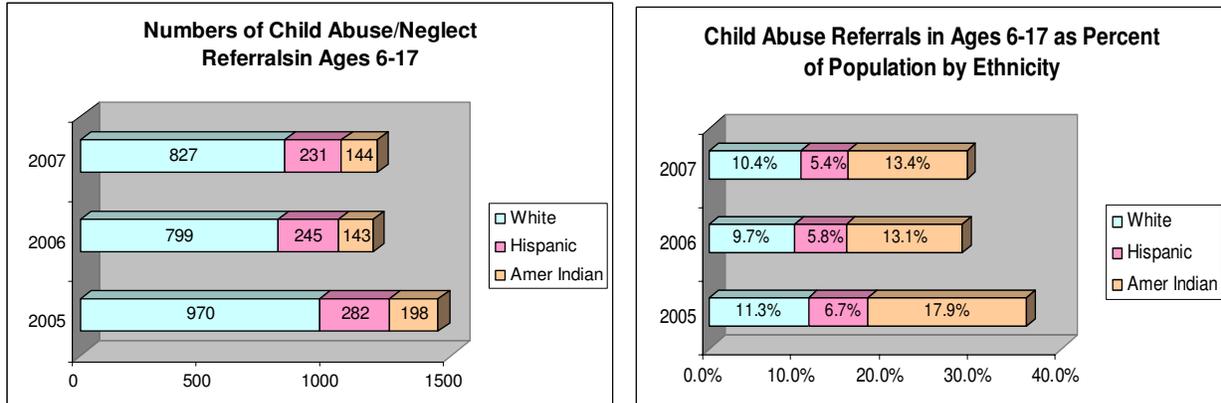
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Allegations of neglect or abuse that come to the attention of Child Protective Services are captured in the form of child abuse referrals. Child abuse typically takes place in the

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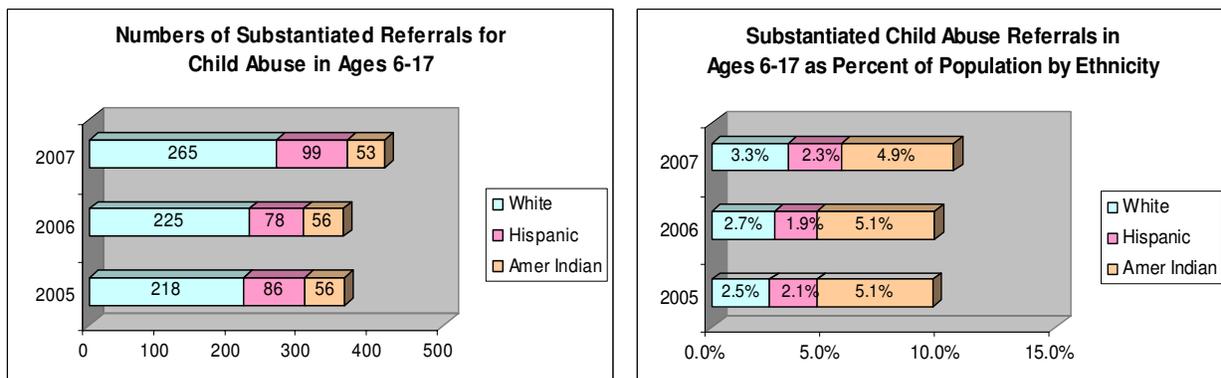
child's home and most often is committed by adults responsible for the care of the child. In 2007, a total of 1,269 children were reported to the Mendocino County Family and Children's Services Division for suspected child abuse or neglect, down 16% from 2005. Looking at these referrals by race/ethnicity for Ages 6-17 reveals the following:



Source: CWS/CMS Dynamic Report System, California Department of Social Services / University of California at Berkeley collaboration, http://cssr.berkeley.edu/ucb_childwelfare

- The largest number of children 6-17 is in the White population for all 3 years.
- The largest percent of the 6-17 population is in the Native American population.

Of these children reported for possible abuse or neglect in 2007, 422 (33%) were substantiated, which was 10% more than in 2005. The race/ethnicity breakdown pattern is similar to the graphs above.



Source: CWS/CMS Dynamic Report System, California Department of Social Services / University of California at Berkeley collaboration, http://cssr.berkeley.edu/ucb_childwelfare

To understand these statistics, it is helpful to remember that the American Indian population is early in the recovery process from post-colonial trauma. Maria Yellow Horse Brave Heart, Ph.D. explains, "Historical trauma is cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences." Poverty, chemical dependency, lack of treatment and other services and supports are also contributing factors. This information is an indication of the need for effective outreach and services designed to meet the particular needs of this group.

Domestic Violence

EXHIBIT B
Community Mental Health Assessment Data Report

Living with domestic violence can be extremely damaging for a child. Recent research has shown that witnessing domestic violence can affect brain and emotional development and have long-term impacts on children’s lives.

Families are referred to Family Mediation from Family Court when there are issues of custody and visitation of minor children in cases of dissolution, parentage (non-married parents), and requests for modifications of custody and visitation orders. Families are also referred to Family Mediation when one parent files for a domestic violence restraining order and there are minor children of the relationship.

The following table indicates the number of children youth between 6 and 18 who have been possible witnesses to domestic violence in their family and whose family was referred to Family Mediation from Family Court:

Number of Families	2007	2008
In Family Court referred to Family Mediation.	242	275
Referred to Family Mediation alleging that there had been domestic violence.	140	153
Referred to Family Mediation where at least one parent applied for a domestic violence restraining order	58	73
Referred to Family Mediation alleging that there had been domestic violence with children between ages 6-18.	56	55

Foster Care

Simply put, foster care is 24 hour, day-to-day care for children outside of their usual homes and families. There can be a variety of reasons for a child to live “out-of-home”, and a variety of placement settings.

The most common reasons for removal for Child Welfare-supervised foster children are severe and general neglect, physical abuse, and sexual abuse. In Mendocino County most foster children are placed in out-of-home care because of neglect. In the period of 1/1/07 through 12/31/07,

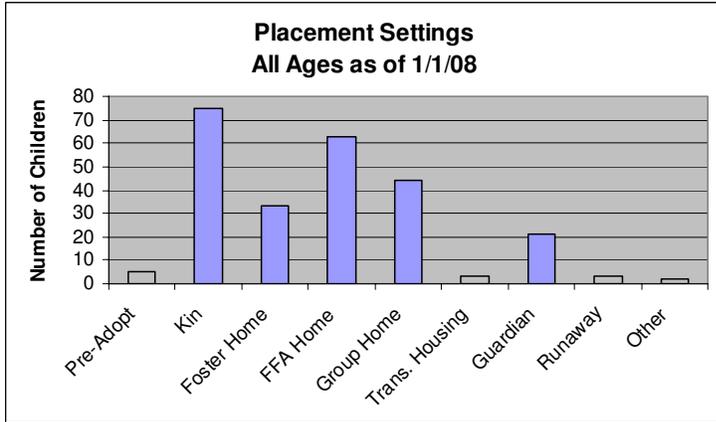
- 145 children entered Child Welfare Services-supervised foster care.
- 128 of them were removed from their homes because of neglect (88%),
- 92 of the 145 children who entered foster care during that time were between the ages of 6 and 17 (63%)
- 78 of these children were removed from their homes because of neglect (85%)

The major ethnic groups in Mendocino County are Whites, Hispanics and Native Americans. Of the children between the ages of 6 and 17 who were removed from their homes because of neglect, during the period of 1/1/07 and 12/31/07,

- 52 were White (57%),
- 8 were Hispanic (9%), and
- 14 were Native American (15%).

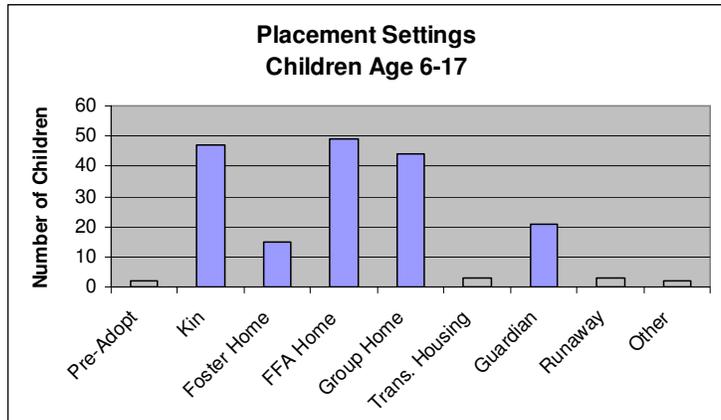
EXHIBIT B Community Mental Health Assessment Data Report

Children may be placed with relatives, non-related extended family members, or guardians. They may also be placed in county or state-licensed foster homes, in homes



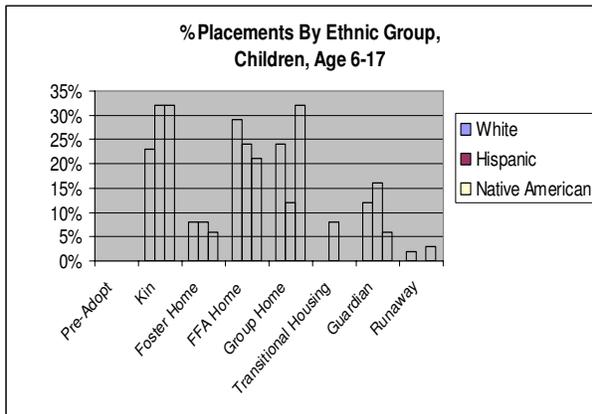
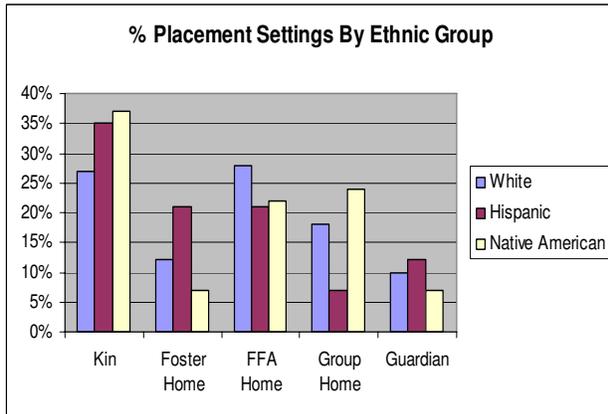
certified by foster family agencies (FFAs), in group homes or institutional care facilities. On January 1, 2008, the most common placement settings overall for Mendocino County Child-Welfare-supervised foster children, were homes of relatives (36%), homes certified by FFAs (27%), group homes (15%), and then county-licensed foster homes (13%).

The placement settings most commonly utilized in our county on that date varied, however, by age group. On January 1, 2008, most of the children between ages 6 and 17 were placed in FFA certified homes (26%), followed by relatives (25%), followed by group homes (24%).



On January 1, 2008, the percentage of all children in particular placement settings varied by ethnic group as well. Likewise, the percentage of children ages 6-17 in each placement setting is different from the numbers and percentages in each placement setting over all ages.

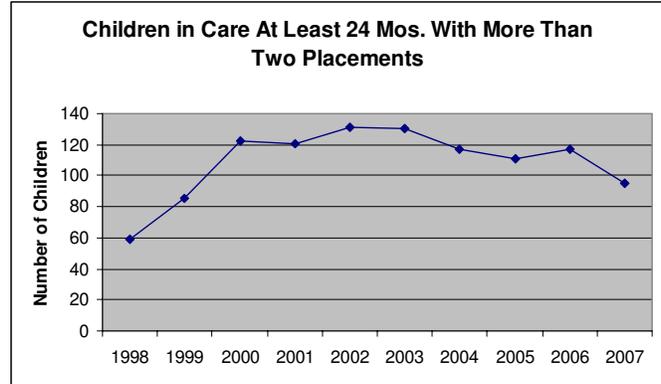
EXHIBIT B Community Mental Health Assessment Data Report



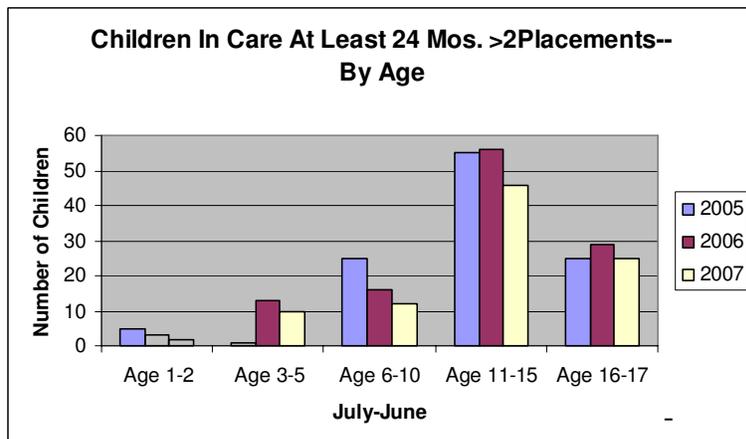
Placement Stability

Among the foster children who may be at risk of serious emotional or behavioral issues are those who have experienced multiple placements over several years in foster care. Because of the potentially damaging effects of multiple placements, the California Department of Social Services is currently requiring all counties to address placement stability, and is monitoring each county's progress in that regard. Counties are required to increase the number of children who experience two or fewer placements, and reduce the number who experience more than two.

In Mendocino County, during the time frame of January 1 through December 31 of each year from 1998 through 2007, the number of children who had been in foster care for at least 24 months and had experienced more than two placements varied as shown to the right.



From January 1 through December 31, 2007 the highest number of these children were



between the ages of 11 and 15 (46 children, 48%), followed by those between the ages of 16 and 17 (25 children, 26%). Altogether, children between the ages of 6 and 17 accounted for 87% of the foster children who had experienced more than two placements and had been in care for at least 24 months. A similar distribution

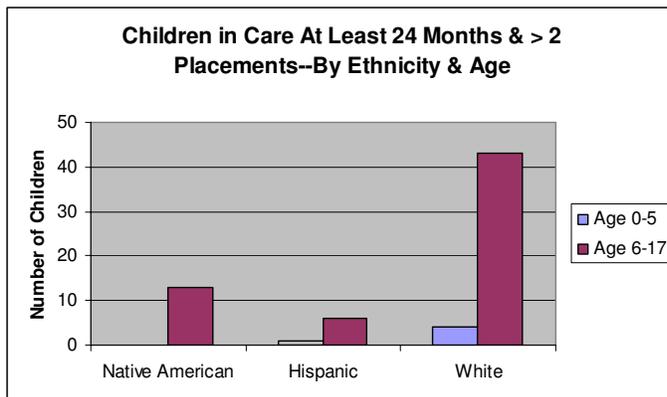
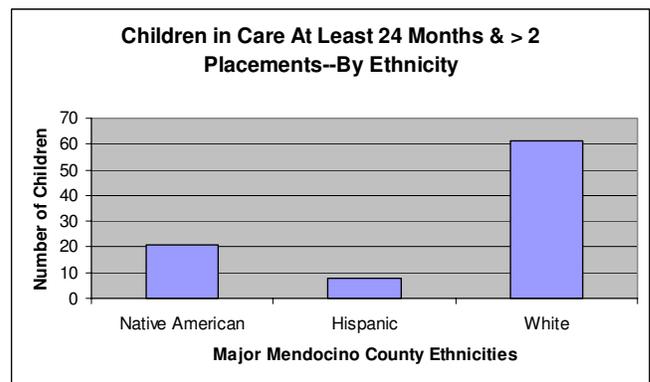
EXHIBIT B Community Mental Health Assessment Data Report

by age occurred in previous years as well. The number of these children between the ages of 6 and 17 were split almost evenly by gender (42 females and 41 males).

During this time, the per cent of children who had experienced more than two placements also varied by ethnic group:

- 53% of the Hispanic children in care for at least 24 months had more than two placements (8 children);
- 73% of the White children in care for at least 24 months had more than two placements (61 children); and
- 78% of the Native American children who had been in care for at least 24 months had more than two placements (21 children).

Looking at the numbers of children by race in the chart to the left, there are twice as many children of the White race than of the Native American and Hispanic races together who have had more than 2 placements.



As might be expected, many more children in the 6-17 age group had been in care for at least two years and had experienced more than two placements in each of these ethnicities.

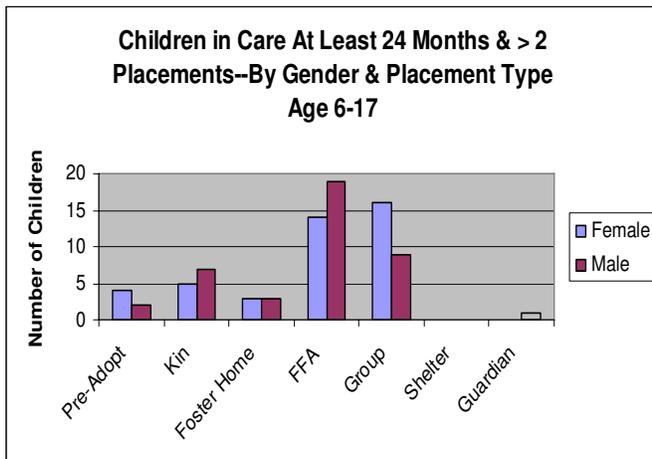
Children with the more difficult emotional and behavioral issues are generally placed in the most restrictive settings. In Child Welfare-supervised foster care, the most restrictive setting would be a group home. Homes certified by FFAs, including intensive treatment foster care homes, are considered to be more “restrictive” than County or State-licensed foster homes because of the additional treatment, monitoring, and other services they provide for children and their caretakers.

Overall, the largest percent of the long-term foster children with more than two placements from 1/1/07 through 12/31/07 resided in FFA homes (38%), followed by the percent placed in group homes (26%). 87% if children who had been in care for at least

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Community Mental Health Assessment Data Report

24 months and had experienced more than two placements, were between the ages of 6 and 17.

FFA & Group Home Placements for Children in Care at Least 24 Months with More Than 2 Placements					
Age	Total #	#in FFA Homes	%	# in Group Homes	%
All Ages	95	36	38%	25	26%
Age 6-17	83	33	40%	25	30%



Fourteen (14) of the 42 females in this age group were placed in FFA homes (33%), and 16 of the 42 females were placed in group homes (38%). However, nineteen (19) of the 41 males between the ages of 6 and 17 were placed in FFA homes (46%) and just nine were placed in group homes (22%) during this same period.

Since FFA homes (including Intensive Treatment Foster Care homes) and group homes are considered to be the most restrictive ongoing settings for Child Welfare-supervised foster children in Mendocino County, it is interesting to examine the distribution of children in the 6-17 age group in FFA homes and group homes by ethnicity.

For the most part, a higher % of the children who had been in care for two years or longer resided in FFA and group homes, the more restricted foster care settings, regardless of ethnicity

FAMILY STRESSORS

Many adults in our modern society have difficulty in providing for their families and live with intense stress like working 2 jobs to make ends meet, living in a single-parent household, living in poverty or going without enough food to eat. Stress can cause emotional problems that may lead to poor parenting skills that can have significant negative effects on developing children.

Poverty

Some of the ethnic disparity seen in the tables on foster care can be attributed as well to living below the federal poverty level and can prevent many families and individuals from accessing needed services and support.

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According to the U.S. Census Bureau, 2005-2007 American Community Survey, in Mendocino County,

- an estimated 20.5% of families with children 0-17 years of age live at the poverty level, or about 1 in 5 families with children live in poverty, and
- an estimated 18.5% of families with children 5-17 years of age live at the poverty level or almost 1 in 5 families.

According to the California Center for Rural Policy at Humboldt State University in their report "Rural Poverty and the Health Impacts: A Look at Poverty in the Redwood Coast Region",

- Poverty rates are higher in the Redwood Coast Region than in the U.S. and California particularly for children and families headed by single women with children and the American Indian and Hispanic populations.
- Physical and social isolation can also occur in rural areas making access to health care, social services, food and work more difficult.

Responses to the Rural Health Information Survey (RHIS), conducted in the fall of 2006 in Humboldt, Del Norte, Mendocino and Trinity counties by CCRP, revealed that

- Respondents living in poverty were 4.1 times more likely to report feeling sad or depressed most or all of the time compared to respondents living at or above 300% poverty. As the socioeconomic status of the respondent improves the likelihood of experiencing sadness or depression decreases.
- Almost 40% of respondents living in poverty reported that were unable to get needed health care (including mental health) in the year prior to the survey or 5.2 times higher than respondents living at or above 300%.

According to the California Department of Social Services, 12.6% of the Mendocino County population were recipients of public assistance programs in 2007.

Food Insecurity

According to the California Health Interview Survey (CHIS) 2007, in Mendocino County

- an estimated 38% of residents were unable to afford enough food, and
- 19% were currently receiving food stamps.

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Community Mental Health Assessment Data Report

Mendocino County
 MHSA Prevention and Early Intervention
 Community Mental Health Assessment, 2009

TRANSITION AGE YOUTH 18-25

POPULATION

The 2007 population of transition age youth ages 18-25 in Mendocino County is estimated to have increased by about 15% since 2003. The racial diversity has changed little in these 5 years with numbers of White and Hispanic transition age youth 18-25 accounting for almost 90% of all transition age youth 18-25.

Mendocino County Estimated Population for Ages 18-25 by Race/Ethnicity

	2003		2004		2005		2006		2007	
White, non-Hispanic	6326	64.1%	6697	64.5%	7074	65.2%	7349	66.0%	7497	66.3%
Hispanic	2406	24.4%	2475	23.8%	2514	23.2%	2517	22.6%	2504	22.1%
Native American	623	6.3%	671	6.5%	692	6.4%	704	6.3%	741	6.6%
Other Races (Asian,Black, Pac.Islander)	708	7.2%	756	7.3%	772	7.1%	779	7.0%	816	7.2%
Multiple Races	287	2.9%	308	3.0%	325	3.0%	328	2.9%	330	2.9%
TOTAL, ages 18-25	9866		10383		10843		11136		11310	

Source: California Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050

MENTAL HEALTH ISSUES

County Mental Health Services

Mendocino County Mental Health Department accepts clients needing mental health services who have Medi-Cal or Medicare through county staff and contracted services provided by local services providers and agencies. The following numbers are based on clients ages 18-25 served in a year through this countywide service provision.

Adults 18-25 served by Mendocino County Mental Health Department (MCDMH) in 2008

Race/Ethnicity, Ages 18-25	# CLIENTS ADMITTED AT MCDMH IN 2008	% OF CLIENTS ADMITTED AT MCDMH IN 2008
White/non-Hispanic	101	34%
Hispanic	16	5%
Native American	12	4%
Other Races (Asian,Black,Pac.Islander)	172	57%
Multirace		
TOTAL, Ages 18-24	301	

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Community Mental Health Assessment Data Report

Young adults ages 18-25 served by Mendocino County Department of Mental Health in 2008 by language spoken at home:

Language Spoken at Home, Ages 18-25	# CLIENTS SERVED AT MCDMH IN 2008	% OF TOTAL
English	267	89%
Spanish	4	1%
Other Language	30*	10%
TOTAL, Ages 18-25	301	

*Other (or unknown) language numbers are high due to lack of data collected on language spoken.

Young adults ages 18-25 served by Mendocino County Department of Mental Health in 2008 by Diagnosis at Admission:

Diagnoses, Ages 18-25	# DIAGNOSES AT MCDMH IN 2008	% OF TOTAL
Adjustment Disorders	31	21%
Attention Deficit Disorder	8	
Anxiety Disorders	10	
Bipolar Disorders	11	
Depression	29	19%
Dysthymic Disorder	12	
Mood Disorders (NOS)	12	
Oppositional Defiant Disorder	2	
Posttraumatic Stress Disorder	12	
Schizophrenia & related Disorders	12	
Other Psychotic disorders (NOS)	11	
TOTAL DIAGNOSES, ages 18-25	150	
Diagnosis Deferred or Left Blank	168	53%
TOTAL, Ages 18-25	318	

NOTE: CLIENTS MAY BE DUPLICATED AS THEY HAVE MORE THAN 1 DIAGNOSIS.

Indications of First Onset of Psychiatric Symptoms among Hospitalizations

In calendar year 2007, of 282 total acute psychiatric hospitalizations in Mendocino County, approximately 58 (Over 20%) were related to the symptoms of first onset, typically in a person aged 16 – 25. As of June 1, 2008, Mendocino County houses 15 individuals in Institutions. Of these, 5 (33%) are young adults whose first hospitalization last year was as a result of first onset. Research and Best Practice models agree that early intervention is of critical importance in mitigating the potential damaging impact of first onset.

EXHIBIT B
Community Mental Health Assessment Data Report

Health Clinics Mental Health Services

Consolidated Tribal Health Project (CTHP)

- 29 mental health clients ages 18-25 were seen in 2008; almost 75% were American Indian.
- 41% were diagnosed with adjustment disorders, 17% with anxiety or PTSD, 17% with bipolar disorders and 21% with depression.

Round Valley Tribal Health Project (RVTHP)

- 17 mental health clients ages 18-25 were seen in 2008; 82% were American Indian
- 76% were seen for alcohol abuse.

Alliance for Rural Community Health (ARCH) Health Centers

The Alliance for Rural Community Health (ARCH) is a organization whose mission is to support the network of six federally qualified community health centers throughout Mendocino County, including: Anderson Valley Health Center (AVHC), Long Valley Health Center (LVHC), Mendocino Coast Clinics (MCC), Mendocino Community Health Clinics (Ukiah and Willits) (MCHC), Potter Valley Community Health Center (PVCHC), and Redwood Coast Medical Services (Pt. Arena and Gualala) (RCMS). Four of the six health centers act as the sole provider of care for their respective communities: Anderson Valley, Long Valley (Laytonville), Potter Valley, and Gualala/Pt. Arena.

**Percent of Total & (Number) of Mental Health Clients
in 2007 with Diagnosed Condition**

CLINIC DIAGNOSTIC CATEGORY	Mendocino Community Health Clinics (3 sites)	Mendocino Coast Clinics	Redwood Coast Medical Services (2 sites)	Long Valley Health Clinic
Depression/Mood Disorders	47% (1219)	70% (597)	61% (119)	40% (52)
Anxiety Disorders and PTSD	43% (1116)	27% (231)	34% (65)	43% (46)
Attention Deficit/Disruptive Behavior Disorders	9% (242)	2% (20)	5% (10)	8% (8)
TOTAL # MH CLIENTS	2,577	848	194	106

- ARCH was unable to break down Mental Health clients by age group.
- While only four of the six health centers collected data on the specific mental health diagnoses described above, in 2008, AVHC and PVCHC provided a combined total of 521 mental health visits.

Suicide

EXHIBIT B Community Mental Health Assessment Data Report

Between 2002 and 2006 the California Department of Public Health, EPIC Branch reports that there were 10 suicide deaths and 46 hospitalized suicide attempts among transition age youth ages 18-25 in Mendocino County.

In 2007 and 2008 combined, Ukiah Valley Medical Center Emergency Room reported that there were 46 attempted suicide injuries in ages 18-25 seen in the ER. About 6% of these were admitted to the hospital. Mendocino Coast District Hospital reported 19 attempted suicides seen in the ER and Howard Memorial Hospital reported 12 attempted suicides seen in the ER in ages 18-25 for these 2 years.

SUBSTANCE ABUSE ISSUES

Dual Diagnosis/Methamphetamine Use

County Alcohol and Other Drug Programs reports that the following numbers of clients ages 18-25 were treated for alcohol and other drug use in 2008 in Ukiah, Willits or Ft. Bragg:

- 120 total admissions (non-duplicated)
- 26 self reported a mental illness diagnosis as well
- 27 had methamphetamine as a primary drug of choice, 11 as a secondary drug of choice
- 15 had a self-reported mental illness diagnosis plus methamphetamine as drug of choice

Binge Drinking

A survey was conducted in a variety of classrooms at Mendocino College in Fall, 2004 and was completed during class. It was not administered in any ESL classes, and there was no Spanish version. It gives an indication on how common “binge drinking” – drinking 5 or more drinks at one time – is among college students in Ukiah:

- 610 students responded.
- Of the 610 respondents, 403 (66%) were under 26.
- Of those under 26, 234 (58%) are male; 167 (41%) are female, and 2 (<1%) are “other.”
- Of those 403 in the under 26 age group, 133 (33%) were “binge drinkers”
- Of the binge drinkers, 70 (53%) are male; 63 (47%) are female.

TRANSITION FROM FOSTER CARE

A portion of children who have been in foster care, especially those who are still in foster care when they turn

Ext

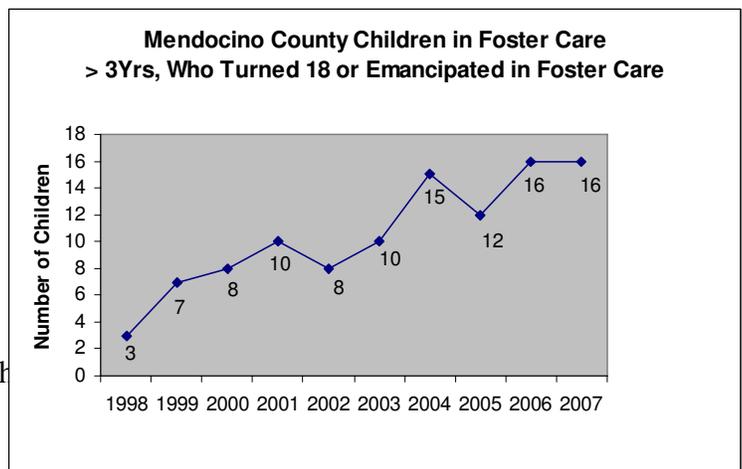
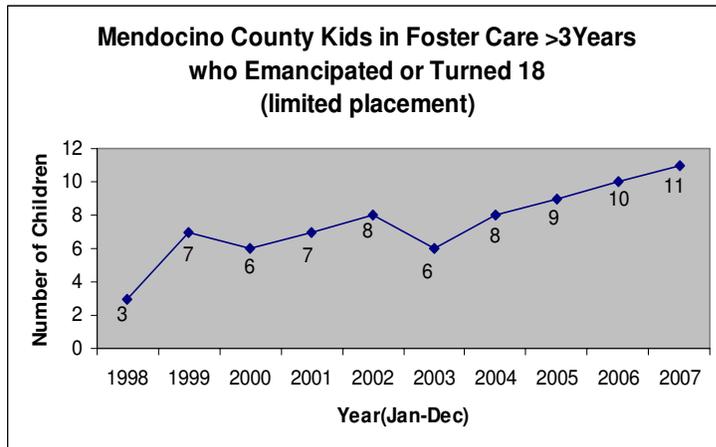


EXHIBIT B Community Mental Health Assessment Data Report

18 or emancipate, have been exposed to trauma and are experiencing emotional or behavioral difficulties as a result. This table shows the number of Mendocino County Child Welfare-supervised children who were in foster care for three years or longer when they turned 18 or emancipated, between January and December of each year from 1998 through 2007. It is interesting to note that in this period, the numbers have trended upward, though they are fairly small numbers. This chart includes children who were placed with relatives, non-related extended family members and guardians.



This chart shows the same information but leaves out the children placed with relatives, non-related extended family members and guardians. Instead, these are the foster children who were placed in County or State-licensed foster homes, FFA homes, Group homes and shelters. It is thought that these children are the most likely to have had exposure to trauma and be experiencing emotional and behavioral difficulties as a result.

FAMILY STRESSORS

Poverty

See section on Ages 0-5.

Homelessness

A comparison of the 2005 and 2007 Mendocino County Homeless Census and Survey, which counted persons on the streets and in emergency shelters, transitional housing, permanent supportive housing, domestic violence shelters, voucher motels, hospitals, jails and rehabilitation facilities, showed estimates of

- 1,947 homeless people in 2005 compared to 1,422 in 2007
- 100 were between 18 and 30 years of age in 2005 compared to 92 in 2007. Few children or older adults (over 60) were found in this homeless census.
- 69% were White, 10% were Native American, 10% were Hispanic

According to the Census Bureau, in 2007, the breakdown of races was as follows: White – 70.8%, Hispanic – 19.8% and Native American – 5.8%. Comparing these estimates with those of the Homeless Census, the Native American race showed a larger percent of homeless people than the population as a whole in 2005 and 2007.

EXHIBIT B
Community Mental Health Assessment Data Report

INVOLVEMENT WITH CRIMINAL JUSTICE

Young Adult Arrests

Arrests for Adults ages 18-24						
	2003	2004	2005	2006	2007	2003 to 2007 % Change
TOTAL	1411	1394	1542	1496	1346	-4.6%
Felony (F) Total	467	529	495	491	381	-18.4%
% of Total	33.1%	37.9%	32.1%	33.2%	28.3%	
Misdemeanor (M) Total	944	865	1047	1005	965	2.2%
% of Total	18.5%	19.0%	13.5%	10.1%	13.5%	
Dangerous Drugs (F) – not marijuana	79	94	94	74	68	-13.9%
% of Felony Total	16.9%	17.8%	19.0%	15.1%	17.8%	
Other Drugs (M) – not marijuana	169	125	225	153	185	9.5%
% of Misdemeanor Total	15.4%	17.0%	15.0%	15.7%	13.5%	

A certain number of people arrested for felonies or misdemeanors who are also dealing with mental health issues. They can be sent to the County jail where the mental health issue must be dealt with by County Mental Health staff.

According to Mendocino County Jail statistics for 3 years, between one-fifth and one-fourth of the inmates in any month are receiving psychiatric medication.

VETERANS MENTAL HEALTH ISSUES

Nationally, a study was published in March, 2007 indicating that of approximately 103,000 veterans surveyed, over half had a mental health disorder. Of those, 31% had post traumatic stress disorder which can lead to depression. Additionally, other diagnoses included anxiety disorder (24 percent), adjustment disorder (24 percent), depression (20 percent) and substance abuse disorder (20 percent).

Source: <http://www.cnn.com/2007/US/03/13/stress.troops/>

Locally, data reported from the Veterans Affairs Clinic in Ukiah showed that for Mendocino and Lake Counties 711 unique veterans were seen by mental health providers in 2008. Of those, 51 were veterans returning recently from combat and in the 18-30 age group.

EXHIBIT B

Community Mental Health Assessment Data Report

Mendocino County
 MHA Prevention and Early Intervention
 Community Mental Health Assessment, 2009

ADULTS AGES 26-59

POPULATION

The 2007 population of adults ages 26-59 in Mendocino County is estimated to have decreased by about 3% since 2003. The racial diversity has changed little in these 5 years with numbers of White and Hispanic adults ages 26-59 accounting for about 80% of all adults ages 26-59.

Mendocino County Estimated Population for Ages 26-59 by Race/Ethnicity

	2003		2004		2005		2006		2007	
White, non-Hispanic	31291	75.6%	30830	74.7%	30290	74.0%	29772	73.2%	29037	72.1%
Hispanic	6536	15.8%	6789	16.4%	6993	17.1%	7238	17.8%	7514	18.6%
Native American	2034	4.9%	2177	5.3%	2206	5.4%	2244	5.5%	2340	5.8%
Other Races (Asian, Black, Pac. Islander)	2342	5.7%	2492	6.0%	2526	6.2%	2571	6.3%	2665	6.6%
Multiple Races	660	1.6%	613	1.5%	564	1.4%	516	1.3%	524	1.3%
TOTAL, ages 26-59	41396		41288		40929		40645		40296	

Source: California Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050

LANGUAGE SPOKEN AT HOME

Language barriers between clients and providers can prevent access to critical services such as employment, transportation, medical and social services. Examining the language spoken at home by the county population helps providers of mental health services to offer language-appropriate services to the community.

According to the U.S. Census Bureau, American FactFinder, among the almost 16,000 people in Mendocino County who speak a language other than English at home, 64.8% are adults 18-64 years of age.

MENTAL HEALTH ISSUES

County Mental Health Services

Mendocino County Mental Health Department accepts clients needing mental health services who have Medi-Cal or Medicare through county staff and contracted services provided by local services providers and agencies. The following numbers are based on clients ages 26-59 served in a year through this countywide service.

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Community Mental Health Assessment Data Report

Adults ages 25-59 served by Mendocino County Mental Health Department in 2008

Race/Ethnicity, Ages 25-64	# CLIENTS ADMITTED AT MCDMH IN 2008	% OF CLIENTS ADMITTED AT MCDMH IN 2008
White/non-Hispanic	607	48%
Hispanic	39	3%
Native American	51	4%
Other Races (Asian,Black,Pac.Islander)	36	3%
Unknown	531*	42%*
TOTAL, Ages 25-64	1,264	

*Unknown race numbers are high due to lack of data collected on race/ethnicity.

Adults ages 25-59 served by Mendocino County Department of Mental Health in 2008 by language spoken at home:

Language Spoken at Home, Ages 26-59	# CLIENTS SERVED AT MCDMH IN 2008	% OF TOTAL
English	1144	91%
Spanish	23	2%
Other Language	97*	8%
TOTAL, Ages 26-59	1264	

*Other (or unknown) language numbers are high due to lack of data collected on language spoken.

Adults ages 25-59 served by Mendocino County Department of Mental Health in 2008 by Diagnosis at Admission:

Diagnoses, Ages 26-59	# DIAGNOSES AT MCDMH IN 2008	% OF TOTAL
Adjustment Disorders	52	
Anxiety Disorders	40	
Bipolar Disorders	180	18%
Depression	245	24%
Mood Disorders (NOS)	62	
Posttraumatic Stress Disorder	50	
Schizophrenia & related Disorders	303	30%
Other Psychotic disorders (NOS)	24	
TOTAL DIAGNOSES, ages 26-59	1005	
Diagnosis Deferred or Left Blank	259	26%
TOTAL, Ages 26-59	1264	

NOTE: CLIENTS MAY BE DUPLICATED AS THEY HAVE MORE THAN 1 DIAGNOSIS.

EXHIBIT B
Community Mental Health Assessment Data Report

Health Clinics Mental Health Services

Consolidated Tribal Health Project (CTHP)

- 149 mental health clients ages 26-59 were seen in 2008; almost 90% of these were American Indian.
- 42% were diagnosed with anxiety or PTSD, 19% with adjustment disorders and 18% with depression or mood disorders.

Round Valley Tribal Health Project (RVTHP)

- 54 mental health clients ages 26-59 were seen in 2008; 69% were American Indian
- 31% were diagnosed with adjustment disorders and 91% were seen for alcohol abuse.

Alliance for Rural Community Health (ARCH) Health Centers

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**Percent of Total & (Number) of Mental Health Clients
in 2007 with Diagnosed Condition**

CLINIC DIAGNOSTIC CATEGORY	Mendocino Community Health Clinics (3 sites)	Mendocino Coast Clinics	Redwood Coast Medical Services (2 sites)	Long Valley Health Clinic
Depression/Mood Disorders	47% (1219)	70% (597)	61% (119)	40% (52)
Anxiety Disorders and PTSD	43% (1116)	27% (231)	34% (65)	43% (46)
Attention Deficit/ Disruptive Behavior Disorders	9% (242)	2% (20)	5% (10)	8% (8)
TOTAL # MH CLIENTS	2,577	848	194	106

- ARCH was unable to break down Mental Health clients by age group.
- While only four of the six health centers collected data on the specific mental health diagnoses described above, in 2008, AVHC and PVCHC provided a combined total of 521 mental health visits.

Suicide

EXHIBIT B

Community Mental Health Assessment Data Report

Between 2002 and 2006 the California Department of Public Health, EPIC Branch reports that there were 52 suicide deaths and 181 hospitalized suicide attempts among adults ages 26-59 in Mendocino.

In 2007 and 2008 combined, Ukiah Valley Medical Center Emergency Room reported that there were 82 attempted suicide injuries in ages 26-59 seen in the ER. About 6% of these were admitted to the hospital. Mendocino Coast District Hospital reported 54 attempted suicides seen in the ER and Howard Memorial Hospital reported 35 attempted suicides seen in the ER in ages 26-59 for these 2 years.

SUBSTANCE ABUSE ISSUES/DUAL DIAGNOSIS

County Alcohol and Other Drug Programs reports that the following numbers of clients ages 26-59 were treated for alcohol and other drug use in 2008 in Ukiah, Willits or Ft. Bragg:

- 402 total admissions (non-duplicated)
- 147 self reported a mental illness diagnosis as well (36.6%)
- 212 had methamphetamine as a primary drug of choice (52.7%), 50 as a secondary drug of choice (12.4%)
- 93 had a self-reported mental illness diagnosis plus methamphetamine as drug of choice (23%).

INCARCERATION

Mental illness is a significant problem within U.S. jails and prisons. In 2004, according to a report from the Bureau of Justice Statistics, U.S. Department of Justice, half of all prisoners have mental illness, defined by a history of mental illness, symptoms of mental illness, or both history and symptoms. Prisoners are also three to five times more likely than the general public to be schizophrenic and one and a half to three times more like to bipolar or diagnosed with major depression. In California, it is estimated that 1 in 10 inmates receives some kind of psychotropic medication, while 1 in 8 receives mental health counseling (Ditton, 1999)

In Mendocino County, a certain number of people arrested for felonies or misdemeanors are also dealing with mental health issues. They can be sent to the County jail where the mental health issue must be dealt with by County Mental Health staff. According to Mendocino County Jail statistics for 3 years, between one-fifth and one-fourth of the inmates in any month are receiving psychiatric medication.

FAMILY STRESSORS

Poverty

See section on Ages 0-5.

Homelessness

EXHIBIT B

Community Mental Health Assessment Data Report

National estimates of psychiatric disorders among homeless people average 50%.¹ The 2005 and 2007 Mendocino County Homeless Census and Survey Interviewed with 334 homeless individuals in 2005 and 405 in 2007 and found that

- 58% experienced depression in 2005, 48% in 2007
- 43% experienced some form of mental illness in 2005, 35% in 2007
- 22% of the respondents reported drug addictions in 2005, 29% in 2007
- 20% reported alcoholism in 2005, 35% in 2007
- In 2007, 52% had ever received services for these conditions.

Demographics of the homeless population show a number of ethnic disparities:

- Hispanics under-represented (6% compared with 18% in the adult population), and Native Americans over-represented (12% compared with 4% in the general population),
- African Americans somewhat over-represented (5% compared with <1% in the general population).
- 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.

A comparison of the 2005 and 2007 Mendocino County Homeless Census and Survey, which counted persons on the streets and in emergency shelters, transitional housing, permanent supportive housing, domestic violence shelters, voucher motels, hospitals, jails and rehabilitation facilities, showed estimates of

- 1,947 homeless people in 2005 compared to 1,422 in 2007
- 211 were between 31 and 70 years of age in 2005 compared to 296 in 2007
- 69% were White, 10% were Native American, 10% were Hispanic

According to the Census Bureau, in 2007, the breakdown of races was as follows: White – 70.8%, Hispanic – 19.8% and Native American – 5.8%. Comparing these estimates with those of the Homeless Census, the Native American race showed a larger percent of homeless people than the population as a whole in 2005 and 2007.

Not many Children or Older Adults (over 60) were found in the Mendocino County homeless census.

Food Insecurity

Data from the 2005 California Health Interview Survey show the following food insecurity (not able to afford enough food) levels:

- an estimate of 18% of Mendocino County residents are food insecure
- an estimate of 10% of Mendocino County residents currently receive food stamps

¹ Fischer PJ, Breakey WR (1991). The Epidemiology of alcohol, drug, and mental disorders among homeless persons. American Psychologist: 46:1115-1125.

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Community Mental Health Assessment Data Report

VETERANS MENTAL HEALTH ISSUES

Nationally, a study was published in March, 2007 indicating that of approximately 103,000 veterans surveyed, over half had a mental health disorder. Of those, 31% had post traumatic stress disorder which can lead to depression. Additionally, other diagnoses included anxiety disorder (24 percent), adjustment disorder (24 percent), depression (20 percent) and substance abuse disorder (20 percent).

Source: <http://www.cnn.com/2007/US/03/13/stress.troops/>

Locally, data reported from the Veterans Affairs Clinic in Ukiah showed that for Mendocino and Lake Counties 711 veterans were seen by mental health providers in 2008. Of those, 51 were veterans returning recently from combat and in the 18-26 age group. It is not known how many of the remaining 660 veterans were in the 26-59 age group.

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Mendocino County
MHSa Prevention and Early Intervention
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SENIORS AGES 60 AND OLDER

POPULATION

The 2007 population of seniors ages 60+ in Mendocino County is estimated to have increased by 14% since 2003. The racial diversity has changed little in these 5 years with numbers of White and Hispanic seniors accounting for about 90% of all seniors.

Mendocino County Estimated Population for Ages 60+ by Race/Ethnicity

	2003		2004		2005		2006		2007	
White	14825	89.5%	15122	89.0%	15494	88.5%	15909	88.1%	16600	87.7%
Hispanic	711	4.3%	769	4.5%	836	4.8%	894	5.0%	984	5.2%
Native American	538	3.2%	577	3.4%	608	3.5%	649	3.6%	695	3.7%
Other Races (Asian, Black, Pac. Islander)	621	3.7%	663	3.9%	701	4.0%	747	4.1%	804	4.2%
Multiple Races	237	1.4%	260	1.5%	278	1.6%	293	1.6%	320	1.7%
TOTAL, ages 60+	16570		16999		17507		18060		18934	

Source: California Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050

This increase in population is particularly significant for older adults. Between 2000 and 2010, the older adult population will have increased over 30%, presenting increased need for services to this age group.

Population Projections for Mendocino County From 2000 through 2030

	2000	2010	2020	2030
Total Population	86,736	93,166	102,017	111,151
Population 60+	15,585	21,293	27,176	29,204
% of Total Population	17.9%	22.8%	26.6%	26.3%
Population 85+	1,497	2,000	2,351	3,547
% of Total Population	1.7%	2.1%	2.3%	3.2%

LANGUAGE SPOKEN AT HOME

Language barriers between clients and providers can prevent access to critical services such as employment, transportation, medical and social services. Examining the language spoken at home by the county population helps providers of mental health services to offer language-appropriate services to the community.

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According to the U.S. Census Bureau, American FactFinder, among the almost 16,000 people in Mendocino County who speak a language other than English at home, 6.8% are seniors age 64 and over. The Hispanic population is the fastest growing ethnic minority in Mendocino Counties. Translating written materials into Spanish is essential for assistance with access to services. Additionally, recruiting bi-lingual staff whenever possible will assist in serving this population.

MENTAL HEALTH ISSUES

The national prevalence rate for mental illness is 5.8% with the local rate reflected in the above numbers (330 of 4,900) being 6.7%. The types of mental health diagnoses seen through the Older Adult System of Care include depression, anxiety, dementia, delusional disorders and adjustment disorders related to aging and loss of independence.

County Mental Health Services

Mendocino County Mental Health Department accepts clients needing mental health services who have Medi-Cal or Medicare through county staff and contracted services provided by local services providers and agencies. The following numbers are based on clients ages 60+ served in a year through this countywide service provision.

Adults ages 60+ served by Mendocino County Mental Health Department in 2008

Race/Ethnicity, Ages 65+	# CLIENTS ADMITTED AT MCDMH IN 2008	% OF CLIENTS ADMITTED AT MCDMH IN 2008
White/non-Hispanic	102	55%
Hispanic	5	3%
Native American	5	3%
Other Races (Asian, Black, Pac. Islander)	2	1%
Multirace		
Unknown	73*	39%*
TOTAL, Ages 60+	187	

*Unknown race numbers are high due to lack of data collected on race/ethnicity.

Adults ages 60+ served by Mendocino County Department of Mental Health in 2008 by language spoken at home:

Language Spoken at Home, Ages 60+	# CLIENTS SERVED AT MCDMH IN 2008	% OF TOTAL
English	173	93%
Spanish	4	2%
Other Language	10*	5%
TOTAL, Ages 60+	187	

*Other (or unknown) language numbers are high due to lack of data collected on language spoken.

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Community Mental Health Assessment Data Report

Adults ages 60+ served by Mendocino County Department of Mental Health in 2008 by Diagnosis at Admission:

Diagnoses, Ages 60+	# DIAGNOSES AT MCDMH IN 2008	% OF TOTAL
Adjustment Disorders	5	
Anxiety Disorders	8	
Bipolar Disorders	41	23%
Depression	63	35%
Mood Disorders (NOS)	2	
Posttraumatic Stress Disorder	4	
Schizophrenia & related Disorders	44	25%
Other Psychotic disorders (NOS)	3	
TOTAL DIAGNOSES, Ages 60+	178	
Diagnosis Deferred or Left Blank	9	5%
TOTAL, Ages 60+	187	

NOTE: CLIENTS MAY BE DUPLICATED AS THEY HAVE MORE THAN 1 DIAGNOSIS.

Health Clinics Mental Health Services

Consolidated Tribal Health Project (CTHP)

- 18 mental health clients ages 60+ were seen in 2008; over 90% were American Indian.
- One-third were diagnosed with adjustment disorders, one-third with depression and one-third with anxiety, PTSD and other psychoses.

Round Valley Tribal Health Project (RVTHP)

- 1 mental health clients ages 60+ was seen in 2008 who was American Indian for alcohol abuse.

Alliance for Rural Community Health (ARCH) Health Centers

The Alliance for Rural Community Health (ARCH) is a organization whose mission is to support the network of six federally qualified community health centers throughout Mendocino County, including: Anderson Valley Health Center (AVHC), Long Valley Health Center (LVHC), Mendocino Coast Clinics (MCC), Mendocino Community Health Clinics (Ukiah and Willits) (MCHC), Potter Valley Community Health Center (PVCHC), and Redwood Coast Medical Services (Pt. Arena and Gualala) (RCMS). Four of the six health centers act as the sole provider of care for their respective communities: Anderson Valley, Long Valley (Laytonville), Potter Valley, and Gualala/Pt. Arena.

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Community Mental Health Assessment Data Report

**Percent of Total & (Number) of Mental Health Clients
in 2007 with Diagnosed Condition**

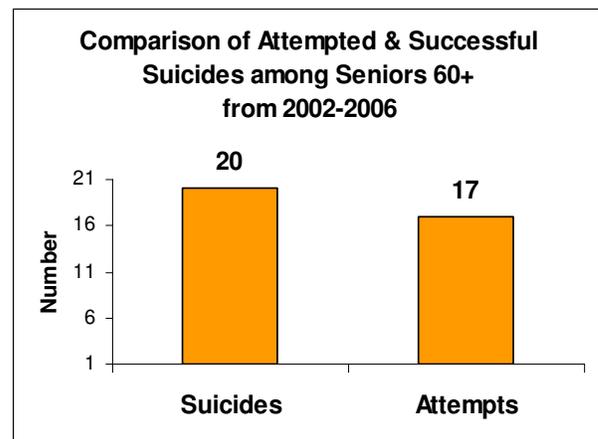
CLINIC DIAGNOSTIC CATEGORY	Mendocino Community Health Clinics (3 sites)	Mendocino Coast Clinics	Redwood Coast Medical Services (2 sites)	Long Valley Health Clinic
Depression/Mood Disorders	47% (1219)	70% (597)	61% (119)	40% (52)
Anxiety Disorders and PTSD	43% (1116)	27% (231)	34% (65)	43% (46)
Attention Deficit/ Disruptive Behavior Disorders	9% (242)	2% (20)	5% (10)	8% (8)
TOTAL # MH CLIENTS	2,577	848	194	106

- ARCH was unable to break down Mental Health clients by age group.
- While only four of the six health centers collected data on the specific mental health diagnoses described above, in 2008, AVHC and PVCHC provided a combined total of 521 mental health visits.

Suicide

The number of suicide deaths in the younger age groups is considerably less than the number of suicide attempts. However, in the 60+ age group this difference becomes very small. This suggests that seniors are more serious about suicide and have the resources to succeed in an attempt at suicide.

In 2007 and 2008 combined, Ukiah Valley Medical Center Emergency Room reported that there were 10 attempted suicide injuries in ages 60+ seen in the ER. About 6% of these were admitted to the hospital. Mendocino Coast District Hospital reported 4 attempted suicides seen in the ER and Howard Memorial Hospital reported 4 attempted suicides seen in the ER in ages 60+ for these 2 years.



Suicides among seniors are often not reported as such due to a variety of factors including the associated stigma for the family, insurance claiming and dignity for the elder. In 2008 OASOC staff were aware of at least 2 deaths attributed to suicide that were not reported.

SUBSTANCE ABUSE ISSUES

Approximately 10% of all of the OASOC clients receiving case management, psychotherapy and/or Senior Peer Counseling present with some varying degree of substance abuse or medication misuse. The average age of an OASOC client is 75 years old. The identified 10% of our clients present with very long histories of substance abuse and/or medication misuse.

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There are many barriers to providing adequate and beneficial substance abuse treatment in a rural setting. 1) In-patient detox is limited to 3 days and then the client is discharged back to their home and told to attend AA meetings; 2) There are no senior focused recovery groups in our county and clients complain that they cannot relate to the 20 year olds at the meetings; 3) The stigma surrounding seniors with substance abuse problems is huge and our clients feel very embarrassed and shamed at their addictions; 4) Not all physician's are aware of the client's addiction and continue to prescribe dangerous and addicting medication without any awareness of the clients issues.

MENTAL DISABILITY/INABILITY TO MANAGE INDEPENDENCE/ISOLATION

The provision of the County Older Adult System of Care (OASOC) services is essential to the prevention and/or delay of placement in long term care. Assessment and outreach services are key to identifying clients in need of in home mental health case management. Loneliness and Isolation contribute to individual mental health and were listed among the top ten issues identified by older adults in the 2007 Area Agency on Aging survey of older adults.

Assessment, counseling, case management and peer counseling services provided through OASOC are an integral part of helping older adults maintain their independence and avoid placement in long term care. The table below shows the ethnic and gender distribution of older adults in nursing homes in Mendocino County.

Older Adults in Nursing Homes

	AFRICAN AMERICAN		NATIVE AMERICAN		ASIAN		HISPANIC		WHITE/NON-HISPANIC	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Number	0	1	4	2	1	0	3	2	67	142
Percent of total nursing home population	0%	<1%	2%	1%	<1%	0%	1.5%	1%	30%	64%

The majority of clients who receive services from the Older Adult System of Care have been referred by APS, IHSS, Physicians, Senior Centers and community agencies. 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. However, in a rural setting such as Mendocino County, geographic isolation, regardless of ethnicity is a barrier to services.

The Mendocino County HHS, Adult and Aging Services Division (AASD), reports that OASOC has been serving approximately 120 seniors each month and that 90% of these individuals have a mental health diagnosis. Among clients served by the In-Home Support Services (IHSS) program also administered at AASD and serving seniors and people with disabilities in their homes, 81.4% are White, 6.6% are Hispanic, 1.1% are African-American, 1.4% are Asian or Pacific Islander and 9.5% are Native American.²

² HHS Adult and Aging Services Division program data are used here to report ethnicity of older adults in the County because they are considered more accurate than census data, 2007.

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Community Mental Health Assessment Data Report

Functional impairments including sensory, physical, mental and self care affect 41% of the elderly population (over 65 years of age) nationally.³ In Mendocino County this translates into as many as 4,900 or 39.2% of the county's 12,000 older adults (over 65 years of age) having a disability that affects their quality of life according to the latest California Department of Finance figures.

ELDER ABUSE

During fiscal year 2007-08, 676 reports were received by Adult Protective Services (APS) for suspected abuse and neglect of dependent and older adults.

Of those reports,

- 95 (14%) cases involved older adults,
- 330 (49%) of the adult cases were specifically for self-neglect.

Often, self-neglect cases are associated with untreated mental illness. The number of older adult cases referred to APS is used as a measure for how many potential clients may need services from the Older Adult System of Care indicating there is a significant potential for growth in the program.

FAMILY STRESSORS

According to the Center for Community Economic Development, half a million older Californians living alone are unable to make ends meet. Median household income in 2007 was \$42,329 in Mendocino County. Median household income declines with age as people turn to retirement income. 15.4% in Mendocino County fall below the federal poverty level – both higher than the state poverty level of 12.4%.

The Elder Economic Security Standard Index or Elder Index was created by this group to quantify the actual costs of meeting basic needs. Using the Elder Index, an older adult homeowner without a mortgage must have an income of \$16,766 to afford living in Mendocino County. Yet the average Social Security Income is just over \$12,000. The median retirement income is \$17,268 for women and \$27,575 for men in Mendocino County. The individuals falling within the gap between eligibility for public assistance programs and these income figures are of greatest concern to the service providers for older adults. These individuals make too much money to qualify for low income programs such as In Home Supportive Services, but not enough to afford needed services.

VETERANS MENTAL HEALTH ISSUES

Nationally, a study was published in March, 2007 indicating that of approximately 103,000 veterans surveyed, over half had a mental health disorder. Of those, 31% had post traumatic stress disorder which can lead to depression. Additionally, other

³ Area Agency on Aging, 2009.

EXHIBIT B

Community Mental Health Assessment Data Report

diagnoses included anxiety disorder (24 percent), adjustment disorder (24 percent), depression (20 percent) and substance abuse disorder (20 percent).

Source: <http://www.cnn.com/2007/US/03/13/stress.troops/>

Although the study was not specific to older adults, it did include Vietnam Veterans, many of whom are now over 60 years of age.

Locally, data reported from the Veterans Affairs Clinic in Ukiah showed that for Mendocino and Lake Counties 711 veterans were seen by mental health providers in 2008. Of those, 51 were veterans returning recently from combat and in the 18-26 age group. It is not known how many of the remaining 660 veterans were in the 60+ age group.

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Community Mental Health Assessment Data Report

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Community Mental Health Assessment, 2009

APPENDIX

Data were collected for this report from a variety of sources including the U.S. Census Bureau, federal, state and local government agencies, hospitals, health clinics, and other sources directly from individuals and over the internet. Many of these sources are listed in this appendix.

American Community Survey, United States Census Bureau. The American Community Survey is conducted every year by the United States Census Bureau in every county, American Indian and Alaska Native Area, and Hawaiian Home Land. It was started in 1996 and only recently (2005) became available for use in Shasta County. It does not replace the decennial census but provides an estimate of various characteristics in our county on a more frequent schedule. www.census.gov/acs

California Department of Education. The California Department of Education's website has an easy to use query tab called Data Quest where county-specific data can be obtained on a variety of school topics. www.cde.ca.gov/ds/

California Department of Justice. This information was extracted from the Criminal Justice Statistics Center within the California Department of Justice. An additional resource was linked from this website and includes information from the Department of Corrections (incarceration data). <http://ag.ca.gov/cjsc/>

California Department of Social Services. This is the data source for both elder and child abuse and neglect. Information is gathered by county social services departments and aggregated and published by the state. www.dss.cahwnet.gov

California Health Interview Survey (CHIS). A random digit dial telephone survey conducted throughout the state with adults, adolescents, and the parents or guardians of children, and broken down by county of residence. This is a source of information on health behavior and health conditions. www.chis.ucla.gov/

California Healthy Kids Survey (CHKS). This is a written survey conducted in schools throughout the state with 5th, 7th, 9th, and 11th graders. This survey is now tied to funding for the schools, so most of the schools in the county participate, resulting in a county-level report of the results.

California Office of Statewide Planning and Development (OSHPD). Patient Discharge Data: When patients are discharged from the hospital, a discharge record is complete and sent to the California OSHPD Department. This data is available to the community via an application process and includes information about the diagnoses that

EXHIBIT B
Community Mental Health Assessment Data Report

caused the hospitalization. This data is for all Mendocino County residents who were discharged from any California Hospital.

California Center for Rural Policy (CCRP) at Humboldt State University. The Center published its report “Rural Poverty and its Health Impacts: A Look at Poverty in the Redwood Coast Region” in 2008. This study was based on the Rural Health Information Survey conducted by CCRP in 2006 in Del Norte, Humboldt, Mendocino and Trinity counties which asked about many health issues of residents, particularly to those living in poverty and in isolated places. www.humboldt.edu/~ccrp

Mendocino County Public Health, Vital Records Office. Birth and death certificate data are used to measure certain characteristics associated with births and causes of death for the people who are born in and die in Shasta County. The information is collected on standardized forms and registered with the Vital Records Office.

Mendocino County and California Department of Mental Health. Data on clients and services provided through Mental County. Mental Health services were provided either by the County Mental Health Department directly, or if otherwise noted, taken from the California Department of Mental Health website. Additional information about mental illness prevalence was provided by the California Department of Mental Health through a contractor with a research consultant.

[www.dmh.cahwnet.gov/Statistics and Data Analysis/Prevalence Rates.asp](http://www.dmh.cahwnet.gov/Statistics_and_Data_Analysis/Prevalence_Rates.asp)

Mendocino County Continuum of Care for the Homeless. This is a regional-based organization comprised of service providers, developers, governmental entities and leaders, faith-based organizations and community members dedicated to end homelessness. Each year, they work with local service providers to collect information from people that are homeless or at-risk of being homeless to better understand their needs. The “point in time” survey is an annual “census” of homeless people that is conducted on one chosen day. 2007 is the most recent data available.

www.mcdss.org/aps

Social Security Administration. Annual Statistical Report and a variety of other publications are available at the Social Security Administration’s website. When they were contacted for more specific data on Shasta County, they declined giving additional County-level data due to confidentiality policies.

<http://www.socialsecurity.gov/policy/data.html>

University of California, Berkeley. The California Department of Social Services contracts with UC Berkeley’s Center for Social Sciences Research to monitor and track federal and California outcomes for Children and Family Services. They also provide a variety of other evaluation services. Some of the data for this report was retrieved directly from UC Berkeley’s website. <http://cssr.berkeley.edu/CWSCMSreports/>

**EXHIBIT C
COMMUNITY ASSETS**

CHILDREN & FAMILIES

Ages	Provider	Service	Needs/Populations Addressed
0-5	Raise and Shine/First 5	County-wide training & logistical support for professionals in Primary Care medical settings to conduct developmental and social/emotional screenings on children (ASQ, ASQ-SE)	Assessment/Screening
		Funding and coordination for professional training in evidence-based behavioral & mental health practices	Professional Training
		Free Triple P training for parents county-wide	Parenting No fee, No Insurance
		Free phone referrals to Triple P training resources and individual and family therapy	Referrals
0-17	HHSa, C&FSOC, Mental Health Div.	In-house and contracted professionals of the healing arts provide assessments, treatment, and case management of children and their families—including family therapy, play therapy, placement services and access to psychiatric services for medication.	Ukiah, Willits, Ft. Bragg Children meeting medical necessity criteria for Mental Health services
0-17	Mendocino County Office of Education (MCOE) SELPA	Consultation & training to districts, schools and	Behavior issues & emotional disturbance

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Service	Needs/Populations Addressed
		classroom teachers about positive behavior supports and strategies for children with challenging behavior & emotional disturbance. Development of Individual Education Plans (IEPs) that can open door to mental health placements and special support services at school.	<p>Functional Behavioral Assessments</p> <p>School-based rehabilitative services</p>
	Orr Creek Day Treatment	Special education, psychiatric treatment, intensive family therapy	<p>School-based rehabilitative treatment</p> <p>Emotionally Disturbed Children with IEPs</p> <p>At risk of out-of-home placement & School failure</p>
	MCOE ALTERNATIVE EDUCATION		
12-18	Probation Alternatives With Counseling & education (PACE)	Multi-agency collaborative of MCOE, Probation and Health & Human Services. Secondary Education including special education services to eligible students, Mental Health services, family & individual therapy, substance abuse counseling, Probation services, anger management and skill-building.	<p>Probation Youth Dual-Diagnosis</p> <ul style="list-style-type: none"> • School-based rehabilitative services • After school program

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Service	Needs/Populations Addressed
12-18	Clean & Sober Classroom	Multi-agency collaborative of MCOE, Probation and Health & Human Services. Secondary education including special education services to eligible students. Substance abuse counseling and Probation services.	Youth with substance abuse issues School-based rehabilitative services
14-18	Young Parent Program	Academic and support services in collaboration with HHSA Child Welfare Services and Community Health Services. Secondary education including special education services to eligible students; Career exploration; early education center for children; peer support groups; pre-natal support; nutrition classes; * mental health counseling; and * parenting classes	Pregnant and Parenting Teens Secondary Education Career Exploration Early Education for Children Peer Support Nutrition *Parenting *Mental Health counseling <i>* indicates no current services or recent funding cuts to that service</i>
12-18	River School	Collaborative of MCOE, Probation and Health & Human Services. Middle and high school education including special education services to eligible students.	Probation referred, expelled, and habitually truant middle and high school students. Substance abuse counseling Mental health counseling

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Service	Needs/Populations Addressed
		Substance abuse counseling, mental health counseling and Probation services	
0-17	Mendocino College Nuestra Casa FRC, Nuestra Alianza de Willits and other FRCS throughout the County	Triple P Parenting and other parenting classes & groups in Spanish; Afterschool programs	Spanish-speaking Children & Families <ul style="list-style-type: none"> • Parent Education & Support • Afterschool programs
13-17	Teen Court	Juvenile defendants resolve legal problems at a peer court without a Juvenile Probation record while reconciling with community. Youth serve as attorneys and jury members and learn about legal system while contributing to community. Victims receive restorative justice through apologies, restitution, community service etc, Provides health reconnection to the community, peers and parents as an alternative to incarceration or other types of involvement with the juvenile justice system	Coastal Communities Youth at Risk of or experiencing juvenile justice involvement Underserved cultural populations Children/Youth in stressed families Increase prevention efforts and responses to the early signs of emotional and behavioral health problems
13-17	Various	Triple P Teen Parenting Classes	Parents of teens County-wide

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Service	Needs/Populations Addressed
			No insurance or fee
0-17	Interagency Case Management Team (IACMT)	Coordination of In-County mental health and other services of multiple agencies to avoid out-of-home, out-of-County placement of children with mental health and behavioral issues.	Across-system, high risk children with mental health & behavioral issues
0-17	MHSA/Child Welfare Services	Coordination of respite care for children whose parents have mental health issues, for parents of children with mental health issues, and for foster parents	Family Respite Care
0-17	Consolidated Tribal Health	Outreach, individual & family services by an LCSW	American Indians throughout the County <ul style="list-style-type: none"> • Outreach, in-home counseling
	Yuki Trails Human Services	Individual and family therapy 1 day per month ?	American Indians in Round Valley <ul style="list-style-type: none"> • Group home for boys • AOD counseling • Individual & group counseling
	Pinoleville Vocational Rehab—Youth Transition Partnership	Support services at Juvenile Hall and advocacy in IEP	American Indian Youth/Juvenile Hall <ul style="list-style-type: none"> • Vocational rehabilitation services to youth and adults

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Service	Needs/Populations Addressed
			<p>with physical, developmental, mental health disabilities & substance use issues</p> <ul style="list-style-type: none"> • Weekly talking circle & counseling for youth in juvenile hall • Advocacy, transportation and assistance with IEPs
10-24	White Eagle Boxing Club	Socialization and healthy afterschool activity for males and females in Covelo	<ul style="list-style-type: none"> • Covelo—American Indian or not
	Building Horizons Youth Program	After school activities, computer access, alternate education site, summer youth camp, community gatherings and cultural activities	<ul style="list-style-type: none"> • American Indians in Round Valley
0-17	HHSA, C&FSOC, Mental Health & Child Welfare Services Division <u>Family Strengths Program</u>	Wraparound Services for children with mental and behavioral health issues to prevent out-of-home placement in Level 12 or higher facility	<p>High risk children with identified mental health issues and their families</p> <ul style="list-style-type: none"> • Child and family support
0-17	HHSA, C&FSOC, Mental Health & Child Welfare Services Division <u>Parent Partner Program</u>	Peer support and mentoring for the families of children with identified mental health and behavioral issues. Plus parent partner assigned to South Coast	<ul style="list-style-type: none"> • Peer Support & Mentoring • Service to outlying areas—South Coast
0-17	Redwood Children’s Services, Children’s Therapeutic Services Program (Mental	Individual, group and family therapy, Therapeutic	Parenting, Therapy, after school program-- Across systems and

**EXHIBIT C
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Ages	Provider	Service	Needs/Populations Addressed
	Health Organizational Provider)	Behavioral Services (TBS), PCIT & Triple P for children referred through Mental Health Division, Therapeutic After School Program; Emergency Shelter for special needs children at risk of placement in group home, or returning from group home to lower level of care; Mendocino House Group home for across-systems youth returning from higher level out-of-County group homes; Multi-dimensional Treatment Foster care (MTFC)	high-risk youth.
7-17	Tapestry Family Services (Mental Health Division Organizational Provider)	Individual, group and family therapy, Therapeutic Behavioral Services (TBS) PCIT & Triple P, and therapeutic after school program for children referred through Mental Health Division; Intensive Treatment Foster Care (ITFC). Plus family-based mental health support in Anderson Valley	Special needs children & their families— Central Inland Mendocino County <ul style="list-style-type: none"> • Parenting, • Therapy, • ITFC, • After School Program Service to outlying areas— Anderson Valley

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Ages	Provider	Service	Needs/Populations Addressed
0-21	Mendocino County Youth Project (Mental Health Division Organizational Provider)	Assessment, treatment planning, individual, group and family therapy, rehabilitation, support services, case management, advocacy	<ul style="list-style-type: none"> • Infants, children, youth and their families—Ukiah and South Coast
11-18	“	Youth crisis services, short-term counseling & mediation, Crisis housing	<ul style="list-style-type: none"> • Crisis Services including crisis housing • No Medi-Cal or other insurance • Non “systems” kids • Ukiah & Ft Bragg
0-18	“	Child Abuse Treatment program. Individual, group or family therapy; crisis management; outreach; case management	<ul style="list-style-type: none"> • Systems kids • No fee • Trauma-exposed
0-18	“	Alcohol & Drug Abuse class for first-time substance abuse offenders—not on formal probation	<ul style="list-style-type: none"> • Alcohol & Drug Abuse Prevention
0-18	HHSA, C&FSOC, Mental Health Div. <u>Psychiatric Services</u>	Psychiatric Services	<ul style="list-style-type: none"> • Child psychiatry for children & adolescents
0+	Family Resource Center Network	The Family Resource Center Network consists of seven private non-profit centers, one school-based center, and two County-operated centers. The centers are located in most	<p>Information & Referral</p> <p>Substance Abuse Prevention & Information</p> <p>Parenting education and support</p>

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Service	Needs/Populations Addressed
		<p>regions of Mendocino County: Pt Arena/Gualala, Ft. Bragg, Anderson Valley, Willits, Laytonville and Ukiah. Most centers offer some services in Spanish, but Spanish-speaking clientele are the focus of two centers—one in Ukiah and one in Willits. One center in Ukiah is devoted to teens and transition-age youth. Services vary at each center, but all provide information and referral services, most provide extensive parent education and support services including classes and support groups, substance abuse information, and afterschool activities and services. Many conduct outreach services and all help local individuals and families complete forms and other necessary steps to obtain services from other agencies.</p>	<p>(including Triple P training)</p> <p>Assistance with accessing resources and services</p> <p>Services to outlying areas—Laytonville, South Coast, Anderson Valley, Potter Valley, Ft. Bragg & Willits</p> <ul style="list-style-type: none"> • Action Network FRC • Anderson Valley FRC • Safe Passage FRC • Nuestra Alianza de Willits FRC • Nuestra Casa FRC • Laytonville Healthy Start FRC • Potter Valley FRC • Arbor on Main Youth Resource Center • Ukiah Family Center • Willits Family Center
0-18	Hillside Health Center—Mental Health Clinic	Counseling & psychotherapy	Sliding Scale or Insurance Ukiah
0-18	Little Lake Health Center—Mental Health Clinic	Counseling & psychotherapy	Sliding Scale or Insurance Willits

**EXHIBIT C
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Ages	Provider	Service	Needs/Populations Addressed
0-18	Long Valley Health Center—Mental Health	Mental health and counseling services	Sliding Scale or Insurance Laytonville
0-18	Manchester-Point Arena Satellite Health Clinic	Medical and behavioral health services	American Indians Outlying Areas--Pt Arena
0-18	Mendocino Coast Clinics—Mental Health Counseling Services	Counseling by LCSWs and Clinical Psychologists; Transportation within Ft. Bragg area	Ft Bragg Sliding Scale or Insurance
0-18	National Alliance on Mental Illness (NAMI)	Mutual respect, peer support, education and advocacy for mentally ill and their families	Peer support Education/Destigmatization
0-18	Redwood Coast Medical Services—Counseling Services	<ul style="list-style-type: none"> • Counseling services; • substance abuse treatment, anger management and group therapy 	Gualala Women

**EXHIBIT C
COMMUNITY ASSETS**

Transition-Age Young Adults

Ages	Provider	Services	Needs/Populations Addressed
16-25	TAY Wellness	<p>Intensive Supportive Housing plus individual therapeutic services, case management, peer support , life skills and career development through Arbor on Main.</p> <p>THP+---Housing support plus individual therapeutic services, case management, peer support , life skills and career development through Arbor on Main.</p>	<p>6 FSPs—specific issues related to a mental disorder</p> <p>Additional 18 youth Priority to those</p> <ul style="list-style-type: none"> • aging out of foster care or children’s mental health, and • Latinos and American Indians
18-25	Catherine Rosoff	Clinical Coach at Mendocino College—assists those with mental health issues to make it through college, some times facilitates access to mental health services and assessments. Helps these students plan ways to talk to their instructors about their challenges	<p>Career Development & Life Skills for those with mental health diagnosis at college</p> <p>Pre-assessment screening & referral</p>
18 +	HHSA, A&OSOC, Mental Health Div.—	Crisis services, short-term post	Psychiatric crisis

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Services	Needs/Populations Addressed
	<u>Psychiatric Emergency Services</u>	-hospitalization rehabilitation, assessments & referrals to housing, medication management, and vocational rehabilitation	Assessment Referrals
18+	HHSA, A&OSOC, Mental Health Div.— <u>Step Down & Home Program</u>	Brings adults with mental illness who have been conserved back from out-of-county placements and helps them with re-entry and independence. Includes housing at Ukiah Park Board & Care facility and intensive wraparound services supporting independence.	Mentally ill adults who have been conserved Priority to young adults Board and Care
16-21	Mendocino County Youth Project (Mental Health Division Organizational Provider)	Transitional Housing for up to 18 months at no cost to youth, while working and saving money toward independence	10 Emancipated non-system youth Young adults Pregnant and parenting teens • Transitional housing
18+	Manzanita Recovery Center (Mental Health Div. Contractor)	Assistance with obtaining physical, mental & emotional health treatment; transportation; lifeskills; substance abuse tx; career and goal development;	Ukiah & Willits Peer Support Substance Abuse Tx Access to Care Homeless or at risk of
18+	HHSA, C&FSOC, Mental Health Div. <u>Red House Recovery Center</u>	Assistance with obtaining physical, mental & emotional health treatment;	Ft. Bragg Peer Support Substance Abuse Tx

**EXHIBIT C
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Ages	Provider	Services	Needs/Populations Addressed
		transportation; lifeskills; substance abuse tx; career and goal development	Access to Care
15-24	Arbor on Main, Youth Resource Center	Peer and professional support services for all youth including specialized programs for young parents, homeless youth, a youth AA group, career development and counseling, housing services through THPP & THP+	Peer Support Alcohol & Drug Abuse Prevention Teen Parents Homeless Youth
	Consolidated Tribal Health		Youth in Juvenile Hall Outreach & counseling
12-18	Round Valley Indian Health Center <u>Yuki Trails Human Services</u>	Individual and family therapy 1 day per month ? Yuki Trails Transitional Living Center—a group home for boys age 12-18. Individual & group counseling; substance abuse counseling and AA groups; a women’s and a men’s anger management group; domestic violence group	American Indians in Round Valley <ul style="list-style-type: none"> • Group home for boys • AOD counseling • Individual & group counseling
	Pinoleville Vocational Rehab—Youth Transition Partnership	Support services at Juvenile Hall, including a weekly talking circle; Advocacy for youth concerning IEPs; Vocational rehabilitation	<ul style="list-style-type: none"> • American Indian Youth/Juvenile Hall • American Indian youth & adults in Mendocino & Lake County for vocational rehabilitation services.

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Services	Needs/Populations Addressed
		services to all American Indian youth and adults living in Mendocino and Lake Counties with physical, developmental, mental health disabilities & substance use issues; transportation to appointments.	<ul style="list-style-type: none"> • Advocacy, transportation and assistance with IEPs • Substance abuse
10-24	White Eagle Boxing Club	Socialization and healthy afterschool activity for males and females in Covelo	<ul style="list-style-type: none"> • Covelo—American Indian or not
	Building Horizons Youth Program	After school activities, computer access, alternate education site, summer youth camp, community gatherings and cultural activities	<ul style="list-style-type: none"> • American Indians in Round Valley
0-18	Hillside Health Center—Mental Health Clinic	Counseling & psychotherapy	Sliding Scale or Insurance Ukiah
0-18	Little Lake Health Center—Mental Health Clinic	Counseling & psychotherapy	Sliding Scale or Insurance Willits
0-18	Long Valley Health Center—Mental Health	Mental health and counseling services	Sliding Scale or Insurance Laytonville
0-18	Manchester-Point Arena Satellite Health Clinic	Medical and behavioral health services	American Indians Outlying Areas--Pt Arena
0-18	Mendocino Coast Clinics—Mental Health Counseling Services	Counseling by LCSWs and Clinical Psychologists; Transportation within Ft. Bragg area	Ft Bragg Sliding Scale or Insurance
0-18	National Alliance on Mental Illness	Mutual respect, peer support,	Peer support

**EXHIBIT C
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Ages	Provider	Services	Needs/Populations Addressed
	(NAMI)	education and advocacy for mentally ill and their families	Education/De-stigmatization
0-18	Redwood Coast Medical Services— Counseling Services	<ul style="list-style-type: none"> • Counseling services; • substance abuse treatment, anger management and group therapy 	Gualala Women

**EXHIBIT C
COMMUNITY ASSETS**

Adults and Older Adults

Ages	Provider	Services	Needs/Populations Addressed
18+	HHSA, A&OSOC, Mental Health Div. <u>Specialty Case Management</u>	Case management for seriously and persistently mentally ill clients of Mental Health Division	Medi-Cal-eligible, seriously & persistently mentally ill adults Dual Diagnosis Case Mgt. Ukiah, North County (thin) & Ft. Bragg (no services to outlying areas)
18+	HHSA, A&OASOC, Mental Health Div. <u>Psychiatric Emergency Services</u>	Crisis services Monday through Sunday from 8AM to midnight; On-call crisis services midnight to 8 AM; Short-term rehabilitation for six weeks after hospitalization; assessments, interventions, and referrals to vocational rehabilitation, housing and medication management resources.	Psychiatric crisis assessment and services Short-term post-hospitalization rehabilitation services Referrals to housing, vocational rehabilitation, medication management.
18+	HHSA, A&OSOC, Mental Health Div. <u>Criminal Justice Services</u>	Training and education to correctional staff regarding mental health issues of inmates; Medication management of adults suffering from a major	Incarcerated Adults in County Jail

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Services	Needs/Populations Addressed
		mental illness	
18+	HHSA, A&OSOC, Mental Health Div <u>Step Down & Home Program</u>	Brings adults with mental illness who have been conserved back from out-of-county placements and helps them with re-entry and independence. Includes housing at Ukiah Park Board & Care facility and intensive wraparound services supporting independence.	Mentally Ill adults who have been conserved Board and Care Wraparound services
18+	Consolidated Tribal Health	Adult substance abuse counseling, alternative to violence, & sobriety groups,	American Indians and others No fee to American Indians Sliding scale or insurance Alcohol and other drug abuse services Domestic Violence services
18+	Round Valley Indian Health Center, <u>Yuki Trails Human Services</u>	Yuki Trails transitional living center group home for boys age 12-18; Individual & group counseling; substance abuse counseling and AA groups; a women's and a men's anger management	American Indians in Round Valley Substance abuse Anger Mgt. & domestic violence

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Services	Needs/Populations Addressed
		group; domestic violence group	Individual and group counseling
18+	Pinoleville Vocational Rehab—Youth Transition Partnership	Vocational rehabilitation services to all American Indian youth and adults living in Mendocino and Lake Counties with physical, developmental, mental health disabilities & substance use issues; transportation to appointments.	<ul style="list-style-type: none"> • American Indian youth & adults in Mendocino & Lake County for vocational rehabilitation services. • Advocacy, transportation • Substance abuse
18+	Hillside Health Center—Mental Health Clinic	Counseling & psychotherapy	Sliding Scale or Insurance Ukiah
18+	Little Lake Health Center—Mental Health Clinic	Counseling & psychotherapy	Sliding Scale or Insurance Willits
18+	Long Valley Health Center—Mental Health	Mental health and counseling services	Sliding Scale or Insurance Laytonville
18+	Manchester-Point Arena Satellite Health Clinic	Medical and behavioral health services	American Indians Outlying Areas--Pt Arena
18+	Mendocino Coast Clinics—Mental Health Counseling Services	Counseling by LCSWs and Clinical Psychologists; Transportation within Ft. Bragg area	Ft Bragg Sliding Scale or Insurance
18+	National Alliance on Mental Illness (NAMI)	Mutual respect, peer support, education and advocacy for mentally ill and their families	Peer support Education/Destigmatization
18+	Redwood Coast Medical Services—Counseling Services	<ul style="list-style-type: none"> • Counseling services; • substance abuse treatment, anger 	Gualala Women

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Services	Needs/Populations Addressed
		treatment, anger management and group therapy	
0+	Family Resource Center Network	<p>The Family Resource Center Network consists of seven private non-profit centers, one school-based center, and two County-operated centers. The centers are located in most regions of Mendocino County: Pt Arena/Gualala, Ft. Bragg, Anderson Valley, Willits, Laytonville and Ukiah. Most centers offer some services in Spanish, but Spanish-speaking clientele are the focus of two centers—one in Ukiah and one in Willits. One center in Ukiah is devoted to teens and transition-age youth. Services vary at each center, but all provide information and referral services, most provide extensive parent education and support services including classes and support groups, substance abuse information, and afterschool activities and services. Many conduct</p>	<p>Information & Referral</p> <p>Substance Abuse Prevention & Information</p> <p>Parenting education and support (including Triple P training)</p> <p>Assistance with accessing resources and services</p> <p>Services to outlying areas—Laytonville, South Coast, Anderson Valley, Potter Valley, Ft. Bragg & Willits</p> <ul style="list-style-type: none"> • Action Network FRC • Anderson Valley FRC • Safe Passage FRC • Nuestra Alianza de Willits FRC • Nuestra Casa FRC • Laytonville Healthy Start FRC • Potter Valley FRC • Arbor on Main Youth Resource Center

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Ages	Provider	Services	Needs/Populations Addressed
		outreach services and all help local individuals and families complete forms and other necessary steps to obtain services from other agencies.	<ul style="list-style-type: none"> • Ukiah Family Center • Willits Family Center
26-59	HHSA, A&OSOC, Mental Health Div. <u>Bridge Program</u>	Discharge, Placement and aftercare planning for adults with mental illness who are hospitalized; monitoring of acute hospitalization	Hospitalized Adults
26-59	HHSA, A&OSOC, Mental Health Div. <u>Wraparound Full Service Partnership</u>	Crisis support, transportation to medical appts, linkage to counseling and other services needed for recovery such as food, housing, life skills & education.	Willits & North County: 10 FSPs Dual diagnosis Homeless or at-risk Remaining County: 35 FSPs Priority to American Indians & Latinos
26-59	HHSA, A&OSOC, Mental Health Div. <u>Forensic Mental Health Program</u>	Medication management for those suffering from major mental illnesses. Collaboration with Correction staff to properly identify inmates with significant mental health problems.	Women with Mental Illness Priority to Latinos and American Indians Formerly incarcerated Homeless or at risk of
26-59	HHSA, A&OSOC, Mental Health Div. <u>Housing—Shelter + Care</u>	<ul style="list-style-type: none"> • Time-limited housing with case management: 10 units at Gibson Street apartments and 6 transitional beds at Holden Street 	Clients of Mental Health Division Housing & Transitional Housing

**EXHIBIT C
COMMUNITY ASSETS**

Ages	Provider	Services	Needs/Populations Addressed
		Apartments—semi-supervised independent living <ul style="list-style-type: none"> • TRA Vouchers, Section * housing 	
	Ford Street Project/Yellow House	Crisis housing for emergency shelter of people who need support and safe housing	Emergency housing Susbtance abuse Tx & dual diagnosis group Lifeskills & job training Socialization
26-59	Manzanita Recovery Center (Mental Health Div. Contractor)	Assistance with obtaining physical, mental & emotional health treatment; transportation; lifeskills; substance abuse tx; career and goal development;	Ukiah & Willits Peer Support Substance Abuse Tx Access to Care Homeless or at risk of
26-59	Red House Recovery Center (HHSA, C&FSOC, Mental Health Div.)	Assistance with obtaining physical, mental & emotional health treatment; transportation; lifeskills; substance abuse tx; career and goal development	Ft. Bragg Peer Support Substance Abuse Tx Access to Care Homeless or at risk of
26-	Homeless Outreach Program Expansion	A collaboration of A&OSOC	FSP clients who are homeless or

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Ages	Provider	Services	Needs/Populations Addressed
59	(HOPE)	Mental Health & Social Services divisions; wraparound services, housing assistance, job and life skills,. Clinic-based outreach in Ukiah and Willits only	at risk of Dual Diagnosis No insurance or CSMP Ukiah, Ft. Bragg & North County (thin) Outreach—Ukiah & Willits (No outlying areas)
60+	<u>HHSA, A&OSOC- Senior Peer Counseling</u>	Weekly visits , outreach, engagement and peer counseling; Training of outreach workers.	Frail homebound older adults Multiple mental health issues Priority to American Indians and Latinos
60+	<u>HHSA, A&OSOC- Full Service Partnership</u>	Wraparound services including transportation to medical Tx and quality of life resources, support for independent living, financial assistance for staples,;one-on-one clinician interaction regarding mental health needs; engagement of family and friends.	Clients of Mental Health Div in FSPs
60+	<u>HHSA, A&OSOC— Widow’s Support Group</u>	Peer support for older adult women who are widows	Ukiah Peer Support
60+	Caregiving Support Group	Stress reduction, information, peer support	Ft Bragg

**EXHIBIT C
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Ages	Provider	Services	Needs/Populations Addressed
			Caregivers of older adults Peer Support
60+	Moving On—Willits Senior Center	Activity-oriented social group for widows or women in divorce	Willits Isolated, At-Risk
60+	VA Ukiah Community Based Outpatient Clinic	Mental health services for veterans	Veterans Ukiah
60+	Senior Centers	Socialization, outreach, food and other services and activities.	Round Valley Senior Center, Indian Senior Center Ukiah, Redwood Coast Senior Center, South Coast Senior Center, Ukiah Senior Center
60+	Community Care	Senior Information Assistance; MSSP for Medi-Cal-eligible adults who qualify for skilled nursing care; Inclusive senior services for Regional Center clients in Ukiah; Multiple services for individuals with developmental disabilities and illnesses.	Information MSSP-Qualified Medi-Cal recipients Senior Regional Center clients Services for individuals with developmental disabilities and illnesses.

EXHIBIT D-1

Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
<p><u>Age 0-5</u></p> <ul style="list-style-type: none"> Native Am. Children over-represented as a % of the population, though numbers are small Covelo geographic area has few mental health services: 1 part-time clinician for grade school children Issue is poverty, not ethnicity <p><u>Age 6-17</u></p> <ul style="list-style-type: none"> High levels of substance abuse—Mendo in highest quartile for Marijuana in this age group Feelings of sadness & hopelessness especially among alternative education kids School drop-out rate and feelings of hopelessness 	<p><u>Age 26-59</u></p> <ul style="list-style-type: none"> People re-entering college who have MH issues Native Americans Displaced workers applying for General Assistance Vets not in VA services Do depression/trauma screenings on AOD clients Use “Zoy’s screening tool” for identifying early onset CalWorks parents exempted from W2W—can include domestic violence issues “92’s” GA clients with disabilities expected to last less than 1 year <p><u>Age 60+</u></p> <ul style="list-style-type: none"> Self-neglect folks coming through APS 	<p>What groups would you target?</p> <ul style="list-style-type: none"> Foster kids—screen for PTSD Foster kids with multiple placements Kids with 504 plans at their schools Older school – aged kids who do not have IEPs but have id’d risk factors—school setting can be a good way to “contain” them for services Kids 0-5—FRCs can use First 5 funds to match & provide MH services in natural settings such as in-home or in play groups Native Americans of all ages Children newly-arrived from Mexico— 	<p>What groups would you target?</p> <ul style="list-style-type: none"> Hard to prioritize need since mental health services are scanty in Covelo and needs are significant All agreed youth were a priority—but this includes infants on up. Kids are dropping out of school in 9th grade because of hopelessness, problems at home and lack of incentives to finish school Youth need healthy activities and opportunities to succeed including employment opportunities—year round and on weekends. Would like to see additional clinicians to facilitate groups: <ul style="list-style-type: none"> Grief counseling 	<p>(Damon D. Paula M, Suzie McC,Carole C,Abbey K)</p> <p>What Groups would you target?</p> <ul style="list-style-type: none"> <u>NOT foster kids.</u> They get lots of services. <u>Teen parents— affects two generations</u> and often are part of a whole <i>family system in trouble</i>. This is also a county-wide issue. Most of these young women are not on welfare and aren’t getting treated unless they have substance issues. Girls in foster care are 6 times more likely to get pregnant & become teen mothers. <u>Alternative Education kids—</u> could combine

EXHIBIT D-1
Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
<p>among Latino children</p> <ul style="list-style-type: none"> Children & parents not covered by Medi-Cal, but exposed to dom. viol., substance abuse, crime etc. and seeking help for emotional/behavioral issues Across-systems youth—and those not in our systems—demonstrating risky behavior of various kinds—potentially unidentified onset of mental illness. Under-reported incidence of dual diagnosis in both MH and AOD data—incidence really reaches or exceeds 50%--higher among homeless. <p><u>Age 18-25</u></p>	<ul style="list-style-type: none"> Indigent older adults 	<p>Mexico—adjustment and behavioral issues—parents under stress</p> <ul style="list-style-type: none"> Undocumented adults Older adults newly arrived from Mexico—especially isolated because of language and cultural diffs. Children in families in which there is domestic violence Families with a family member who has a chronic or catastrophic illness Grandparents raising grandchildren Children with incarcerated parents Children of divorced parents 	<ul style="list-style-type: none"> Domestic violence Sexual abuse Depression & anxiety Substance abuse Need 24/7 crisis facility/capacity <ul style="list-style-type: none"> Mental health Domestic violence Homelessness Need parenting education, outreach and in-home assistance with emotional & behavioral & relationship issues Senior services are also needed <p>What are the assets in the community?</p> <ul style="list-style-type: none"> Group of committed and creative adults willing to work hard to bring services and assistance to youth 	<p>teen parent and alternative education kids as a group to serve. Lots of breakdown in the “family system”, lots of stress and hopelessness, poor school attendance.</p> <ul style="list-style-type: none"> <u>Some kids on “independent study”</u>. Sometimes used because they are not coping with school or peers, or, again, the family is dysfunctional in some way. <u>Dual diagnosis children</u>—combination of a disability such as autism or retardation AND a mental health issue. The mental health

EXHIBIT D-1
Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
<ul style="list-style-type: none"> Data sources for this segment use various age spreads—makes data-gathering and comparing difficult. Suicide rate in Data Report is low. Only shows hospitalizations. Many more go to ER and are released—or never go. Under-reported incidence of dual diagnosis in both MH and AOD data (Same as above) The # of mentally ill individuals in local jails & in prisons is growing for lack of alternatives Age groups represented in homeless population changes at different points in 		<p>divorced parents</p> <ul style="list-style-type: none"> Divorcing parents Children in families with multi-generational issues, low functioning etc. who are already partaking of some FRC services Older adults who don't work and are isolated or frail Newly unemployed Returning military Poverty-stricken & homeless 	<p>and children;</p> <ul style="list-style-type: none"> White Eagle Boxing Club for youth aged 10-24, male or female, Native American or not. Building Horizons Youth Program: After school activities, computer access, alternate education site, Summer Youth Camp (includes motivational speakers), Community gatherings and cultural activities. Yuki Trails: 1 Behavioral Health Director, 1 additional therapist soon, 2 chemical dependency clinicians. Indian Tribal Health—Now includes TANF; Head Start Sr. Center: Food & socialization—Indian 	<p>issue goes untreated until extreme problems occur. Need early intervention with these kids on their mental health issues.</p> <ul style="list-style-type: none"> <u>Kids who come to attention of Care Teams and Student Study Teams</u> in elementary schools—referred for health and attendance issues—frequently do more poorly as time goes on without help. <u>In general, children and youth of families that do not qualify for mental health services</u> because they aren't Medi-Cal eligible, and don't qualify for

EXHIBIT D-1
Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
<p>the year.</p> <p><u>Age 26-59</u></p> <ul style="list-style-type: none"> • Under-reported incidence of dual diagnosis in MH & AOD data as above • The # of mentally ill individuals in local jails & in prisons is growing for lack of alternatives • Age groups represented in homeless population changes at different points in the year. <p><u>Age 60+</u></p> <ul style="list-style-type: none"> • Under-reported incidence of dual diagnosis in MH & AOD data as above • The # of mentally ill individuals in local jails & in prisons is growing for lack of 			<p>Tribal Health does some outreach there as well</p> <ul style="list-style-type: none"> • Sports—middle school and high school • Unity Youth Council—Leadership skills & making needs known to elders 	<p>other types of assistance because of income or no IEP, or condition not yet severe enough.</p> <p>What kinds of services are needed?</p> <ul style="list-style-type: none"> • <u>Suicide prevention</u>. They did this before, but should be done annually—train pre-school & K-12 teachers and parents. A simple flyer helps—signs to look for and where to go for help. Schools could dovetail their annual child abuse reporting training with suicide prevention training.

EXHIBIT D-1
Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
<p>alternatives</p> <ul style="list-style-type: none"> Age groups represented in homeless population changes at different points in the year 				<ul style="list-style-type: none"> <u>PIPs worked</u>—Primary Intervention Program—pre-school through grade 2. Was funded through DMH—EMHI. Not happening now. Each school district must apply for funds each year and they require matching funds.. Addressed kids with risk factors, but not extremely high risk. <u>Behavior Specialist Services</u>—parent training on behavior management. Addressed the <i>family system</i>. Behavior is now the #1 challenge for schools. This program worked

EXHIBIT D-1
Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
				<p>with parents with very high stress index and kids aged 0-5— services that were not Medi-Cal billable. Used BA level person working under a Board certified person, but First 5 \$ was cut. Need this kind of program for all levels.</p> <ul style="list-style-type: none"> • <u>Having mental health clinicians in the schools worked.</u> • <u>Programs or counselors that “follow” at risk or troubled kids all the way through school— especially transitions from Elementary to Middle School to High School. Schools no longer</u>

EXHIBIT D-1
Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
				<p>have enough school counselors or school psychologists to do the job and Middle and High School teachers have too many students to give time to these kids.</p> <ul style="list-style-type: none"> • <u>Teen Pregnancy Prevention</u> program that includes mileage, supplies and a person to talk to the teens—especially Latino teens. • <u>Couples Counseling for teen parents</u> • <u>Services that take place at school or pre-school</u> (most pre-school-aged kids are attending pre-school)—could be after school programs,

EXHIBIT D-1

Focus Group/Consultation Input

Stakeholder's 4/13/09 & 5/11/09	ASOC Mgt Team 5/18/09	FRC Network 5/26/09	Covelo Building Horizon Grp. 6/2/09	MCOE—Selected Staff 6/11/09
				<p align="center">but on school campus.</p> <p>What Services Currently Exist? See web site info gathered by Phyllis— however—most of or all these programs could be cut soon.</p>

EXHIBIT D-2
Focus Group/Consultation Input

Latino Community Nuestra Casa	PCCY/CAPC + June 25, 2009	GLBT Group(s) 6/5, 6/11	Youth Services Group(s) TSOC July 6, 2009 1-2:45	Law Enforcement July 9, 2009
<p>Who Would You Target? EARLY INTERVENTION (Spanish-speaking)</p> <ul style="list-style-type: none"> • People are coming in to Nuestra Casa with <ul style="list-style-type: none"> ○ Major depression ○ Anxiety ○ PTSD ○ Trauma ○ Domestic Violence ○ Adjustment disorders ○ “V “ Codes ? ○ Dual Diagnosis • <u>Sr. Citizens—especially those newly arrived from Mexico—</u> adjustment disorders, depression, isolation 	<p>Who Would You Target? PREVENTION</p> <ul style="list-style-type: none"> • Children Youth & Families that are stressed, especially those with kids 0-8 years old. • Adolescents 9-18 years old—there are lots of services for 0-5 year olds. This group has self-esteem and drug and alcohol issues developing. • Low income Latino children age 0-through adolescence—are not Medi-Cal eligible and not served, but have lots of stressors. • Adolescents—need education about mental health as well as 	<p>PRIDE ALLIANCE FRIDAY NIGHT GROUP (6/5/09) Who would you target?</p> <ul style="list-style-type: none"> • Youth (means 0-18 to some), 13-25 to others; • Teens in this population have the highest suicide rate; • Would be best to begin providing service as early as age 9 or 10, when children in this population are realizing that they are “different”. There is no help from the school or their peers. There is no identified “place “ for them; • Children in this population who are growing up in religious households 	<p>Who Would You Target? PREVENTION or EARLY INTERVENTION</p> <ul style="list-style-type: none"> • School-aged children, their parents and teachers and providers—Need psycho-social education. In TAY/Wellness population, see mental illness among 19& 20 year olds, but looking back, there were symptoms earlier • Youth with mental health issues—need earlier education for staff in schools. With youth, anxiety and depression manifest as laziness or 	<p>Who Would You Target? PREVENTION</p> <ul style="list-style-type: none"> • Kids with poor attendance—utilize “Attendance Improvement Monitoring” program • 13-18-year olds—Expand and do more with Probation’s “Impact Program”—fund counselor and Probation officers, and add Probation Officer training as per the Napa County model. <p>EARLY INTERVENTION</p> <ul style="list-style-type: none"> • The people Mental Health “won’t take”. Law Enforcement gets calls and responds

EXHIBIT D-2
Focus Group/Consultation Input

Latino Community Nuestra Casa	PCCY/CAPC + June 25, 2009	GLBT Group(s) 6/5, 6/11	Youth Services Group(s) TSOC July 6, 2009 1-2:45	Law Enforcement July 9, 2009
<p>PREVENTION AND EARLY INTERVENTION</p> <ul style="list-style-type: none"> • <u>Children & Youth</u>—developing behavioral and emotional issues because they have no supervision—parents working long hours. Teens with low self-esteem. • <u>Those without Medi-Cal or other insurance</u> • <u>Whole Spanish-speaking community</u>—Information/education about mental illness—both de-stigmatization and recognizing signs and symptoms. <p>What would help?</p>	<p>services—especially kids who “fall through the cracks” and are “out of control”—not CWS dependents or Probation wards, not Medi-cal eligible, or have inadequate private insurance, so can’t access Mental Health services.</p> <ul style="list-style-type: none"> • Teachers, Therapists, other professionals—funding to enable them to screen and refer middle school and high school aged kids (age 11—24). • 5th, 6th and 7th grade kids—have self-esteem issues and co-occurring disorders. • Counseling & Intervention for 	<p>wherein their orientation is considered wrong;</p> <ul style="list-style-type: none"> • Children of gays; • Lesbian adults—high alcoholism rate; • Older gay men estranged from families, and without partners to provide company or assistance of other kinds. <p><u>What kinds of services would you suggest?</u></p> <ul style="list-style-type: none"> • Education for themselves, peers and teachers about homosexuality; • Services that provide a sense of community; • A shelter for homeless youth of this group who have been kicked out of their homes 	<p>rebellion whereas kids are overwhelmed. Can’t get out of bed, can’t cope with day-to-day life. Per cent of kids with mental health issues in supported work program on the Coast has grown from about 10% to over 50% over a couple of years.</p> <ul style="list-style-type: none"> • Many of youth with mental health issues in transition-age population are kids who have been “noticed” earlier by various agencies for problems they have had. • Young parents—addresses two generations—lots of depression, suicide risk, 	<p>and then finds the person is mentally ill. Mental Health either won’t respond or releases them back into the community and they become a problem again—sometimes in a different jurisdiction from the one they were in when Law Enforcement first responded. Families see it as a failure of law enforcement, but law enforcement can’t deal with their issues.</p> <ul style="list-style-type: none"> • Weakest link is the initial contact with Mental Health at the hospital—1st half hour—Crisis workers either don’t show up or

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Focus Group/Consultation Input

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<ul style="list-style-type: none"> • Mental Health counselor at Nuestra Casa—bi-lingual/bi-cultural available evenings and weekends. • Meeting place for Spanish-speaking Srs.—reduce isolation & identify MH issues • Add information about signs, symptoms and services for Mental Health problems to existing Nuestra Casa programs—after school tutoring program, Crianza con Carino—also information about promoting mental health, de-stigmatization. Educational forums for all ages, rather than calling them “therapy”. 	<p>foster parents (kids 0-18); Spanish-speaking parents(kids 0-18, but especially 0-5) And child care providers (kids age 0-13)</p> <ul style="list-style-type: none"> • Middle School kids with Impulse control issues. • Parents of kids of all ages. They are their children’s first therapists, have daily, high-intensity involvement with kids and could have greatest impact on their mental health. Parents should be partners with the schools in dealing with behavioral health issues. • Native American teens and other teens in outlying areas. Many get 	<p>because of their orientation;</p> <ul style="list-style-type: none"> • Services that link kids up to information about STDs, human sexuality, health care options, substance use, life skills and so on. • An organization like “Positive Images” in Santa Rosa—a place just for gay, lesbian, bi-sexual & transgender youth—a safe place to go <p><u>What are our community’s assets ?</u></p> <ul style="list-style-type: none"> • GLAM—Thursday night teen meeting • MCAVN—gathering place and services for people who have AIDS or are HIV positive—any age. 	<p>anxiety, domestic violence.</p> <ul style="list-style-type: none"> • Substance abusers and children of substance abusers • Probation children—many have been abandoned by parents literally or psychologically before they got in trouble. Most aggressive kids really have abandonment issues. • Native American children in Probation—many have PTSD • Kids that “fall through the cracks”—need services of Mental Health, Probation, CWS, and get inadequate or no services from any of these entities— 	<p>release patient on a contract, or just release them. Again they might be in a different jurisdiction in the hospital and so become a problem to another law enforcement entity. The result is that the individual could be taking up a lot of the staff time of several law enforcement agencies each time they have a crisis; the needs of the individual and his/her family not being served.</p> <ul style="list-style-type: none"> • Need a better crisis response—Law Enforcement can’t babysit people who are having some kind of mental health problem, and now

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Focus Group/Consultation Input

Latino Community Nuestra Casa	PCCY/CAPC + June 25, 2009	GLBT Group(s) 6/5, 6/11	Youth Services Group(s) TSOC July 6, 2009 1-2:45	Law Enforcement July 9, 2009
<ul style="list-style-type: none"> • Crisis & suicide prevention service in Spanish. • Mentoring program for teens in general and those in Juvenile Hall—include activities that keep them busy. • Outreach to kids who are not attending school—some are afraid to go. • Family & couples therapy 	<p>on home study, are disconnected, not in school and getting involved in crime and drugs.</p> <ul style="list-style-type: none"> • Native Americans of all ages—under-served. • Kids age 0-8—but regardless of age, in ways that will leverage funds so more can be done. • Community Education to destigmatize mental illness and educate about first break symptoms and interventions that will help. • Youth just leaving foster care. • Hispanic youth and other youth age 12-18. • Children exposed to domestic violence—all ages. But services do 	<ul style="list-style-type: none"> • Willits Gay/Straight Alliance • Arbor on Main 	<p>don't fit criteria or ineligible because of income of parents.</p> <p><u>What Services Would Help?</u></p> <ul style="list-style-type: none"> • Psycho-social education for providers, parents, youth themselves. • Provide services on school campuses or other community settings • Bring back the PIP program—mental health staff on campuses. • Wide-scale destigmatization efforts • Get to parents of young children—a campaign about how their response to their children today determines behaviors they have to deal with 	<p>Mental Health has no one to do that either, so there is no capacity to enable the person to sober up or be watched to monitor their status before they are out on the street again.</p> <ul style="list-style-type: none"> • For Probation clients—used to have a mental health “caseload” with a Probation Officer assigned—worked well. They could monitor meds and ensure they stayed on them. <p><i>Incarceration issues pending</i></p>

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Focus Group/Consultation Input

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	<p>exist in Ukiah.</p> <ul style="list-style-type: none"> • School-aged children & Youth (K-12)—especially kids in outlying areas (outside Ukiah valley) and kids falling through the cracks—no Medi-Cal, not Dependents or wards, minimal insurance. • General Population—information campaign about mental illness. • Bring children, youth and elderly together to address mental health issues in all age groups. Doing this in Hopland. <p>EARLY INTERVENTION</p> <ul style="list-style-type: none"> • Children Youth & Families (Kids 0- 		<p>tomorrow</p> <ul style="list-style-type: none"> • Support groups for youth and young parents –how to cope with life, rules to live by—engage older parents to mentor younger ones. • Have youth who have experienced mental health issues go to schools and speak as part of destigmatization campaign. • Have young parents go to Middle Schools to talk about difficulty of being a parent at young age. • Utilize “grandparents” to interact with kids in juvenile hall— could serve to help older adults who are isolated and 	

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	<p>8).</p> <ul style="list-style-type: none"> • Adolescents (9-18 years old)—drug and self-esteem issues. • Low income Latino families who are ineligible for Medi-Cal (kids 0-adolescence). • Out-of-control kids who are “falling through the cracks”—no Medi-cal, no association with CWS, or Probation. • Teachers, therapists, other professionals—funding to enable them to screen and refer middle school and high school aged kids (age 11—24). • TAY-First break kids—age 19-20, losing Medi-Cal. • Middle School kids 		<p>the kids at the same time—working well now with a grandmother who visits kids at juvenile hall. Kids with abandonment issues get the most out of this service.</p>	

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	<p>with impulse control issues.</p> <ul style="list-style-type: none"> • Native American teens and other teens in outlying areas. Many get on home study, are disconnected, not in school and getting involved in crime and drugs. • Native Americans of all ages—underserved. • Community Education to destigmatize mental illness and educate about first break symptoms and interventions that will help. • Youth just leaving foster care. • Hispanic youth and other youth age 12-18. • Children exposed to domestic violence—all ages. 			

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Focus Group/Consultation Input

Latino Community Nuestra Casa	PCCY/CAPC + June 25, 2009	GLBT Group(s) 6/5, 6/11	Youth Services Group(s) TSOC July 6, 2009 1-2:45	Law Enforcement July 9, 2009
	<p>But services do exist in Ukiah</p> <ul style="list-style-type: none"> • School-aged children & youth (K-12)—especially kids in outlying areas (outside Ukiah valley) and kids falling through the cracks—no Medi-Cal, not Dependents or wards, minimal insurance. • General Population—information campaign about mental illness. • Bring children, youth and elderly together to address mental health issues in all age groups. Doing this in Hopland. • Kids in Juvenile Hall—many showing mental health issues or 			

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	<p>are already receiving some level of mental health care—either lose continuity of care while in JH or are at first break—no adequate mental health service for these kids or their families.</p> <p><u>What Services would help?</u></p> <ul style="list-style-type: none"> • Expand “Raise & Shine”—use a Raise and Shine-like approach for older kids. • Provide Mental Health services to low-income non-Medi-Cal-eligible kids that are equivalent to those Medi-Cal eligible kids get. • Expand community knowledge of 			

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	<p>needs and facts about mental illness and effective interventions.</p> <ul style="list-style-type: none"> • Coordinate mental health services with law enforcement to address “out-of-control” adolescents. • Fund the education of teachers, therapists, and other professionals about how to screen for mental health issues and where to refer clients for services. • Provide curriculum to address self-esteem and co-occurring disorders for 5th, 6th & 7th graders • Provide counseling and support services and 			

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	<p>Behavior Intervention Training to child care providers and parents—provide through community based agencies and child care settings. Make it bi-lingual!</p> <ul style="list-style-type: none"> • For TAY first-break kids, provide a program that allows for a quick response and builds hope. • Utilize evidence-based practices addressing impulse control. • Work with and support parents through the schools. • Provide prevention services that reconnect youth in outlying areas and teach them life skills, address 			

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	<p>health and education and substance use.</p> <ul style="list-style-type: none"> • For kids at first break be sure to work with them to obtain employment. • Leverage funding and bring back the Primary Prevention Program (PIP) at each school site. • Community education campaign to de-stigmatize mental illness. • Literacy education, mentoring and tutoring for Spanish-speaking youth. • AODP services for youth. • Treatment for child victims or children exposed to domestic violence—and/or 			

EXHIBIT D-2
Focus Group/Consultation Input

Latino Community Nuestra Casa	PCCY/CAPC + June 25, 2009	GLBT Group(s) 6/5, 6/11	Youth Services Group(s) TSOC July 6, 2009 1-2:45	Law Enforcement July 9, 2009
	<p>information about existing treatment & services.</p> <ul style="list-style-type: none"> • Provide Prevention and Early Intervention services on school sites and employ leadership training with kids to de-stigmatize. • Establish a Mental Health 211 line—answers covering the gamut from facts and information to crisis services. • Bring elders and youth together to provide mental health services across the generations—more impact on whole community. • Link prevention services to community resources. 			

EXHIBIT D-2
Focus Group/Consultation Input

Latino Community Nuestra Casa	PCCY/CAPC + June 25, 2009	GLBT Group(s) 6/5, 6/11	Youth Services Group(s) TSOC July 6, 2009 1-2:45	Law Enforcement July 9, 2009
	<ul style="list-style-type: none"> Utilize SARB to identify and refer children and their families to various mental health services. 			

EXHIBIT D-3
Focus Group/Consultation Input

Consolidated Tribal Health July 16, 2009	Manzanita Recovery Center (GLBTQ group) 6/12/09	CMIST 6/15/09	Health Care Providers Agency Adv. Board 6/24/09 ARCH?	Coast Group Coast IACMT 7/2/09
<u>WHO SHOULD BE TARGETED?</u>	<u>WHO SHOULD BE TARGETED?</u>	<u>WHO SHOULD BE TARGETED?</u>	<u>WHO SHOULD BE TARGETED?</u>	<u>WHO SHOULD BE TARGETED?</u>
<p>PREVENTION & INTERVENTION</p> <ul style="list-style-type: none"> • <u>Young parents of small children</u> (13, 14, 15-year-olds) in outlying areas. Maternal Child Health Programs are incoherent—don't reach all areas. • <u>Folks with co-occurring alcohol and drug abuse and mental illness</u>—need means/expertise to sort through and address both. Need to include and educate whole family about what is going on with their family member. • <u>Youth</u>—school drop-out rate. Need outreach to these 	<ul style="list-style-type: none"> • <u>Anyone who doesn't fit in</u> • <u>People who don't have Medi-Cal.</u> • <u>Teens and others</u> who are just discovering their orientation • <u>Homeless</u> in general, but especially in the GLBTQ community—more vulnerable, suffer from more stigma and danger • <u>Transgender folks</u>—require two years of therapy, among other needs and there are no therapists specializing in their issues in our 	<p>PREVENTION</p> <ul style="list-style-type: none"> • <u>Middle school kids</u>—need education about the effects of substances during pregnancy—prevent fetal alcohol syndrome • <u>Kids who are “marginally diagnosed”</u>—early <u>mild problems showing up in school</u>—quiet etc. Often later develop into more severe issues that are harder to treat—kids 12-17 who are underperforming, and even earlier, age 6 or 7 or preschool. Raise and Shine can't 	<p>PREVENTION</p> <ul style="list-style-type: none"> • <u>Geographical parity</u>—if this project is really to be countywide, make it county-wide • <u>Pick one or two priorities and do them well</u>—don't dilute this. • <u>Kids at age 7 or earlier</u> if this is where clinical research indicates prevention works best. • <u>All primary care providers</u>—ARCH clinics car for 43,000 residents, about 42% of total population. • <u>School-aged</u> 	<p>PREVENTION</p> <ul style="list-style-type: none"> • <u>Sexual education for for people with developmental issues</u> There is a lot of victimization, especially sexual victimization of this population; • <u>Undiagnosed “dual diagnosis” clients</u>—that is both mental health issues and developmental delays. Usually don't get treatment for mental health issues—usually see problems at 18-22, but began to develop earlier. • <u>Parents of children with</u>

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Focus Group/Consultation Input

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<p>families by someone equipped to recognize and address mental health issues and dual diagnosis—at least LCSW level.</p> <ul style="list-style-type: none"> • <u>Youth in jail</u>. “drop-out” from CTHP –go into jail and don’t access CTHP services afterward until next big crisis. Need discharge and after care services for the youth and the family. • <u>Whole Native American community</u>—education about <u>what mental health is</u>—but in a way they can accept <ul style="list-style-type: none"> ○ Services at reservation ○ Youth Wellness Gathering— 	<p>county</p> <ul style="list-style-type: none"> • <u>Educators, police, human services workers of all kinds, parents</u>—Need education campaign about the issues/facts of children in the GLBTQ group, and those of all ages. Counter-balance misconceptions, myths and hate so that this group is seen as human, worthy, & not stigmatized. • <u>Native American Community</u>—Used to have concepts that honored those with gender/sexual orientation differences--- 	<p>reach all of them.</p> <ul style="list-style-type: none"> • <u>Kids in Juvenile Hall</u> showing mental health symptoms. Need a “mental health bridge” between juvenile hall and home—continuity of services. • <u>Isolated kids and families</u> kids on independent study, kids with attendance problems, and those bouncing from one school district to another. • <u>Adolescents and other kids at key transition points</u> • <u>Parents</u>—education about suicide risk and signs of mental illness • <u>Teen and Young</u> 	<p><u>children</u>—seeing children with ADHD, OCD, depression and anxiety</p> <ul style="list-style-type: none"> • <u>Children & young families</u> Poor parenting & communication skills leading to self-esteem issues in kids; Exposure to drugs and alcohol leading to a variety of mental health problems in parents and children. • <u>Community-based FRCs</u> • <u>Teens</u> • <u>Foster Children</u> <p>EARLY INTERVENTION</p> <ul style="list-style-type: none"> • <u>Geographical parity</u>—if this 	<p><u>developmental delays</u>—lots of single parents of children with developmental delays trying to go it alone.</p> <ul style="list-style-type: none"> • <u>Developmentally-delayed youth</u>—need something to look forward to and give meaning to their lives. • <u>Any at-risk children or adults and their families</u> – • <u>Parents of teens</u> • <u>Out-of-Control kids who “fall through the cracks” of various systems & their parents</u> • <u>Young children who are out-of control at school</u>—whole family system is dysfunctional.

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Focus Group/Consultation Input

Consolidated Tribal Health July 16, 2009	Manzanita Recovery Center (GLBTQ group) 6/12/09	CMIST 6/15/09	Health Care Providers Agency Adv. Board 6/24/09 ARCH?	Coast Group Coast IACMT 7/2/09
<p>invite parents and elders—use positive approach that promotes wellness rather than using the term “mental illness—such as “walking in balance” approach</p> <p>What Services are Needed?</p> <ul style="list-style-type: none"> • <u>Someone to provide direct services in Round Valley and other tribal areas—LCSW at least.</u> (There are 3000 people living in Round Valley Reservation.) Person should be in community every day and be able to recognize and 	<p>(two-spirit people, berdache=bridge people, between genders.) Mostly these concepts no longer prevail and GLBTQ folks are victimized.</p> <p>What Services Are Needed?</p> <ul style="list-style-type: none"> • Mental Health Services and support groups for GLBTQ are too segmented and confusing now. <u>Need a facility,</u> (Or at least a central place to call.)-- a hub with multiple services for multiple groups. A safe, central meeting place with open door to all ages and 	<p><u>parents</u> often lots of stressors and few resources.</p> <ul style="list-style-type: none"> • <u>Kids falling between the cracks of our systems</u> (Mental Health, Probation, CWS) • <u>Kids exposed to domestic violence, gang violence or any other form of violence</u> <p>EARLY INTERVENTION</p> <ul style="list-style-type: none"> • <u>Program for folks of any age with co-occurring substance and mental health issues</u> • <u>Kids in Juvenile Hall.</u> Though the numbers of kids with mental health 	<p>project is really to be countywide, make it county-wide</p> <ul style="list-style-type: none"> • <u>All primary care providers—ARCH</u> clinics car for 43,000 residents, about 42% of total population. • <u>School-aged children & jail population</u> School-aged children—seeing children with ADHD, OCD, depression and anxiety; Jail population—need rehabilitation and coping strategies • <u>Children, youth, young adults</u> Poor parenting & communication skills leading to self-esteem 	<p>EARLY INTERVENTION</p> <ul style="list-style-type: none"> • <u>Dual diagnosis youth</u>—coming up more and more that youth with developmental delays also have mental health issues going unaddressed—18-22-year olds • <u>Adolescents and younger children with developmental delays and separation anxiety</u>—Seeing this issue more often • <u>Downs Syndrome adults with early dementia</u>—late 30’s to early 40s.

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Focus Group/Consultation Input

Consolidated Tribal Health July 16, 2009	Manzanita Recovery Center (GLBTQ group) 6/12/09	CMIST 6/15/09	Health Care Providers Agency Adv. Board 6/24/09 ARCH?	Coast Group Coast IACMT 7/2/09
<p>address mental health issues and dual diagnosis.</p> <ul style="list-style-type: none"> • <u>Education/Information about how to identify early onset.</u> • <u>Parenting skills, mental health services for teen and young parents</u> of young children in outlying areas. • <u>Outreach to families—especially those of youth who are no longer attending school.</u> • <u>Discharge services and aftercare services to families of youth who are in juvenile hall or jail.</u> • <u>Tribal police</u> at Coyote Valley, Hopland, Coto and Sherwood could <u>develop relationship with behavioral health</u> 	<p>types, and parents & relatives thereof.</p> <p><u>Need to collaborate</u>—the various GLBTQ support groups and non-profits to consolidate resources to provide support mutually, ensure sustainability.</p> <p><i>Should NOT be run by County.</i></p> <ul style="list-style-type: none"> • <u>Need a liaison</u> to help people “on the margins” navigate and obtain services. • <u>Homeless</u> Need services provided at the shelter and/or transportation to get from shelter to food, to crisis services etc. 	<p>issues in juvenile hall have not increased, the severity of their problems has gotten worse. Some of them are seeing a therapist when they enter JH, but their therapy with that therapist ends at that point. This allows for no continuity of service.</p> <ul style="list-style-type: none"> • <u>Young parents and Teen Parents</u> Can be at early onset of a mental illness. Affects the next generation. <p>What Services Are Needed? <u>PREVENTION Education</u>—Middle school, about effects</p>	<p>issues in kids; Exposure to drugs and alcohol leading to a variety of mental health problems in parents and children.</p> <p>What Services Are Needed?</p> <ul style="list-style-type: none"> • Basic evaluation of risk for mental health issues on an annual basis & appropriate treatment; Use an assessment tool for each 7-year-old, and annually thereafter, and then make a treatment plan. • Education in school—destigmatize mental health by 	<p>Have no neurologists or geneticists on coast, and none come to the coast for clinics now.</p> <ul style="list-style-type: none"> • <u>Children and adults in crisis on coast</u>—Need post-hospitalization services, and services to help with issues below level of crisis leading to hospitalization. <p>What Services Are Needed?</p> <ul style="list-style-type: none"> • Mental health assessments and services for developmentally delayed clients • Sexual education and life-skills programs and healthy socialization

EXHIBIT D-3
Focus Group/Consultation Input

Consolidated Tribal Health July 16, 2009	Manzanita Recovery Center (GLBTQ group) 6/12/09	CMIST 6/15/09	Health Care Providers Agency Adv. Board 6/24/09 ARCH?	Coast Group Coast IACMT 7/2/09
<p>programs for Native Americans.</p> <ul style="list-style-type: none"> • <u>Localized services on the reservation that educate Native American Community about what mental health is</u>—need a positive approach such as a Youth Wellness gathering that includes parents and elders—include mental health issues and make professionals available to get to know the community members and facilitate mental health wellness activities. Youth could actually help mentor elders about mental wellness. Have examples/speakers to describe what mental 	<p>Homeless are less healthy, more vulnerable. Sometimes have small children & can't walk the distances to all the services they need.</p> <p>Need place to go during the day. Homeless with mental health issues need a special, quicker way to get crisis services and medications.</p> <ul style="list-style-type: none"> • <u>Suicide Prevention</u> A 24-hour line with a continuum—from information (warm line) to crisis. Could be staffed by peers who are well-trained. 	<p>of substance use while pregnant—to prevent fetal alcohol syndrome.</p> <p><u>Education</u>—Parents about suicide prevention and signs of mental illness</p> <p>PREVENTION/EARLY INTERVENTION</p> <p><u>Referral & Assessment</u> of kids/families who are isolating themselves— independent study, poor attendance— perhaps utilize SARB.</p> <p><u>Referral & Assessment</u> of young elementary school- aged kids who are showing mild issues</p> <p><u>Peer support groups for parents & kids and/or therapeutic groups</u>—linked to services</p>	<p>comparing it to physical health;</p> <ul style="list-style-type: none"> • Partner with drug court • Identification of early mental health issues • Building resiliency—i.e., 40 developmental assets • Parenting, communication and self-esteem building • Summer school programs 	<p>programs for above;</p> <ul style="list-style-type: none"> • Family therapy for parents of developmentally delayed clients— especially those exhibiting mental health symptoms • Mental health crisis services for developmentally delayed clients. • Other-than crisis services for children and adults on the coast— including services to client and families post-hospitalization. There are no such services on coast now. • Services for teens and their parents—would be good to have a

EXHIBIT D-3
Focus Group/Consultation Input

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<p>health looks like.</p> <ul style="list-style-type: none"> • <u>Provide services to Native Americans in the outlying areas</u>—they could spill over into the rest of the Native American community. • <u>Mini grant for youth in Pinoleville.</u> Expand program they have that provides services to youth in Juvenile Hall and accompany children to IEPs. 	<ul style="list-style-type: none"> • <u>Education Campaign</u> Create a program that “puts a face” to the GLBTQ community—low cost speakers bureau that utilizes members of this community to educate the community at large, tell their “story”, also could address like groups—transgender to transgender, lesbian to lesbian etc. • <u>Peer Support Groups</u> Peers can provide acceptance and safety net for each other at low cost. <p>What Services</p>	<p><u>Mental Health “Bridge” for kids in Juvenile Hall</u>—providing continuity of therapeutic services at JH and outside.</p> <p><u>Play rooms at schools</u> Latency aged kids</p> <p><u>Saturation campaign</u> to end all violence in local community as a social priority; provide education about the effects of violence on brain development, future relationships etc. This could involve kids and parents in all our systems—CWS, Probation, Mental Health, Youth Project.</p> <p><u>Services related to exposure to violence</u></p>		<p>phone number to call for general information about teens and a class or group to refer them to.</p> <ul style="list-style-type: none"> • Joint services for youth and children “falling through the cracks”—ineligible for current systems services, or services are inadequate to their needs. • Destigmatization effort • SARB—focus on younger kids and parents—Ft Bragg has dropped SARB for teens because it is too late. • Bring back the PIP—mental health clinicians on campus—

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Focus Group/Consultation Input

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	<p>Exist? The GLBTQ community could collaborate better than it currently does. Services exist but are not well known by members of the community:</p> <ul style="list-style-type: none"> • Manzanita Recovery Center GLBTQ support group • Pride Alliance • GLAM—young • PFLAG • MCAVN (Aids/HIV) 	<p>Link saturation campaign to support groups for children and parents. Include peer support, and parent partners to reach out to families.</p> <p>EARLY INTERVENTION Program to serve the substance use and mental health needs of clients with co-occurring issues—any age group.</p> <p>What Services Exist?</p> <ul style="list-style-type: none"> • Youth Project has services for youth exposed to violence. • SARB in Ft. Bragg is beginning to address attendance issues earlier than 		<p>destigmatizes mental health services.</p> <ul style="list-style-type: none"> • Education for school personnel and other community members that provides a tiered approach to assessing mental health issues—red flags and behavioral interventions at various levels to address needs as early as possible • Lots more effort to destigmatize mental health issues—on the coast, families wait too long to get services because of stigma—everyone will know.

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Focus Group/Consultation Input

Consolidated Tribal Health July 16, 2009	Manzanita Recovery Center (GLBTQ group) 6/12/09	CMIST 6/15/09	Health Care Providers Agency Adv. Board 6/24/09 ARCH?	Coast Group Coast IACMT 7/2/09
		<p align="center">previously</p>		<ul style="list-style-type: none"> • Use motivational speaker to go to Middle and High schools to talk with kids about common fears and issues related to mental health. Have people on site to answer individual questions. Need regular follow-up to maintain awareness

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p>Serve Adults 18 & up. Unit open Mon-Sun 8AM to midnight. Someone is on site during those hours. Midnight to 8AM, on-call only.</p> <p>Medi-Cal rates are lower for adult Mental Health clients than they are for children. Mental Health has a better reputation than it used to, but there is a big discrepancy between adult services and services to children. There are amazing services for children, but the minute they turn 18, the services dwindle to</p> <ul style="list-style-type: none"> • Crisis • Visit with Dr, 1 X Mo. • Case manager if severe disorder 	<p>Who Would You Target? BOTH PREVENTION & EARLY INTERVENTION</p> <ul style="list-style-type: none"> • Kids aged 11-18 <u>who have no Medi-Cal or insurance,</u> and are not eligible for CHAT services. <p>Serious issues. See hundreds every month in crisis, could see more if they had sufficient staff. This is critical age—chance to help before it's too late.</p> <p>What Are the Issues?</p> <ul style="list-style-type: none"> • Kids living in stressed families—growing numbers since recession. Finding families have no <u>family connectedness.</u> <p>No one to turn to for</p>	<p>Who Would You Target?</p> <ul style="list-style-type: none"> • <u>Exempt and Family Child Care Providers</u> Headstart and Center providers are usually better educated and trained. Bulk of children are in exempt or family child care settings. These tend to be the subsidized child care slots and families utilizing them tend to be the more stressed families—alcohol & drugs, poverty, criminal history, etc. In some cases the child care provider is under as much stress as the family for whom they are providing care—or they are part of the 	<p>Who Would You Target? PREVENTION & EARLY INTERVENTION</p> <ul style="list-style-type: none"> • <u>Native American & Latino population—substance abusers enrolled in AODP</u>. Dual diagnosis and not. <p>AODP is losing its capacity to serve Spanish-speakers. There is about 100% PTSD for Native American AODP clients.</p> <ul style="list-style-type: none"> • <u>Isolated older adults—especially in Gualala and Pt Arena</u> • <u>Spanish-speaking older adults across the board.</u> <p>What Services Are needed?</p>	<p>Who Would You Target? PREVENTION & EARLY INTERVENTION</p> <ul style="list-style-type: none"> • <u>Underserved cultural groups—Native Americans and Hispanics</u> • <u>Children and families in which there is a parent with dual diagnosis—and children may be removed</u> • <u>Jr. High and high-school-aged children who are being home-schooled.</u> At this age level they are often being homeschooled because they are not fitting in—often really a mental illness • <u>18-25-year olds—need programs</u>

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p>Crisis unit does 0-8 crisis assessments per day. They deal with people who need to be hospitalized as well as people coming out of the hospital. The ratio is about 3 clients coming out to 2 clients going into hospital.</p> <p>Crisis unit also does some on-phone service: assessing whether or not the crisis is really a mental health crisis or not, determining whether or not to hospitalize. They also provide rehab sessions for six weeks after hospitalization.</p> <p>Crisis team also supports Redwood Valley Board and Care nightly.</p>	<p>assistance with kids, to take pressure off.</p> <ul style="list-style-type: none"> • Drug and alcohol abuse • Cutting • Teen Pregnancy • STDs • Family dysfunction • Gang violence & vicarious violence • Suicidality • Depression • Anxiety • Aggression • Attachment & Relationship issues—including growing incidence of peer bullying through the internet. It allows distancing. Especially bad among girls at Pomolita and Eagle Peak. Need to get to these kids by 6th grade, teach empathy & 	<p>family. May be unwittingly contributing to mental health/behavior issues. This groups is also least able/inclined to come to training.</p> <p>What Services Would Help?</p> <ul style="list-style-type: none"> • <u>Behavior Intervention Support Services</u>—education and training of providers about how to utilize • <u>Child Find curriculum</u>—helps providers recognize and address a variety of special needs • <u>Net Program—assessment</u> • <u>NCO provides a training series</u> for 	<ul style="list-style-type: none"> • Culturally relevant interventions such as “<u>At home</u>” <u>program and supplemental counseling for Native Americans and Latinos</u> who are substance abusers and/or have dual diagnosis • <u>Coordinator and trainer for outreach workers & Sr. Peer counselors</u>—how to conduct screening for depression and other mental health issues • <u>Expansion of suicide prevention model utilizing Meals on Wheels drivers</u> to conduct screenings for depression —has United Way funding that could be 	<p>including residential programs for this age group. Many in this age group who should have dual diagnosis and be treated as such.</p> <ul style="list-style-type: none"> • <u>Kids in middle and high school with social anxiety from peer bullying through text messages and other means.</u> Kids with OCD, and <u>kids who come to health providers with other complaints</u>—like overweight or anorexia when underlying problem is depression and other mental health disorders. • <u>Children of homeless families in which there is mental illness or</u>

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p>Who Would You Target? <u>EARLY INTERVENTION</u> The person really needs to be hospitalized first to intervene effectively. Clients often don't believe they are mentally ill and are resistant to taking medications because of side effects, stigma etc. Families are in denial, fear etc.</p> <ul style="list-style-type: none"> • So...Would target <u>adult clients who have been hospitalized for first time. Typically older than TAY group or don't meet TAY's criteria</u> Typically these are people in early 20s to age 26 in men, or 21 to 25 in women. Often 	<p>empathy & communication.</p> <ul style="list-style-type: none"> • Homicidal thoughts • Bi-polar disorders • Personality disorders • Psychosis • Oppositional Defiance disorder • Eating Disorders • Runaways from other areas—often victims of abuse or trauma <p>What Services Are Needed?</p> <ul style="list-style-type: none"> • <u>Need school-based counselors again.</u> This allows counselors to observe the dynamics, build trust with the kids, and stop problems from becoming worse; It is a “natural setting” for both kids and parents: 	<p>new providers—<u>could include information about mental health issues and services.</u></p> <ul style="list-style-type: none"> • Any program for child care providers or parents they serve would have to be offered on <u>weekends or in the evenings</u>—may need to do on-site, in-home • Helps to provide <u>stipends/gift certificates</u> to get parents and providers to training • NCO used to provide outreach services to families and providers—funds have dwindled, so too have outreach services. Same is 	<p>leveraged also would continue the service when United Way funding is gone.</p> <ul style="list-style-type: none"> • <u>Spanish-speaking clinician and service providers</u> • <u>De-stigmatization efforts</u> for all older adults, but especially Spanish-speakers 	<p><u>dual diagnosis.</u></p> <ul style="list-style-type: none"> • <u>Children and adults in juvenile hall or jail</u> who have mental illnesses. • <u>Newly chronically unemployed</u>—recession is last straw <p>What Services Are Needed?</p> <ul style="list-style-type: none"> • <u>Outreach and information to underserved cultural groups</u> • <u>Outreach, assessment & services to home-schooled youth</u> • <u>Cognitive behavioral therapy</u>—short-term for Jr. High & High School suffering from social anxiety, OCD and some depressions

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p>this is not really the first break, because both clients and families dismiss symptoms and incidents and rationalize them in many ways.</p> <ul style="list-style-type: none"> • <u>Newly Incarcerated adults who are mentally ill</u> • <u>Dual Diagnosis Folks</u> Drugs—even marijuana—are a lot worse now and have especially negative effects on mentally ill. <p>What Services Are Needed?</p> <p><u>FOR NEWLY HOSPITALIZED:</u></p> <ul style="list-style-type: none"> • Outreach to hospital <i>before discharged</i> to home. 	<p>parents; Both Native Americans and Latinos resist availing themselves of therapy/counseling in the traditional settings of therapists' offices or Mental Health. More willing to access help at schools; Can do individual and small-group work at schools; use creative ways to engage kids—drama, games, peer counseling/helpers.</p> <ul style="list-style-type: none"> • <u>Need interagency providers group</u>—one step down from MPST—to share resources, collaborate on grants and service provision, address difficult cases and get help with solutions—especially 	<p>true of Health Advocate Program.</p> <ul style="list-style-type: none"> • Lake County offers “Health Hot Line”—Easter Seals is involved. • “Parent consent” gets in way of some referrals for developmental, mental health or behavioral health services. Therefore it is wise to provide child care providers with tools to use. • Napa County has Infant/Parent Mental Health Fellowship—for child care providers or mental health providers. \$1800. 		<ul style="list-style-type: none"> • <u>Cognitive therapy</u> for children of families in which there is mental illness or dual diagnosis • <u>Education/training of in-home health providers</u> to recognize and report mental health concerns they see in their clients • <u>A Mental Health counselor at or available to MPIC for unemployed.</u> • <u>Mental Health counselors at juvenile hall and jail.</u>

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p>Would provide a really good psycho-social program for clients and their families starting before they leave hospital. Need good support program for parents, peer and family support for clients and families. Need “tough love” training for parents, and clients, Educate them about disease and what to expect, what services are available, what meds do and side effects and how to deal with them. Peer support for both family members and clients.</p> <p>If clients were willing to talk about their illnesses, could be effective education/peer support.</p>	<p>essential with budget cuts.</p> <p>What Services Currently Exist? Youth Project Crisis is a “gateway” program serving kids age 11-18 plus their siblings in some cases, and parents. They do 24-hour crisis and short-term counseling (3-6 months) Then they send those who need more counseling to Mental Health. They often spend considerable time helping clients become eligible for longer-term services. Sometimes response to requests for services from Mental Health or Family Strengths is slow. Youth project sometimes is able to</p>			

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Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p><u>FOR INCARCERATED</u> They bounce in and out of jail. Would help to have a <i>Mental Health clinician at the jail again</i> to do really good discharge planning with these folks to keep them from being incarcerated again</p> <ul style="list-style-type: none"> ○ Medical follow-up ○ Housing ○ Get assessment and case manager ○ Help them obtain SSI or GA <p><u>FOR DUAL DIAGNOSIS</u></p> <ul style="list-style-type: none"> • Need collaboration with AODP to provide a good dual diagnosis group <i>to include</i> 	<p>continue services to a family if they have an additional crisis—because time-limits are per-crisis. Youth Project is connected to all schools, including South Valley, Clean & Sober Classroom, and they work with Probation as well. If they get the grant they've applied for, they'll be able to serve homeless youth again.</p> <ul style="list-style-type: none"> • Arbor on Main is becoming a great resource for Homeless youth and others. 			

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p><i>clinical staff as well as peer support.</i></p> <ul style="list-style-type: none"> • Would be good to have an <i>AOD clinician to plug into Crisis Unit</i> and Adult Mental Health Services in general for dual diagnosis clients <p><u>FOR PREVENTION:</u> Mendocino College has a “college coaching program” run by Catherine Rosoff—brief interventions with students referred by teachers usually. She assesses them and refers them to Mental Health and elsewhere for service. It would be good to <i>have a Catherine Rosoff-type service at high schools to catch kids younger.</i></p>				

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p><u>FOR ALL:</u></p> <ul style="list-style-type: none"> • Education for police and jail staff as well as the other agencies we work with about recognizing mental illness, what to expect, what is available—what types and degrees of help. <p>What Services Are currently Available?</p> <ul style="list-style-type: none"> • AVA—Art therapy program for Adult MH clients • Ukiah Park Board & Care • Manzanita Recovery Center (peer support only?) • Capable Mental Health staff, but no money for programs • College “Coaching” 				

EXHIBIT D-4
Focus Group/Consultation Input

MH Crisis Workers 6/18/09	Youth Project Crisis 6/18/09	NCO Resource & Referral Staff 6/30/09	OASOC Workgroup 7/7/09	Homeless Services Advisory Board 7/20/09
<p>program at Mendocino College—prevention/early intervention</p> <ul style="list-style-type: none"> • National Alliance for Mentally Ill (NAMI)—but have adversarial relationship with Mendocino County Mental Health, and not as aggressive on outreach as they could be. 				

**EXHIBIT D-5
Focus Group/Consultation Input**

Client Council 7/22/09	AAA Advisory Council— 8/6/09	ARCH 8/14/09	Pinoleville Pomo Nation Vocational Rehabilitation Program Staff 8/7/09
<p>PREVENTION/EARLY INTERVENTION</p> <p>Who would you target?</p> <ul style="list-style-type: none"> • <u>Homeless who have mental illness</u> • <u>Those in the midst of trauma</u>—child abuse, domestic violence, etc. • <u>Children of mentally ill parents</u> • <u>Individuals experiencing first break or early symptoms</u> • <u>Parents of children experiencing first break or early symptoms</u> • <u>Community</u>—first responders, local clinics, educators—existing structures within our community where info about mental illness and its signs are needed or from which it can be easily disseminated. 	<p>PREVENTION & EARLY INTERVENTION</p> <p>Who Would You Target?</p> <ul style="list-style-type: none"> • <u>Older adults with co-occurring disorders.</u> A person with dementia can still have treatable clinical depression, for example. However, the Alzheimer’s or dementia becomes the primary diagnosis precluding mental health services. • We could provide services for these patients to prevent PTSD, bi-polar disorder etc. • <u>Isolated older adults and/or those with unidentified mental illness.</u> Especially, single & homebound. Need to expand the Meals-on-wheels suicide prevention program because it constitutes an outreach 	<p><i>This consultation was held after the PEI Work Group had determined the need and populations to be addressed through PEI funds here. Therefore our conversation centered around strategies.</i></p> <p><u>Prevention/Early Intervention—Youth & Families</u></p> <ul style="list-style-type: none"> • Need a baseline curriculum at all schools that addresses mental health and suicide prevention. It could include topics that focus on key self-esteem issue such as body imaging. • Schools could offer peer groups or empowerment groups for kids that address issues such as their parents abusing substances, domestic violence, suicide, peer bullying, gender identity 	<p>Who would you target?</p> <p><u>PREVENTION & EARLY INTERVENTION</u></p> <p>Would focus on youth age 14 and up, but engage whole family. Substance abuse is a huge mental health issue, especially methamphetamine. We need to have programs that help individuals with dual diagnosis. Also kids are now using worse substances than in previous generations—prescription drugs, oxycotin, heroine as well as meth.</p> <p>Would like to expand current early intervention program wherein Pinoleville Vocational Rehabilitation goes into Juvenile Hall and works with kids in “talking circles” and afterward helps them get into residential treatment and other services.</p>

**EXHIBIT D-5
Focus Group/Consultation Input**

Client Council 7/22/09	AAA Advisory Council— 8/6/09	ARCH 8/14/09	Pinoleville Pomo Nation Vocational Rehabilitation Program Staff 8/7/09
<p>What Services Would Help?</p> <ul style="list-style-type: none"> • <u>Peer support (sponsors, mentors)</u>. Can take a variety of forms, but peer supporters need to be trained about how to do it effectively. Having peer support available during transports really helped. This approach could also help the children of mentally ill parents. These children may lack for friends because of the odd behavior of their parents. In addition, child is frightened and needs someone to explain what is happening, worried about having the same problem. • <u>Speakers Bureau</u>. As a way of educating both mentally ill and their families and community, first responders. Use people who have been 	<p>program to these older adults and can link them to services they would otherwise not access.</p> <ul style="list-style-type: none"> • <u>Widowers</u> few if any support groups for men whose spouses have died. • <u>Older Adults in general</u>. They currently comprise 22% of our population in Mendocino County, and their numbers will be growing substantially over the next decade. They are people with multiple losses from their own abilities and health to the loss of loved ones and friends=vulnerable to mental health issues • <u>Older adults with a housing crisis</u>—losing homes for various reasons. If housing issue can be resolved, hopelessness and depression can be 	<p>etc. The group would have to be named and operated in a way that would not stigmatize those attending. The group could include peer mentors. Engage Soroptimists or other service groups in providing college scholarships to kids who attend or become peer mentors.</p> <ul style="list-style-type: none"> • Utilize community health clinics for prevention. Girls go to these clinics for birth control. Many kids go for sports exams. These are occasions when the child is not accompanied by a parent. Nurse practitioners can ask kids key questions about their emotions, home lives and lifestyles. Are already equipped to do assessment of depression which can lead to other assessments. This could 	

EXHIBIT D-5
Focus Group/Consultation Input

Client Council 7/22/09	AAA Advisory Council— 8/6/09	ARCH 8/14/09	Pinoleville Pomo Nation Vocational Rehabilitation Program Staff 8/7/09
<p>through the illness to provide a human face and demonstrate that having mental illness doesn't mean you are scary, strange etc. Also offers hope to the victims and families.</p> <ul style="list-style-type: none"> • <u>Mental Health professional to accompany law enforcement</u>—when picking up a mentally ill individual. • <u>Crisis House</u> .—a safe place where people can go when they are on the edge and get motivated to get help—like the Light House in Clearlake. • <u>Education</u>. About the first signs of mental illness and where to go for help. This info needs to be broadly disseminated—parents, first responders, schools, clinics, children to some degree. 	<p>prevented.</p> <ul style="list-style-type: none"> • <u>Older adults in need of medication management</u>.—They are seeing them in emergency rooms because they haven't taken medication, or haven't taken it appropriately. Some have to choose between food and their medicines. Others forget to take it or fail to order it. <p>What Services are needed?</p> <ul style="list-style-type: none"> • <u>Need to de-couple mental health issues from other diagnoses</u>. Could provide mental health services that prevent or treat their mental health issues as well as their other problems. • <u>Expand and enhance the Meals on-Wheels Suicide Prevention Program</u>—train more volunteers to recognize mental health 	<p>provide gateway to peer groups or empowerment groups at the schools.— and to other services. Therapists at clinics could provide therapy for those kids who need it.</p> <ul style="list-style-type: none"> • Every community would need a place to send the children who needed support • High School-age kids need program that helps them learn how to deal with the realities of life—basic coping and life skills. Prevents anxiety and depression later on. • Prevention efforts for youth need to engage troubled parents. Need means to do this that does not single them out as deficient. Parents likely to get engaged around kids. Could be some kind of fun social event that includes 	

**EXHIBIT D-5
Focus Group/Consultation Input**

Client Council 7/22/09	AAA Advisory Council— 8/6/09	ARCH 8/14/09	Pinoleville Pomo Nation Vocational Rehabilitation Program Staff 8/7/09
<ul style="list-style-type: none"> • <u>Help immediately available at first break or early signs.</u> Individual who is experiencing this feels “at the bottom”. Need to provide them with role models, examples of people with mental illnesses who are doing well and making fabulous contributions. This also helps the parents and families of those with mental illness. Having this information at schools for kids will help <u>de-stigmatize mental illness in general.</u> • <u>De-stigmatization</u> Both ill individual and others need to see mental illness in the same way as diabetes. It is an illness that needs to be managed, and the individual with the illness needs to learn to manage their own illness. • Families and ill individuals 	<p>issues and who to refer to.</p> <ul style="list-style-type: none"> • <u>Increase Peer Counselors</u>—there is always a waiting list. They can be excellent primary prevention/early intervention resource. They are in the home and can see how older adults are living, vs. what they say. Trained to recognize mental health and medication mis-use or non-use issues. Peer counselors are trained in “wellness survey” and “depression scale”. • <u>Expand (or bring back) the Sr. Companion Program</u>—these companions can take seniors to medical appointments and other places that peer counselors can’t • <u>Expand and enhance Sr. Center Outreach</u> 	<p>information about mental health, suicide, substance abuse etc.,. (Chili Cook-off etc.)</p> <p><u>PREVENTION –OLDER ADULTS</u></p> <ul style="list-style-type: none"> • <u>Go to Senior Centers and Grange Meetings.</u> Seniors go to these places for free food and socialization and because they’re used to meeting there. These would be excellent venues for providing education and de-stigmatization information and suicide prevention information. Meals on Wheels does not reach everyone. <p><u>PREVENTION/EARLY INTERVENTION—OLDER ADULTS</u></p> <ul style="list-style-type: none"> • <u>Go to service groups such as the Sorooptimists & Lions Clubs</u> These are good venues for providing 	

**EXHIBIT D-5
Focus Group/Consultation Input**

Client Council 7/22/09	AAA Advisory Council— 8/6/09	ARCH 8/14/09	Pinoleville Pomo Nation Vocational Rehabilitation Program Staff 8/7/09
<p>need <u>communication skills training</u>. This needs to happen right away at first onset because typically communication has been poor for months before. NAMI has a curriculum which includes a communication module that could be used with the community at large. There is also a national expert on schizophrenia—Dan Fischer who has a compassion training module that helps people get a feel for what it is like to hear voices etc. It could be used for first responders.</p>	<p><u>programs</u>. Provide substantive training program so that current structure can be utilized more effectively—professional who oversees paraprofessionals who oversee and train a host of volunteers—built on food programs. This is low-cost, constant service to a fragile population. Could select the best outreach person at each senior center to train others.</p> <ul style="list-style-type: none"> • <u>In-home psychological, psychiatric services on the Coast</u>. Essential that the services be available in home as seniors will not got to Mental Health even if they are able. Also, home is “an open book”. The patients life situation is clear. • <u>Day Care Center at all Senior Centers</u> 	<p>education, suicide prevention and de-stigmatization efforts. Lots of Seniors participate. In addition, they might help fund some prevention or early intervention projects.</p> <ul style="list-style-type: none"> • <u>Check out Redwood Coast Medical Services</u>. They have a “Living Well” Program for seniors that includes assessments and interventions that are working. • <u>Establish a partnership in each community</u>—between Community Health Clinics and other service providers in that community. Need to conduct assessments that sort out the mental health vs. medical issues. Clinic would do that for the clients they already have, and then could provide many of the mental health services at the clinics. But 	

**EXHIBIT D-5
Focus Group/Consultation Input**

Client Council 7/22/09	AAA Advisory Council— 8/6/09	ARCH 8/14/09	Pinoleville Pomo Nation Vocational Rehabilitation Program Staff 8/7/09
	<ul style="list-style-type: none"> • <u>Service to manage the medications</u> of older adults who are unable to do so. This means helping them obtain their medications, organize them, use them appropriately, and remember to take them. Could contract with for a nurse to check on the medications of specifically identified clients. Can do this now through MSSP, but this is only for Medi-Cal patients who fit MSSP criteria. Could also set up a phone tree to remind forgetful patients to take their medications at right times. • <u>Training for GPs about psychiatric medications for seniors.</u> • <u>Service to coordinate with multiple physicians of seniors.</u> 	<p>people could also be referred or drop in for service in which case the clinics would need a link to refer the person for the appropriate service.</p> <ul style="list-style-type: none"> • Most Community Health Clinics already equipped to do assessments and all but Anderson Valley have mental health component. • Community health clinics reach all of the outlying areas of Mendocino County. They can't turn anyone away. They serve a large proportion of our population 	

EXHIBIT D-6
Additional Consultations For PEI

Supervisor's Support Group 6/9/09

- *Peter Burtis*
- *Marla*
- *Masha*
- *Rico*
- *Alex Bricken*

Who should be targeted?

- Kids with no Medi-Cal
- 26.5 kids—too few and too late. Need to get to kids showing behavior problems much earlier. Teachers need to be trained to recognize issues, and then have some kind of service to refer them to. Current after school programs are not enough.
- There are almost no services on the coast—1 TBS worker. Need to get to kids earlier.

Arbor on Main Youth Resource Center 6/9/09

- *Alese Jenkins*
- *Tawney Bailey*

Who should be targeted?

- Do NOT select foster youth—kids active to CWS or RCS. They get almost too many services.
- Problem is with kids who do not qualify for Medi-Cal and don't have other insurance or enough money to pay for the treatment they need—and they do have mental health needs,

What kinds of services are needed?

- Used to have an Area Casework Team—through Youth Project and MCOE. At schools—Jr High and High School—worked well and covered “300” and “600” kids and linked to ILS services. Had funding for both case management and direct services/activities.

**Teen Parent Programs—Adolescent Family Life Program through
Community Health Cheryl Newman**

Do teen parents get any kind of mental health service through this program? Any kind of education, counseling or peer support related to stress, depression, anxiety, domestic violence etc.?

AFLP case managers are public health nurses, and our clients psych-social needs are addressed through assessment and follow-up. They receive lots of education and active listening by the case manager, but if they need formal counseling services, we refer them to a therapist. The AFLP clients who attend

Mendocino County, MHSA Prevention & Early Intervention Component of the Three-Year
Program Expenditure Plan

EXHIBIT D-6
Additional Consultations For PEI

the Young Parent Program receive group counseling each week, which can include “peer support”. Domestic violence and its effects on the brain development of our clients’ children is covered in depth. YPP students also get education from Project Sanctuary staff periodically.

Do you think there are teens falling through the cracks in our county?

Definitely. Clients under 18 are usually NOT referred to the Mental Health Department because of the requirement that parents have to give their permission. Our clients often do not have parents who care or who are cooperative with “agencies” unless they are forced to be. If there is CPS involvement, often our clients get needed counseling without difficulty. It’s the clients who are pretty much struggling on their own with little support or resources who can fall through the cracks or have a delay in getting needed mental health services. They have Medi-Cal if pregnant, but if it’s the Father of the child, he may not have that coverage. We frequently refer to MCYP/Redwood Counseling Services and to therapists via Hillside Health Center, Mendocino Coast Clinic and sometimes via Project Sanctuary and Nuestra Casa. I personally have never had a client who could access a therapist unless payment is through Medi-Cal or free. My clients in Anderson Valley have good access to the school psychologist –IF they are in school.

Depression is a significant issue for our young moms. A 20-year-old AFLP and later Cal-Learn client recently committed suicide.

Cal-Learn Program—Lynn McGuire, SW III 7/2/09

Do Cal-Learn teen parents get any kind of mental health service through the program? Any counseling, education, or peer support related to stress, depression, domestic violence etc?

Nothing like that is offered directly through Cal-Learn. All done through referrals. Cal-Learn participants who attend the Young Parent Program at Ukiah High do get on-site weekly group counseling and domestic violence education.

Do you think there are teen parents falling through the cracks in terms of mental health services in our county? Who?

I think many teens fall into a gaping hole of lack of mental health services in our county. They are so stressed with trying to get to school and doctor appointments and Social Services and WIC and so on. They mostly don’t have cars. Homelessness is going up while TANF is decreasing. Most have lived in domestic violence situations growing up, and many have been victims of sexual abuse

EXHIBIT D-6
Additional Consultations For PEI

What would you say are the significant mental health issues of the teen parents you work with?

Depression and stress. Mostly undiagnosed and untreated. . In the last 6 months alone, one girl made a very serious suicide attempt and another Cal-Learn girl, barely 20 years old, killed herself. More and more, cutting is disclosed when I do a beginning assessment.

How prevalent are these issues?

I can only guess, but I'd say at least half

About how many teens do you serve at any given time?

In the past 12 months, anywhere from 24 to 34 teens in a month.

Pinoleville Vocational Rehabilitation Program

Vaughn Pena & Dino Franklin

Who would you target?

Youth aged 14 and up, and their whole families

Seeing lots more substance abuse with more problematic drugs—meth and prescription drugs, and heroine. Some youth and adults retaining psychotic symptoms after stopping their use.

Dual diagnosis folks.

In American Indian community there is a lot of ingrained PTSD.

EXHIBIT E

Mendocino County Mental Health could receive as much as \$692,000 in Prevention and Early Intervention funds over a three-year period. The funds are intended for the prevention of, or early intervention in mental illness.

For the purposes of these funds, “prevention” means prior to a mental health diagnosis. “Early intervention” means very early in the manifestation of a serious mental illness.

We are in the process of developing a needs assessment which will lead to the development of a three-year plan for the most effective use of these funds in our county. We need:

- ***Your help*** in identifying the populations in need of prevention and early intervention services;
- ***Your knowledge*** of services currently available to serve them; and
- ***Your ideas*** about services that could address their mental health needs,

The attached brief survey consists of two pages—one for prevention services and one for early intervention services.

Would you please complete the survey and return it to:

Jill Singleton

Mendocino County Health & Human Services Agency

Children & Family Services Branch

727 South State Street

Ukiah, CA 95482

467-6016 or 463-7929

singletj@co.mendocino.ca.us or

singletonj@mcdss.org

EXHIBIT E

THANK YOU!

PEI Survey

Prevention Services

1. If you could target a group or groups of people to receive **prevention** services for mental health in our county, what group(s) would that be? (for example, age group, gender, region, ethnicity, and so on.)
2. What is your estimate of the number of people in this group, or groups?
3. What are the mental health issues you perceive in them?
4. Do you know of existing services or programs in our county that address any of their needs now? What are they?
5. What kinds of service(s) and program(s) do you think would help them?

EXHIBIT E

Early Intervention Services

1. If you could target a group or groups of people to receive **early intervention services** for mental health in our county, what group(s) would that be? (for example, age group, gender, region, ethnicity, and so on.)
2. What is your estimate of the number of people in this group, or groups?
3. What are the mental health issues you perceive in them?
4. Do you know of existing services or programs in our county that address any of their needs now? What are they?
5. What kinds of service(s) and program(s) do you think would help them?

Exhibit F
SURVEY RESPONSES
Agency Advisory Board

Who would you target? (Prevention or Early Intervention)

- Children prior to age 7—or wherever your clinical research indicates prevention works
- Primary care providers—countywide. ARCH clinics care for 43,000 residents—about 42% of the total population.
- Homeless patients—those in shelters—
- Low socio-economic status; all adult CMSP and Medi-Cal patients

(PREVENTION ONLY)

- School-aged children
- Children and young families
- Community-based FRCs
- Teens
- Foster children

(EARLY INTERVENTION ONLY)

- jail population
- Children
- Young adults
- Youth

What are the mental health issues you see?

- School-aged children—ADHD, OCD, Depression, Anxiety
- Poor parenting skills and low self-esteem in kids
- Lack of communication skills
- Exposure to drugs and alcohol
- Homeless in shelters
Many suffer from conditions that require meds that they are incapable of managing
- CMSP & Medi-Cal patients
Depression, anxiety, personality disorders, alcoholism

What kinds of services do you think would help?

(PREVENTION OR EARLY INTERVENTION)

- Geographic parity. If this is truly a countywide project, make it countywide
- Pick one or two priorities and do them well. Don't dilute this.
- Parenting
- Self-esteem building
- Communication building
- Identification of early mental health issues
- Building resiliency, i.e., 40 developmental assets
- Summer school programs
- Homeless in shelters
Same-day visit with psych MD to start/change meds

Exhibit F
SURVEY RESPONSES

If a worker could be assigned to them to get them to appointments and get them their meds, it would prevent a tremendous number of visits to ER, jail, etc.

- CSMP & Medi-Cal patients
Inpatient services; psychiatry services

(PREVENTION ONLY)

- Basic evaluation of risk for mental health issues on an annual basis and appropriate treatment
- Use an assessment tool for each 7-year-old and then annually thereafter, and then make a treatment plan.
- Education in school—de-stigmatization of mental health by comparing it to physical health

(EARLY INTERVENTION)

- Jail population—rehab and coping strategies

What programs/services already exist?

(PREVENTION & EARLY INTERVENTION)

- All ARCH health centers, countywide
- Drug Court
- Community Resource Centers
- Manzanita Services
- Preschool Programs
- Raise & Shine
- Homeless
Buddy Eller Center, Ford Street, AODP
- Medi-Cal, CSMP patients
Court, Mental Health

(PREVENTION ONLY)

- Raise and Shine

(EARLY INTERVENTION ONLY)

Exhibit F SURVEY RESPONSES

ORGANIZATIONAL PROVIDERS AND INDIVIDUALS UNDER CONTRACT TO MENTAL HEALTH

Who would you target?

(PREVENTION OR EARLY INTERVENTION)

- All middle school children and high school students
- Children pre-school to 6th grade
- Teenagers—males and females
- Adolescents, children, single parents
- Children & adolescents
- Caregivers of individuals with recent injuries or health crises
- Latino, Native American and low income families.
- Families with substance abuse issues

(PREVENTION ONLY)

- All children 4th-12th grade
- Caregivers of the chronic, long-term ill (example: caregiver for Alzheimer's client), cross-gender
- Dual diagnosis clients
- Parents of children who have been abused
- Women survivors of sexual molest
- Men survivors of sexual molest
- Children who have been molested
- Disability group
- Pain Group
- Latency age youth 10-13
- Tribal youth, youth in out-of-home placement or at risk of out of home placement

(EARLY INTERVENTION ONLY)

- Teen agers who are using alcohol or drugs
- Children acting out at school
- Young children "Pre-tween"
- All 0-5 whether they have Medi-Cal or not

What are the mental health issues you see?

- Children 4th-12th grade—PTSD from child abuse/domestic violence, alcohol and drug abuse, sexual orientation issues.
- Middle school children and high school students—PTSD, depression, thought disorder, alcohol and drug abuse, gender dysphoria
- Children pre-school-6th grade—Early exposure to various traumas, mental health risks for poor school adjustment and drop-out

Exhibit F SURVEY RESPONSES

- Teen-agers, males and females—substance abuse, violence, family dysfunction
- Adolescents, children, single parents—anxiety, PTSD, depression
- Caregivers of chronic, long-term ill—Severe depression, severe stress, suicidal ideation, grief/loss issues, anger management, feelings of incompetency.
- Children & adolescents—Substance abuse, the beginning signs of bipolar, schizophrenia
- Families and caregivers of people with recent injuries & health crises—Stress, dysfunctional relationships
- Young children, pre-tween—Bullying, exposure to drugs, precocious sexuality
- Latency-age youth, tribal youth, youth in out-of-home placement or at risk of out-of-home placement—Anxiety, depression, eating disorders, substance use, learning disabilities.
- All 0-5, Medi-Cal or not-- At risk for socio-educational disorders due to low SES, domestic violence, substance use in family and separation/divorce.
- Latino, Native American, and low income families with substance abuse issues—Substance abuse, PTSD, domestic violence, child abuse, general conflict

Do you know of existing services or programs in our county that address any of their needs now?

- Children pre-school to 6th grade—GRIP (gang prevention), Second Step (violence prevention)
- Adolescents, children, --RCS/CTS, Tapestry
- Caregivers of Chronic, long-term ill, dual diagnosis clients, parents of children who have been abused—only Redwood Caregivers and it isn't enough
- Pain Issues—Mendocino Coast Clinic sometimes addresses pain issues
- Families and caregivers of people with recent injuries and health crises—In-Home Services—need training and more funding
- Young children, pre-tween—in-school psychological services
- Latency-age youth 10-13, tribal youth, youth in out-of-home placement or at risk thereof—Tribal youth are largely under-served as a whole. There is unequal access to services depending on tribal registry; high rate of stigma & social consequences for those who seek help.
- All 0-5 Medi-Cal or not-- Our divorce mediation services are scant, but they could be a referral source for early intervention services for kids whose families are in the divorce/separation/custody process.

What kinds of services do you think would help?

- Children 4th-12th grade—Supportive one-on-one counseling; small group psycho-educational material; large groups; school-site counseling.

Exhibit F
SURVEY RESPONSES

- Children pre-school to 6th grade—Prevention education based on substance abuse, bullying, domestic violence, molestation, gang prevention; PIP (Primary Intervention Programs), Second Step.
- Teenagers, males and females—Activity programs, groups, individual therapy for severe.
- Adolescents, children, single parents—Children: groups, play activities, after school programs. Adults: Child care for single parents; support groups for single parents.
- Caregivers of chronic, long-term ill; dual diagnosis clients; parents of children who have been abused—Respite, support groups, psychotherapy, parallel education groups.
- Women & men survivors of sexual molest; children who have been molested; disability group; Pain group—Groups for each weekly.
- Teenagers using alcohol or drugs; children acting out at school—On-going support groups.
- Children & adolescents—individual and group therapy
- Families and caregivers of people with recent injuries and health crises—LMFT assessment, supplement(?) & counseling.
- Young children, pre-tween—More classroom assistants for Behavior Plans, more screening and assessment, observation, mediation, coordination between systems of care.
- Latency age youth 10-13, tribal youth, youth in out-of-home placement or at risk thereof—Culturally relevant, experientially-based outpatient services that incorporate mentoring which can *continue* after “services” have terminated; Equine-facilitated psycho-therapy.
- All 0-5, Medi-Cal or not—Parents United; Equine-facilitated psychotherapy.
- Latino, Native American and low-income families; families with substance abuse issues—Triple P, Healthy Start, parenting classes, Non-violent Communication, culturally sensitive interventions, skill-building, reconnection to other than human world, child development education, support.

Exhibit F SURVEY RESPONSES

MISCELLANEOUS SURVEYS—NO NAME OR AGENCY GIVEN

Who would you target?

(PREVENTION OR EARLY INTERVENTION)

- Youth age 5-13 who are children of alcoholics/drug abusers
- Children & teens with loss/grief/bereavement issues
- Children and teens who have been sexually molested or abused
- Children & teens who have experienced domestic violence in their family
- Families with children 0-5, minorities, low socio-economic status, both genders, in south coast and round valley
- Children with no health insurance in Laytonville and Covelo
-

(PREVENTION ONLY)

- Parents of young children on autism spectrum, with non-verbal learning disability, ADHD.
- Children whose parents are in prison/jail, are orphans, whose parents have lost parental rights, and children who are below grade-level in school.
- Children and young adults.
- Individuals in Adult Drug Court, Juvenile Drug Court, and Family Dependency Drug Court.
- Those experiencing acute economic hardship whether it be due to divorce or separation, reduced benefits, job loss or reduced hours, particularly those facing bankruptcy, eviction foreclosure.
- Many of those using homeless services—mainly males between the ages of 25-40, not to exclude other groups.
- I work with older adults (60+) with an axis I mental health diagnosis. Therefore I am most familiar with this population, and am aware of the growing need for supportive prevention services for this age group....Although I think that these prevention services...are needed in all regions of the county, the outlying areas are of a concern due to the obvious lack of available services, transportation etc. Prevention services need to be designed ...with a variety of ethnic and cultural differences in mind.

(EARLY INTERVENTION ONLY)

- Middle school-aged youth on the coast
- Girls 12-15
- Persons of all ages with known family histories of mental health problems
- Those who show up in our community without a support system (like local family or friends) They often show up as guests of the shelter first.
- Older adults with axis 1 mental health diagnosis, especially in outlying areas—growing numbers

Exhibit F SURVEY RESPONSES

What are the mental health issues you see?

(PREVENTION OR EARLY INTERVENTION)

- Parents of young children in autism spectrum etc
Parents without special skills will promote anxiety and other disorders which are disabling for the youth. These maladaptations hinder the youth's ability to individuate.
- Middle School-aged youth on the coast
Self-medication, combined mental health/AODP suite of services.
- Youth age 5-13 who are children of alcoholics/drug abusers
Need to develop healthy coping skills
- Children/teens w/loss/grief/bereavement
Understand the issues related to the illness, experience, family dynamics
- Children/teens who have been molested/sexually abused
Normalize feelings

(PREVENTION ONLY)

- Families with children preschool age or younger/low socio-economic status
Anxiety, depression, trauma, psychosis, uncertainty in getting basic needs met, which is the foundation for higher needs being met, isolation.
- Children with no health insurance
Need for counseling, case management, wraparound services and support groups for parents.
- Children whose parents are in prison/jail, are orphans, whose parents have lost parental rights, and children who are below grade-level in school.
Agitation/depression
- Children and young adults
Anxiety; depression; & stressors related to relationships with parents, peers and other adults; inadequate coping skills.
- Individuals in Adult Drug Court, Juvenile Drug Court, and Family Dependency Drug Court
The whole range
- Those experiencing acute economic hardship whether it be due to divorce or separation, reduced benefits, job loss or reduced hours, particularly those facing bankruptcy, eviction foreclosure
Many people faced with divorce, job loss, foreclosure, find themselves in a position they never thought they would be in. I think the stress of this situation could be overwhelming for some people, probably resulting in a range of issues.
- Many of those using homeless services
Untreated conditions that are exacerbated by poor diets and lack of preventative care.
- Older adults

Exhibit F SURVEY RESPONSES

Axis I Mental Health diagnosis
(EARLY INTERVENTION ONLY)

- Families with children preschool age or younger/low socio-economic status—South Coast & Round Valley
Isolation, depression, anxiety, psychosis
- Girls 12-15
Extreme emotions, hyper-sensitivity
- Older Adults
Depression, stress, anxiety

Do you know of existing services or programs in our county that address any of their needs?

(PREVENTION OR EARLY INTERVENTION)

- Families with children preschool age or younger/low socio-economic status
First 5 of Mendocino

(PREVENTION ONLY)

- Children with no health insurance in Laytonville and Covelo
Family Connections; Wraparound/Family Strengths; First 5 Mendocino
- Children whose parents are in prison/jail, are orphans, whose parents have lost parental rights, and children who are below grade-level in school.
Mental Health Branch
- Children and young adults
School-based programs such as peer-to-peer, group and individual counseling and socialization such as Kids Clubs
- Many of those using homeless services
Yes. Homeless staff work closely with County Mental Health.
- Older Adults
Community Care-MSSP and Senior Referral Services, Senior Center Outreach and transportation services, MOWs, MCHHSA—Older Adult System of Care (case mgt, in-home therapy and Senior Peer Counselors), In-Home Support Services, and Adult Protective Services.

(EARLY INTERVENTION ONLY)

- Middle school-aged youth on the coast
I believe that AOD has a grant that may cover some of the AOD issues
- Those who show up in our community without a support system (like local family or friends)
Yes Homeless staff work closely with County Mental Health
- Older Adults
Community Care-MSSP and Senior Referral Services, Senior Center Outreach and transportation services, MOWS, MCHHSA-Older Adult System of Care (case management, in-home therapy and Senior Peer Counselors), In-Home Supportive Services, and Adult Protective Services.

Exhibit F SURVEY RESPONSES

What kinds of services do you think would help?

(PREVENTION OR EARLY INTERVENTION)

- Youth age 5-13 who are children of alcoholics/drug abusers
Al-anon-type support & education
- Children/teens w/loss/grief/bereavement
Time-limited groups, 6-8 weeks; educate care-givers and education providers (teachers, medical personnel, social workers etc.) Have a referral system that is easy! Not complicated
- Children and teens who have been sexually molested or abused
Time-limited groups; educate care-givers and education providers (teachers, medical personnel, social workers etc.) Have a referral system that is easy! Not complicated
- Children & teens who have experienced domestic violence in their family
Time-limited groups; educate care-givers and education providers (teachers, medical personnel, social workers etc.) Have a referral system that is easy! Not complicated.

(PREVENTION ONLY)

- Parents of young children on autism spectrum, with non-verbal learning disability, ADHD
Expanded Triple P; In-home support; Collaboration w/schools, MCOE (behavior specialists)
- Families with children preschool age or younger/low socio-economic status
Education; support; some kind of process (wraparound?) to identify and access resources—both natural and programmatic—that minimize risk factors.
- Children whose parents are in prison/jail, are orphans, whose parents have lost parental rights, and children who are below grade-level in school
After school and weekend programs
- Children and young adults
Information and referral to mental health assessments; individual and group counseling programs that improve socialization skills, and drop-in services and respite for caregivers. A program that will improve socialization could include work/employment opportunities in a controlled setting. It might also include participation in community events.
- Individuals in Adult Drug Court, Juvenile Drug Court, and Family Dependency Drug Court
Assign Mental Health workers to each Drug Court Team. Screen all participants during phase 1.
- Those experiencing acute economic hardship whether it be due to divorce or separation, reduced benefits, job loss or reduced hours, particularly those facing bankruptcy, eviction foreclosure.

Exhibit F SURVEY RESPONSES

Maybe a combination of crisis and financial counseling; help in adjusting to the new realities of their lives and making the best choices.

- Older Adults
Programs that address medical and mental health needs, isolation, transportation, and assistance with ADLS/IADLS. Existing programs that could use expansion with increasing need are; Senior Center Outreach Programs, Senior Transit, Adult Day Health Programs, MOWs, all OASOC programs, Senior Companions, IHSS and other affordable services for assistance with ADLS/IADLS, MSSP services, affordable housing programs for seniors.

(EARLY INTERVENTION ONLY)

- Middle school-aged youth on the coast
Combined Mental Health/AOD services that include education, recovery, family and individual counseling.
- Families with children preschool age or younger/low socio-economic status—South Coast & Round Valley
Education; support; some kind of process (wraparound?) to identify and access resources—both natural and programmatic—that minimize risk factors.
- Girls 12-15
Parent support groups and parenting skills
- Persons of all ages with known family histories of mental health problems
Access to assessments including applications to funding sources such as Medi-Cal, and a way to pay for assessments and treatment for CSMP clients.
- Those who show up in our community without a support system (like local family or friends)
Better coordination between relevant services that will better address medications and then basic needs while recovering,
- Older Adults
Programs that address medical and mental health needs, isolation, transportation and assistance with ADLS/IADLS. Existing programs that could use expansion with increasing need are: Senior Center Outreach programs, Senior Transit, Adult Day Health Programs, MOWs, all OASOC programs, Senior Companions, IHSS and other affordable services for assistance with ADLS/IADLS, MSSP services, affordable housing programs for seniors.

Exhibit F SURVEY RESPONSES

Eileen Bostwick

(PREVENTION OR EARLY INTERVENTION)

Who would you target?

Older adults. Often they are reluctant to participate in these types of activities, and even if they are aware of services, due to isolation, attitude, and transportation obstacles, they may not be able to participate.

What are the mental health issues you perceive?

Depression is one that I observe most frequently. Suicide is a concern in this population. Stress and anxiety are also observed. Drug abuse, especially with alcohol occurs with many of the individuals we see. Statistics have shown that females seek out treatment less often for themselves, and that they obtain care for others for whom they provide care. Limited counseling services are available for older adults, especially if the individuals are covered by Medi-Care, or don't have health care coverage at all.

Do you know of existing services that address any of their needs now?

For depression I am not aware of resources besides seeing a medical doctor or therapist which is expensive for low-income adults. For drug abuse, a number of programs exist, like Alcoholics Anonymous, however, in my experience, many older adults do not admit they have this problem.

What kinds of services do you think would help?

Outreach is important. Expanding services like the Senior Companion Program, In-Home Health Services, Friendly Visitors and Senior Peer Counselors could assist individuals who are isolated. Social interaction is very important for many older adults. Transportation services need to be expanded to serve those off main transportation routes or those who live further away from senior centers or other services.

MARY BUCKLEY, PLOWSHARES EXECUTIVE DIRECTOR

(PREVENTION ONLY)

Who would you target?

Children as young as possible, in formative years—especially children of homeless, displaced, mentally ill and addicted persons.

What are the mental health issues you perceive?

Lack of physical health support damages emotional and mental health. Lack of parenting skill and support teaches destructive behaviors. Family crises instill fear, anxiety, and often inappropriate coping mechanisms.

Do you know of existing services that address any of their needs now?

The Family Center, First 5 Mendocino, The Youth Project, Boys & Girls Club, Big Brother/Big Sisters and various school programs.

What kinds of services do you think would help?

Prevention at early ages would consist of behaviors that encourage physical, mental and emotional health: Exercise, good nutrition, music, art and useful

Exhibit F
SURVEY RESPONSES

work-related skills all contribute to a sense of self-esteem. Parenting classes would be extremely helpful in teaching parents to be supportive and nurturing instead of reinforcing family patterns.

MORGAN ZEITLER, SECTOR SUPERINTENDENT, CALIFORNIA

STATE PARKS, MENDOCINO DISTRICT OFFICE

(PREVENTION ONLY)

Who would you target?

- Under-served populations. Mendocino County has a large transient population of campers, homeless, substance-abusers, members of the illicit drug industry, itinerant labor and others drawn to the region by its free-spirit reputation.

What are the mental health issues you perceive?

- While many or most of the encounters park employees have are people with existing problems, some are no doubt in the early stages of turning to substance abuse to escape the beginnings of mental instability. Others may experience acute episodes brought on by a traumatic experience or by a host of issues associated with travel to new places. I'm guessing here, but we see a fair amount of odd or extreme behavior. Since these people are mobile, are camping, or otherwise living outdoors, I think a lot of them fall through the cracks. The recent suicide by an alleged undocumented marijuana garden laborer in south county is a case in point.

What services do you think would help?

- State Parks would appreciate any flyers, posters or other means of informing persons who may need help coping with their circumstances about how to find local MH help.
- A gutsy thing would be to hire outreach staff to physically seek out people living under bridges, in bushes, and on the streets and make sure they are aware of services.

CATHY OUELLETTE, ELEMENTARY SCHOOL TEACHER, FRANK ZEEK

ELEMENTARY SCHOOL, UKIAH

(PREVENTION ONLY)

Who would you target?

- Elementary-school-aged children

What are the mental health issues you perceive?

- Various emotional and behavioral issues of concern, but about which the teacher has insufficient expertise to resolve.

What services do you think would help?

Exhibit F
SURVEY RESPONSES

- Put a contracted therapist in the schools as a resource to teachers for classroom behavioral issues. This person could come into the classroom and have their eyes on a child during the regular day, and give feedback to the teacher as to the best way to help this child within the classroom setting. The therapist could also attend CARE Team meetings if needed.
- A referral process could be developed, and the plan could start small—such as one school or maybe two until you see what the demand for these services will be.

PHYLLIS BLUESTEIN, ELEMENTARY SCHOOL TEACHER

(PREVENTION AND EARLY INTERVENTION)

Who would you target?

Children as young as 5, 6 & 7 years old are already demonstrating emotional problems which prohibit them from giving their all in the classroom. Many parents are reluctant or just refuse to believe that their children have issues until they have been hearing about them for a few years.

What are the mental health issues you perceive?

They are affected emotionally by issues of abandonment, neglect and inconsistencies in their daily lives. Afraid, nervous, oppositional and unmotivated. Some have no sense of boundaries or social norms. Some are starving for attention or a sense of structure in which to function safely.

Do you know of existing services that address any of their needs now?

- Some children with severe issues which have been identified over time have had the opportunity to receive counseling services. At my school there is one MFT who comes over one or two times per week to work with such children. Other children receive services as a result of an IEP..
- Tapestry, Redwood Children's Services, Nuestra Casa, Raise and Shine, Mental Health Services or Crisis Unit in severe instances.

What do you think would help?

- I would love to see counseling done with individual children from a licensed professional therapist who is able to work with children. That may not be possible without the consent of parents. In that light, it sure would be great for a licensed professional to observe students who are at risk, and advise teachers on how to deal with their issues.
- A great need for parent education which focuses on what parents need to do to help their children succeed in school and life—an ongoing training which provides them with an opportunity to put what they learn into action, and get feedback—and that helps them address issues for children of varying ages.

KELLEY LABUS, SCHOOL PSYCHOLOGIST, ORR CREEK SCHOOL

**Exhibit F
SURVEY RESPONSES**

(EARLY INTERVENTION ONLY)

Who would you target?

- Students with emotional disturbance from kindergarten through early elementary school grades

What do you think would help?

- Some of my early training as a school psychologist was in the PIP grant program. Though these programs have ended, there is a lot of research to show that programs such as this are effective.

MARTINA, NEW MORNING MONTESSORI

(PREVENTION OR EARLY INTERVENTION)

Who would you target?

- Pre-school children demonstrating emotional/behavioral issues

What do you think would help?

- I would love for there to be a service that preschool teachers could make use of that would enable there to be a person to come and observe children with behavior issues in the classroom. Depending on their assessment and evaluation, we could then make a referral to mental health. Preschool teachers are not taken seriously, nor are we qualified to make a diagnosis. We need a person to be able to meet with us, and the parent to facilitate a referral if necessary.

**MICHAEL MABANGLO, LCSW, PhD, BEHAVIORAL HEALTH DIRECTOR,
MCHC UKIAH**

(PREVENTION ONLY)

Who would you target?

- Patients of primary care providers. Because primary care provides one of the first lines of intervention for people experiencing mental health issues, we believe a successful community effort at preventing the sequelae of mental illness should target primary care.

What is your estimate of the number of people in this group?

- 536

What are the mental health issues you perceive?

- Anxiety, Depression, PTSD, Alcohol/Substance Use Disorders, ADHD, Conduct Disorders, Bi-polar, Schizophrenia

Do you know of existing services or programs that address any of their needs?

- Licensed professional level: At Home for PTSD/Substance abuse with our counselors coordinated with AODP

Exhibit F
SURVEY RESPONSES

- We will be starting a session-limited Depression/Anxiety Class 9/1/09. We have implemented components of a Project Impact model over the last 4 years.
- Manzanita, NAMI, 12-step, Triple P

What do you think would help?

- Expanded Manzanita, NAMI, 12-step and Triple P plus having a person such as Rob Henderson, the Clinic Services Specialist who is a CMH employee but stationed at our clinics, is a model pilot program worth expanding.
- Because County Mental Health can be a stigmatizing place to receive services, I suggest Community-based organizations, schools, and health clinics are the site for interventions.

(EARLY INTERVENTION)

Who would you target?

- Individuals at early onset of a mental illness who are seen by both a medical provider and one of our licensed clinical mental health clinicians.

What is your estimate of the number of people in this group?

- 441

What are the mental health issues you perceive?

- Anxiety, Depression, PTSD, Alcohol/Substance Use Disorders, ADHD, Conduct Disorders, Bi-polar, Schizophrenia

What kinds of programs and services do you think would help?

- SPMI populations die 25 years earlier than non-clinical populations. Model programs already exist which target other chronic health conditions. Essential components for [such a program for SPMI] include: coordination with medical providers who are familiar with the needs of SPMI populations, electronic registries to monitor progress, clear outcome measures, case management, counseling, group interventions, and cross-system coordination.
- Our clinics have most of these components, and are targeting this as part of our interventions in the coming year. If we had true HHS coordination and resources, our outcomes would be maximized.

Exhibit F SURVEY RESPONSES

TOPICS IN RECOVERY GROUP, MANZANITA RECOVERY SERVICES7/09 (PREVENTION ONLY)

Who would you target?

- The earlier you start prevention, the earlier issues will be exposed—preschool-age; 11-18. Families are too dysfunctional—need to share issues in a “safe” setting (school, Project Sanctuary etc.)
- Older adults—organizations and families need to be educated about Mental Health issues
- Education needs to be cross-culturally informed.
- Homeless children and families—and/or children and families with a family member who is incarcerated or in a mental institution.
- AOD families and families of people with co-occurring issues.
- LGBTQ people—cross-cultural competency needed.

What are the mental health issues you perceive?

- Trauma from discrimination, profiling, stigmatization, objectification
- Suicidality
- PTSD
- Depression
- Bi-polar
- Phobias
- Issues around medications
- Schizophrenia
- Multiple personalities
- Homicidality
- Alzheimers
- Dementia
- Amnesia
- Aphasia

Do you know of existing services or programs that address any of their needs?

- Manzanita Recovery Services—Ukiah & Willits
 - Resource center
 - Peer support
 - Groups—Living Skills, art, music, WRAP, socializing, taking care of business & Ourselves, services for homeless, housing etc
- Mental Health
 - Crisis services
 - Medication support
 - Diagnosis for medication support
 - Patient Rights Advocate
- Social Services

Exhibit F SURVEY RESPONSES

- CMSP
- Food stamps
- GA
- IHSS
- Mendocino Works
- CPS
- APS
- TANF
- Clinics
 - Medical support; dental
 - Behavioral health, psychotherapy
 - Pharmacy meds
 - Women's Health—Care for Her
 - HIV & HEP C testing
- MCCAVN
 - HIV, HEP C testing
 - Needle exchange
 - Medicinal Marijuana support
 - GLAM, young people's group
 - Shelter Plus Housing
 - Free shoes and socks
- Community Center
 - Supports homeless, Shelter Plus, collaborates with the shelter, food bank, Manzanita.
 - People can get mail, payee drop-off, telephone, hang out, food in the AM, Case management for homeless, loans for bills, deposits by referral.
- Project Sanctuary
 - Safe house, transitional house
 - Groups: anger management, women's empowerment; Women molested as children
 - Individual & family counseling; legal consultant—help with restraining orders.
- Shelter, Buddy Eller
 - Dinner on weekends
 - Showers
 - Beds for men, women & children; pets allowed with license & shots
- Plowshares
 - Lunch and dinner
 - Laundry & laundry soap
 - Vouchers
 - Dog and cat food
- Ford Street
 - AOD residential and outpatient services
- UVA
 - Services for disabled, dually diagnosed, developmentally delayed

Exhibit F SURVEY RESPONSES

- Consolidated Tribal Health
 - Medical & behavioral health for Native Americans
- Nuestra Casa
 - Supports Hispanic community
- Veterans Services
- PFLAG
- Senior Centers

What do you think would help?

- More peer support with train-the-trainers by clients who have “been there”.
- Trauma-informed training—cross training with police services
- Safe affordable housing for mentally ill—with choice of types including boarding house type
- Centralized one-stop center
- Children’s services evaluations as soon as possible
- “Looking at You 2000”
- Intergenerational support groups for various issues
- Money-making activities that mentally ill coordinate and participate in: art gallery, café, cottage industries; Animal/pet support: Vet visits, doggie day care, play are and training
- Group rates for physical exercise programs
- Opportunities to give back to the community
- Certificate program to train people to provide specialized peer support
 - Sitting with clients at crisis hospital
 - IHSS services to peers and others
- Intercommunications between all agencies to be all on the same page.

TOPICS IN RECOVERY GROUP, MANZANITA RECOVERY SERVICES, 8/09 (EARLY INTERVENTION)

Who would you target?

- People in domestic violence situations
- MH clients coming out of hospital or Board & Care who come back to their original county
- Those with challenging mental health issues need support before it becomes a crisis—and the support needs to be in a safe place, more restrictive environment.
- Homeless population needs support in stabilizing so they don’t go into crisis
- People in recovery AOD/Mental Health co-occurring issues

Need for culturally competent services for all age groups—ethnicity and other cultural differences and approaches—such as involving the whole family not just the individual.

What are the mental health issues you perceive?

Exhibit F
SURVEY RESPONSES

- AOD psychosis & impairment due to drug use or any use of hard drugs and hallucinogens
- Wet Brain, Fetal Alcohol Syndrome, along with learning disabilities such as ADD, ADHD, Dyslexia, Cognitive disabilities
- Disabilities due to trauma; PTSD

What do you think would help?

- Transportation to services in larger communities
- Services in outlying communities
- Peer support centers
- Services for people with co-occurring disorders
- Voc Rehab work programs to help people stay or get stabilized
- Any program to keep people from being isolated
- More shelters for outlying communities
- More and different types of housing—Board and Care, Half-way house, transitional housing, boarding houses that allow more independence but provide daily living needs such as meals, laundry social activities and media rooms.
- Program like PAWS that enables a person to have a visit from pets when pets are not allowed where they live.
- Crisis stabilization unit in every community where someone can stay for longer than 24 hours
- Mobile crisis unit: Have peer support people to assist police with ride-alongs to help support compassionate action with people in crisis.
- Warm Line—phone to talk with trained peer support people
- Community drop-in centers in every town—triage, get info about how to get assistance.

**Exhibit F
SURVEY RESPONSES**

FAMILY MEMBERS

Who would you target?

(PREVENTION OR EARLY INTERVENTION)

- There has to be a way to make mentally ill persons acceptable and regarded as having a health problem.
- Education about mental illness is the most important thing. This education has to be made available in every community, every high school for students, teachers and counselors, and through many other local groups, and open to the public. Educating people about mental illness so they can recognize it when it occurs could perhaps shorten the time of denial.

(PREVENTION ONLY)

- Parents of children age 6-18

(EARLY INTERVENTION ONLY)

- People who have been court-appointed to anger management (precursor to potential first break. Indeed, in the case of domestic violence or child abuse, it may be the first break.)
- Teenagers

What are the mental health issues you perceive?

(PREVENTION OR EARLY INTERVENTION)

None listed

(PREVENTION ONLY)

None Listed

(EARLY INTERVENTION ONLY)

- Teenagers
Lots of substance abuse becoming ingrained, implying possible self-medication of a mental health issue.

Do you know of existing services that address any of their needs now?

(PREVENTION OR EARLY INTERVENTION)

None listed

(PREVENTION ONLY)

Parents of children age 6-18

Head Start has a mental health worker; School districts do IEPs on mental health; Numerous CBOs; Redwood Children's Services, Tapestry & others.

(EARLY INTERVENTION ONLY)

Exhibit F SURVEY RESPONSES

- Teenagers:
Mendocino Youth Project

What kinds of services do you think would help?

(PREVENTION OR EARLY INTERVENTION)

- Persons who have been court-appointed to anger
A small flex fund (\$15,000?) for their use. Court could be asked to provide a list of therapists for anger management throughout the county or, if they allow the person to get their own therapist, then when sentenced, they could be made aware of funds to help them get therapy if they are indigent per federal poverty criteria, for instance.
- De-stigmatization/Early intervention
The mentally ill person need to be channeled into a right direction for help, which requires a degree of engagement and commitment seldom found because of stigma.
- Education/De-stigmatization
I suggest something similar to the class I'm teaching at College of the Redwoods, and taught last year at Mendocino Coast District Hospital. The class has to have sufficient enrollment for the college to make \$140, and then they pay me for teaching it. The classes would be open to everyone in each community, although the high school classes would be limited to the local school/community school/court school population, and perhaps family members of students.

(PREVENTION ONLY)

- Parents of children age 6-18
Education required to relieve stigma about mental health issues in children so they know when, and will seek help. Training and ideas to educate parents so the stigma is erased and the help available is known.

(EARLY INTERVENTION ONLY)

- Teenagers
Intensive diagnostic and therapeutic services to quickly address medication (if needed), to get any diagnosis clearly assessed and under control—and to get client educated about his/her illness.

EXHIBIT G2

Mendocino County Health & Human Services Agency

Public Health Advisory Board Member Profiles 2/11/2010

1120 S. Dora St. Ukiah, CA 95482

707 472-2699 fax 707 472-2773 • www.co.mendocino.ca.us/ph

<p>Diane Agee Redwood Coast Medical Services PO Box 1100 Gualala, CA 95445-1100 Work: 884-4005 Ext 140 Home: 884-9614 Fax: 884-9728 Email: rcmsagee@mcn.org Term: 1/99-5/2011</p> <p>Area of Representation: Allied Health (<i>S Coast</i>)</p>	<p>Antonio Andrade 401 West Mill St. Ukiah, CA 95482 Work: 462-4930 Home: 463-0336 Fax: 462-1121 Email: asand@pacific.net Term: 01/96-2/2010</p> <p>Area of Representation: Community Rep. (<i>Environmental Issues</i>)</p>	<p>Susan Baird Kanaan 621 Capps Ln. Ukiah, CA 95482 Home: 468-8478 Email: susanbairdkanaan@yahoo.com Term: 1/07-1/2010</p> <p>Area of Representation: BOS District 2</p>	<p>Patty Bruder Willits Action Group 413 N. State St. Ukiah, CA 95482 Work: 462-2596 x102 Fax: 462-0191 Email: pbruder@ncoinc.org Term: 10/03-1/2012</p> <p>Area of Representation: Community Rep. (<i>WAG</i>)</p>
<p>Terry Burns Ukiah Valley Medical Center 275 Hospital Dr. Ukiah, CA. 95482 Work: 463-7360 Fax: 463-7384 Email: burnstm@ah.org Term: 10/07-10/2010</p> <p>Area of Representation: Allied Health</p>	<p>Paula Cohen Mendocino Coast Clinics, Inc. 205 South St. Fort Bragg, CA 95437 Work: 961-3431 Fax: 961-2653 Email: pcohen@mccinc.org Term: 9/07 – 9/2010</p> <p>Area of Representation: 4th District</p>	<p>Jendi Coursey 275 Hospital Dr. Ukiah, CA. 95482 Home: 462-1025 Work: 463-7606 Email: coursejd@ah.org Term: 4/08-04/2011</p> <p>Areas of Representation: Allied Health Representative</p>	<p>Andy Coren 233 Oak Knoll Rd. Ukiah, CA 95482 Work: 463-3663 Home: 467-1875 Fax: 463-2557 Email: andycoren@sbcglobal.net Term: 5/05-01/2011</p> <p>Area of Representation: Mendocino-Lake Medical Society</p>

EXHIBIT G2

Mendocino County Health & Human Services Agency

Public Health Advisory Board Member Profiles 2/11/2010

1120 S. Dora St. Ukiah, CA 95482

707 472-2699 fax 707 472-2773 • www.co.mendocino.ca.us/ph

<p>Chris Dewey Ukiah Police Department 300 Seminary Ave. Ukiah, CA 95482 Work: 463-6245 Home: 485-1495 Fax: 462-6068 Email: dewey@cityofukiah.com Term: 9/99-1/2012 Area of Representation: Community Rep. <i>(Law Enforcement)</i></p>	<p>Judith Dolan Anderson Valley Health Center 13500 Airport Rd. Boonville, CA 95415 Work: 895-3477 Fax: 895-2035 Email: jdolan@avhc.org Term: 2/07- 2/2010 Area of Representation: Allied Health <i>(Rural Comm., Underserved, Mental Health)</i></p>	<p>Cathy Frey Alliance for Rural Community Health 367 N. State St. Ste. 201 Ukiah, CA 95482 Work: 462-1477 ext. 101 Fax: 462-1503 Email: cfrey@ruralcommunityhealth.org Term: 1/09-1/2012 Area of Representation: Allied Health</p>	<p>Sheila Gray 131 Mill Creek Dr. Willits, CA 95490 Email: sheilagray@att.net Term: 2/09- 2/2012 Area of Representation: Community Rep. <i>(IHSS Advisory Committee)</i></p>
<p>Libby Guthrie Mendocino County AIDS Volunteer Network PO Box 1350 Ukiah, CA 95482 Work: 462-1932 Fax: 462-2070 Email: libbyg@mcavn.org Term 8/09-7/2012 Area of Representation: Community Rep. <i>(HSP Group)</i></p>	<p>Sara O'Donnell Cancer Resource Center of Mendocino Cty PO Box 50 Mendocino, CA 95460 Work: 937-3833 Home: 937-4734 Fax: 937-1143 Email: sara@crcmendocino.org Term: 01/99-1/2011 Area of Representation: BOS District 5</p>	<p>Michele Schott Laytonville Healthy Start PO Box 1382 Laytonville, CA. 95454 Work: 984-8089 cell 841-7070 Fax: 984-8620 Email: healthy@mcn.org Term: 4/00-2/2010 Area of Representation: BOS District 3</p>	<p>Bill Waring 1961 Antler Rd. Ukiah, CA 95482 Home: 462-3498 Email: threew@pacific.net Term: 12/95-2/2010 Area of Representation: Community Rep.</p>

MENDOCINO COUNTY

POLICY COUNCIL ON CHILDREN AND YOUTH

June 25, 2009

MEMBERSHIP DIRECTORY

MEMBER NAMES AND ADDRESSES	Interagency Children's Coordination Council Membership	PHONE	FAX	E Mail Address
1 Patricia Guntly Mendocino County Health & Human Services Agency Adult System of Care 1120 S. Dora Street Ukiah, CA 95482	Representative of Alcohol and Other Drug Programs	472-2607	472-2658	guntlyp@co.mendocino.ca.us
2 Becky Wilson Mendocino County Health & Human Services Agency Children & Family System of Care, Social Services Branch 727 S. State St. Ukiah, CA 95482	Family and Children's Services Representative	463-7787	463-7960	wilsonr@mcdss.org
3 Todd Crabtree Community Development Commission of Mendocino County 1076 N. State Street Ukiah, CA 95482	Person Responsible for Management of Housing and Redevelopment	463-5462 x112	463-4188	crabtret@cdhousing.org or director@cdhousing.org
4 Zoy Kazan Mendocino County Health & Human Services Agency, Children & Family System of Care, Mental Health Branch 860 Bush Street Ukiah, CA 95482	Person Responsible for Management of Mental Health Services	467-2543		kazanz@co.mendocino.ca.us
5 Wesley Forman Mendocino County Probation Department 280 E. Standley Street Ukiah, CA 95482	Chief Probation Officer	463-5750	463-5461	formanw@co.mendocino.ca.us
6 Linda Bouskill Nagel, PHN Mendocino County Health & Human Services Agency Community Health Services 1120 South Dora Street Ukiah, CA 95482	Public Health Services	472-2720	472-2735	nagell@co.mendocino.ca.us
7 Mary Elliott Mendocino County Health & Human Services Agency, Children & Family System of Care, 860 Bush Street Ukiah, CA 95482	Welfare or Public Social Services	463-4480		elliottm@co.mendocino.ca.us

MENDOCINO COUNTY

POLICY COUNCIL ON CHILDREN AND YOUTH

	MEMBER NAMES AND ADDRESSES	Interagency Children's Coordination Council Membership	PHONE	FAX	E Mail Address
8	Judge Leonard LaCasse Courthouse 100 North State Street, Room 107 Ukiah, CA 95482	Judge of the County Juvenile Court	468-3498	468-3459	luv2fish@mendocino.courts.ca.gov
9	Dennis Ivey Mendocino County Office of Education 2240 Old River Road Ukiah, CA 95482	Representative for Superintendent of County Office Of Education	983-6171		divey@mcoe.us
10	Donald F. Armstrong 312 S. Lincoln St. Fort Bragg, CA 95437	Superintendent of a Unified School District	961-2850	964-5002	darmstrong@fbusd.us
11	Meredith Lintott Mendocino County District Attorney 100 N. State St., G-10 Ukiah, CA 95482	Prosecuting Attorney of the County	463-4211	463-4687	lintottm@co.mendocino.ca.us
12	Karin Wandrei Mendocino County Youth Project 776 S. State Street, #107 Ukiah, CA 95482	Private Non-Profit Corporation - Mendocino Youth Project	463-4915	463-4917	kwandrei@mcyp.org
13	Supervisor John Pinches Board of Supervisors 501 Low Gap Road/room 1090 Ukiah, CA 95482	Member of County Board of Supervisors	463-4221	463-4245	bos@co.mendocino.ca.us
14	Gary Hudson Mendocino County, Sheriff's Office 589 A Low Gap Road Ukiah, CA 95482	Law enforcement	463-4084	468-3404	hudsong@co.mendocino.ca.us
15	Camille Schraeder Director Redwood Children's Services 950A Waugh Lane Ukiah, CA 95482	Representative of the Local Child Abuse Council	467-2000	467-2002	camille@pacific.net or camille@rcs4kids.org
16	Damon Dickinson Mendocino County Office of Education 2240 Old River Road Ukiah, CA 95482	Local planning agency in Early Intervention Program	467-5166	463-4898	damon@mcoe.us
17	Denise Gorny North Coast Opportunities 413 N. State Street Ukiah, CA 95482	Local Child Care Resource and Referral Agency	462-1954 ext. 210	467-3216	dgorny@ncoinc.org
18	Tanya Ridino, Esq. Self Help Legal Access Center	Community Organization tied to Ethnic	467-9685 or 468-2026	866-485- 3364	tridino@lsnc.net

MENDOCINO COUNTY
POLICY COUNCIL ON CHILDREN AND YOUTH

	MEMBER NAMES AND ADDRESSES	Interagency Children's Coordination Council Membership	PHONE	FAX	E Mail Address
	100 N. State St. Ukiah, CA 95482	Communities -Latino Coalition			
19	Julie Vedolla-Fuentes Hopland Band of Pomo Indians 3000 Shanel Road Hopland, CA 95449	Community Organization tied to Ethnic Communities – Native American	744-1647, ext. 1105	744-2110	jvedolla@hoplandtribe.com
20	Linda Crockett Action Network FRC PO Box 880 Gualala, CA 95445	Representative for Juvenile Justice and Delinquency Prevention Commission	884-5413		Linda@foureyedfrog.com
21	Mary Nevarez 3250 Road I Redwood Valley, CA 95470	Representative of an Indian Child Welfare Act Agency	485-0361	485-5726	maryjnevarez@yahoo.com
22	Laura Welter Safe Passage FRC 208 Dana St. Fort Bragg, CA	WIB Youth Council Representative	964-3077	964-3087	Safepass@mcn.org
23	Moises Soria Nuestra Casa 487 North State Street Ukiah, CA 95482	Representative of a Private Non-Profit Corporation Serving Children & Youth	463-7834 or 463-8181	463-8188	moises@nuestracasafrc.org
24	Cathy Frey Alliance for Rural Community Health 367 N. State St. Ste. 201 Ukiah, CA 95482	Rural Health Clinics	462-1477 ex. 101	462-1503	cfrey@ruralcommunityhealth.org
25	Sheryn Hildebrand CASA P.O.Box 1434 327 N. State Street, Suite 204 Ukiah, CA 95482	Community At-Large Member	463-6503	463-4624	casamc@pacific.net
26	Anne Molgaard FIRST 5 Mendocino 166 East Gobbi St. Ukiah, CA 95482	Community At-Large Member	462-4453	462-5570	acmolgaard@mendochildren.org
27	Morgaine Colston North Coast Opportunities 413 North State Street Ukiah, Calif. 95482	Community At-Large Member	467-3236	462-0191	mcolston@ncoinc.org
28	Lisa Vance 190 H Washington Court Ukiah, CA 95482-6331	Community At-Large Member, Parent Volunteer	462-8281		lisavance1964@yahoo.com

OASOC PLANNING COMMITTEE

EXHIBIT G4

NAME	TITLE	ADDRESS	PHONE/FAX	EMAIL
Adams, Nancy, MFT	HHSA, Mental Health Branch	860 N. Bush St. Ukiah, CA 95482	463-6859 463-4594 (fax)	adamsn@co.mendocino.ca.us
Baughan Young, Kim, MFT	Clinical Consultant, Lake County Senior Peer Counseling Program, AAA Advisory Council	P.O. Box 773 Clearlake Oaks, CA 95482	350-3590	kimyoungmft@mchsi.com
Beards, Trayce	ASOC Coordinator, HHSA	747 S. State St. Ukiah, CA 95482	467-5887	beardst@mcdss.org
Berry, Jane	Vice-Chair, Mendocino County Mental Health Board	700 E. Gobbi St., Sp. 20 Ukiah, CA 95482	467-1126	janb918us@yahoo.com
Bridge-Mount, Susan, MFT	OASOC Administrator, HHSA, Adult & Aging Services Division	747 S. State St. Ukiah, CA 95482	463-7885 467-5883 (fax)	bridge-mounts@mcdss.org
Bush, Charles	Exec. Director, Redwood Coast Senior Center	490 N. Harold St. Fort Bragg, CA 95437	961-4317 964-8449 (fax)	cbush@mcn.org
Chambers, Diana, MFT	Deputy Director, HHSA, Mental Health Branch	860 N. Bush St. Ukiah, CA 95482	463-6591 463-5443 (fax)	chamberd@co.mendocino.ca.us
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Revised 6/18/09

OASOC PLANNING COMMITTEE

EXHIBIT G4

	Health Board	Ukiah, CA 95482		
Rundlet, Frederick, A.C.H.E.	Exec. Director, Consolidated Tribal Health	P.O. Box 387 Calpella, CA 95481	467-5616	frundlet@cthp.org
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Revised 6/18/09

**Mendocino County, MHSA Prevention & Early Intervention Component of the Three-Year Program Expenditure Plan
Exhibit G4**

Mendocino County Continuum of Care for the Homeless
Homeless Services Planning Group (HSPG)
HSPG Structure
EXHIBIT G5

HOMELESS SERVICES PLANNING GROUP (HSPG)	TYPE OF ORGANIZATION	HSPG CORE TEAM
Mendocino County Health and Human Services Agency <ul style="list-style-type: none"> • Social Services Branch • Mental Health Branch • Public Health Branch (Alcohol and Other Drug Program) 	<i>Local Government Agency</i>	Social Services Mental Health Public Health
Community Development Commission	<i>Public Housing Authority</i>	Community Development Commission
Ukiah Community Center	<i>Non-profit Organization</i>	Ukiah Community Center
Ford Street Project	<i>Non-profit Organization</i>	Ford Street Project
Hospitality House	<i>Non-profit Organization</i>	Hospitality House
Project Sanctuary	<i>Non-profit Organization</i>	Project Sanctuary
Redwood Legal Assistance	<i>Non-profit Organization</i>	Redwood Legal Assistance
Willits Community Services	<i>Non-profit Organization</i>	Willits Community Services
Mendocino County Office of Education (MCOE)	<i>Education</i>	Mendocino County Office of Education (MCOE)
Mendocino County Youth Project (MCYP)	<i>Non-profit Organization</i>	Mendocino County Youth Project (MCYP)
Plowshares	<i>Non-profit Organization</i>	Plowshares
Mendocino County AIDS Volunteer Network (MCAVN)	<i>Non-profit Organization</i>	Mendocino County AIDS Volunteer Network (MCAVN)
Ukiah United Methodist Church	<i>Faith-based Community</i>	A Healing Cooperative (AHC); a program of the Ukiah United Methodist Church
Homeless Representatives	<i>Community Volunteers</i>	Homeless Representatives
Community Volunteers	<i>Faith-based Community</i>	Doug Strong
Mendocino County Health and Human Services Agency <ul style="list-style-type: none"> • Public Health Branch, Public Health Nursing 	<i>Non-faith based Community Volunteers</i>	John McCowen
Community Resources for Independence	<i>Local Government Agency</i>	
Mendocino Community Health Clinic, Inc.	<i>Non-profit Organization</i>	
North Coast Opportunities	<i>Health Facility</i>	
Mendocino County Health and Human Services Agency <ul style="list-style-type: none"> • Veteran's Services 	<i>Non-profit Organization</i>	
	<i>Local Government Agency</i>	

Mendocino County Continuum of Care for the Homeless
 Homeless Services Planning Group (HSPG)
 HSPG Structure
EXHIBIT G5

Division		
All Cities in County staff, city council members, planning commission members	<i>Local Government Agency</i>	
Therapeutic Drug Court	<i>Local Government Agency</i>	
Mendocino County Sheriff's Department & all City Police Departments	<i>Law Enforcement</i>	
Community Foundation of Mendocino County	<i>Non-profit Organization</i>	

The Mendocino County Continuum of Care for the Homeless is coordinated by the Homeless Services Planning Group (HSPG), and its decision-making body, the Core Team. The HSPG is a collaborative of over thirty-one organizations and is convened and facilitated by the Mendocino County Health and Human Services Agency, Social Services Branch. It is the role and responsibility of the HSPG Core Team to plan and coordinate resources and systems to reduce homelessness in Mendocino County and to assist the county's homeless to achieve residential stability. The Core Team serves as the policy setting body for the Supportive Housing Programs (SHP) and Shelter Plus Care (S+C) Program and brings planning and proposals to the full HSPG.

In the mid-eighties, the Mendocino County Housing Task Force was established as the first local body dedicated to the needs of the homeless. The group was tasked by the Mendocino County Board of Supervisors to study the needs of homelessness in the county, assess conditions and challenges faced by the homeless and make recommendations for action. In 1993, many of the same participants of the Housing Task Force convened as the Homeless Services Planning Group to plan for that year's HUD NOFA for McKinney funding for homeless populations. That planning process formally established the Seamless Transition Empowerment Program (STEP) and fixed the HSPG as the group responsible for county-wide planning and oversight of services and resources for the homeless.

In general, there are four levels at which members of the HSPG work to serve the county's homeless.

First, there are annual meetings of the full HSPG to conduct ongoing information and education of the homeless services system county-wide; provide a forum for broad-level review and input on program planning, and collectively consider resource development to maintain and improve homeless services.

Mendocino County Continuum of Care for the Homeless
Homeless Services Planning Group (HSPG)
HSPG Structure

EXHIBIT G5

Secondly a Core Team of the HSPG, consisting of representatives of the primary service provider agencies to the homeless, meets every other month. The Core Team evaluates the ongoing functioning and sets policy for the SHP STEP, the SHP Transitional Housing Program, and the Shelter Plus Care (S+C) Program. In addition, the Core Team plans for programmatic expansions and improvements, and considers significant program issues and recommendations.

Thirdly, the SHP / S+C Management Team meets to troubleshoot policy and programmatic decisions specific to the HUD-funded SHP and S+C programs that cannot wait until the monthly Core Team meeting, or are of a day to day operational nature not requiring the larger body. The Management Team is comprised of the HHSA, Social Service's Homeless Services / Housing Coordinator, the executive director of the two resource centers (Ukiah/ Coast Community Center, the providers of transitional housing (UCC and Ford Street Project, and are staffed by the resource center Homeless Service Coordinators.

Fourthly, line staff in each geographic region representing primary providers of housing and support services for the homeless hold weekly case conference meetings at the coastal and inland resource centers. The purpose of these meetings is two-fold, to triage STEP clients into the program's limited transitional and S+C housing units, and to update participant service plans and integrate them with the SHP "Housing Self Sufficiency Plan." The case conferencing meetings have proven instrumental in ensuring that service and housing plans are implemented and by encouraging philosophical continuity among providers.

EXHIBIT H1
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
De-Stigmatization, Education

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
De-stigmatization & Education	<ul style="list-style-type: none"> • <u>Suicide prevention.</u> Schools did this before, but should be done annually—train pre-school & K-12 teachers and parents. A simple flyer helps—signs to look for and where to go for help. Schools could dovetail their annual child abuse reporting training with suicide prevention training. 			
	<ul style="list-style-type: none"> • <u>De-stigmatization</u> Both ill individual and others need to see mental illness in the same way as diabetes. It is an illness that needs to be managed, and the individual with the illness needs to learn to manage their own illness. 			
	<ul style="list-style-type: none"> • Having information at schools for kids will help <u>de-stigmatize mental illness in general</u> 			
	<ul style="list-style-type: none"> • <u>Education.</u> About the first signs of mental illness and where to go for help. This info needs to be broadly disseminated—parents, first responders, schools, clinics, children to some degree 			
	<ul style="list-style-type: none"> • <u>Speakers Bureau.</u> As a way of educating both mentally ill and their families and community, first responders. Use people who have been through the illness to provide a human face and demonstrate that having mental illness doesn't mean you are scary, 			

EXHIBIT H1
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
De-Stigmatization, Education

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	strange etc. Also offers hope to the mentally ill individuals and families.			
	<ul style="list-style-type: none"> • Education for police and jail staff as well as the other agencies we work with about recognizing mental illness, what to expect, what is available—what types and degrees of help. • Trauma-informed cross-training with law enforcement 			
	<ul style="list-style-type: none"> • Use motivational speaker to go to Middle and High schools to talk with kids about common fears and issues related to mental health. Have people on site to answer individual questions. Need regular follow-up to maintain awareness 			
	<ul style="list-style-type: none"> • Lots more effort to de-stigmatize mental health issues—on the coast, families wait too long to get services because of stigma—everyone will know. 			
	<ul style="list-style-type: none"> • Education for school personnel and other community members that provides a tiered approach to assessing mental health issues—red flags and behavioral 			

EXHIBIT H1
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
De-Stigmatization, Education

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	interventions at various levels to address needs as early as possible			
	<ul style="list-style-type: none"> • Community Education to de-stigmatize mental illness and educate about first break symptoms and interventions that will help. 			
	<ul style="list-style-type: none"> • Psycho-social education for providers, parents, youth themselves 			
	<ul style="list-style-type: none"> • Wide-scale de-stigmatization efforts • General Population—information campaign about mental illness. 			
	<ul style="list-style-type: none"> • Bring children, youth and elderly together to address mental health issues in all age groups. Doing this in Hopland. 			
	<ul style="list-style-type: none"> • Have youth who have experienced mental health issues go to schools and speak as part of de-stigmatization campaign. 			
	<ul style="list-style-type: none"> • Expand community knowledge of needs and facts about mental illness and effective interventions. • Education/Information about how to identify early onset. 			

EXHIBIT H1
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
De-Stigmatization, Education

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> • Education—Parents about suicide prevention and signs of mental illness 			
	<ul style="list-style-type: none"> • <u>Education</u>—Middle school, about effects of substance use while pregnant—to prevent fetal alcohol syndrome. 			
<i>Coast</i>	<ul style="list-style-type: none"> • <u>Free classes on mental illness through College of the Redwoods, and in each of three high schools</u> (including community school and court school). High school classes would be open to high school students, parents, teachers, and counselors. The college classes would be open to the entire community. Special effort would be made to reach out to disabled students and their families . There would be four classes, two hours each. The first hour would be a video with people who have the illnesses talking about their experiences. Handouts with additional info and local resources. At each class effort would be made to form self-help groups for people who are dealing with mental illness, and another group for family members/friends. Potential to train others to teach class. Classes are: <ul style="list-style-type: none"> • Exploring Depression • Exploring Bi-polar Disorder • Exploring Schizophrenia 			

EXHIBIT H1
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
De-Stigmatization, Education

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> The Choice of a Lifetime: Returning from the Brink of Suicide Sonya Nesch has more details and teaches class. 			
<i>GLBTQ youth</i>	<ul style="list-style-type: none"> Education for GLBTQ youth, peers and teachers about homosexuality. 			
	<ul style="list-style-type: none"> Services that link kids up to information about STDs, human sexuality, health care options, substance use, life skills and so on. 			
	<ul style="list-style-type: none"> <u>Educators, police, human services workers of all kinds, parents</u>—Need education campaign about the issues/facts of children in the GLBTQ group, and those of all ages. Counter-balance misconceptions, myths and hate so that this group is seen as human, worthy, & not stigmatized. 			
	<ul style="list-style-type: none"> <u>Education Campaign</u> Create a program that “puts a face” to the GLBTQ community—low cost speakers bureau that utilizes members of this community to educate the community at large, tell their “story”, also could address like groups—transgender to transgender, lesbian 			

EXHIBIT H1
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
De-Stigmatization, Education

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	to lesbian etc.			
<i>Spanish-Speaking</i>	<ul style="list-style-type: none"> • Add information about signs, symptoms and services for Mental Health problems to existing Nuestra Casa programs—after school tutoring program, Crianza con Carino—also information about promoting mental health, de-stigmatization. Educational forums for all ages, rather than calling them “therapy”. 			
	<ul style="list-style-type: none"> • Crisis & suicide prevention service in Spanish. 			
	<ul style="list-style-type: none"> • <u>De-stigmatization efforts</u> for all older adults, but especially Spanish-speakers 			
<i>American Indians</i>	<ul style="list-style-type: none"> • <u>Whole Native American community – education about what mental health is—</u>but in a way they can accept <ul style="list-style-type: none"> ○ Services at reservation ○ Youth Wellness Gathering—invite parents and elders—use positive approach that promotes wellness rather than using the term “mental illness—such as “walking in balance” 			

EXHIBIT H1
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
De-Stigmatization, Education

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	approach			
	<ul style="list-style-type: none"> • <u>Localized services on the reservation that educate Native American Community about what mental health is</u>—need a positive approach such as a Youth Wellness gathering that includes parents and elders—include mental health issues and make professionals available to get to know the community members and facilitate mental health wellness activities. Youth could actually help mentor elders about mental wellness. Have examples/speakers to describe what mental health looks like 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
Early Intervention Transition-Age Youth	<ul style="list-style-type: none"> • Community Education to de-stigmatize mental illness and <u>educate about first break symptoms and interventions that will help.</u> 			
	<ul style="list-style-type: none"> • Coordinate mental health services with law enforcement to address “out-of-control” adolescents. 			
	<ul style="list-style-type: none"> • Coordinate with medical providers who are familiar with the needs. Community Health Clinics can provide registries to monitor progress, clear outcome measures, case mgt., counseling, group interventions, and cross-systems coordination. 			
	<ul style="list-style-type: none"> • For TAY first-break kids, provide a program that allows for a quick response and builds hope. Include information to the families about <ul style="list-style-type: none"> ○ What is happening ○ What services are available & how to get them, step by-step ○ What to expect and how to deal with behavior effectively ○ Support groups 			
	<p><u>FOR NEWLY HOSPITALIZED:</u></p> <ul style="list-style-type: none"> • Outreach to hospital <i>before discharged</i> to home. <p>Would provide a really good psycho-social</p>			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p>program for clients and their families starting before they leave hospital. Need good support program for parents, peer and family support for clients and families. Need “tough love” training for parents, and clients, Educate them about disease and what to expect, what services are available, what meds do and side effects and how to deal with them. Peer support for both family members and clients.</p> <p>If clients were willing to talk about their illnesses, could be effective education/peer support.</p>			
	<ul style="list-style-type: none"> • <u>Help immediately available at first break or early signs.</u> Individual who is experiencing this feels “at the bottom”. Need to provide them with role models, examples of people with mental illnesses who are doing well and making fabulous contributions. This also helps the parents and families of those with mental illness. Having this information at schools for kids will help <u>de-stigmatize mental illness in general.</u> 			
	<ul style="list-style-type: none"> • Families and ill individuals need <u>communication skills training.</u> This needs to happen right away at first onset because typically communication has been poor for 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p>months before. NAMI has a curriculum which includes a communication module that could be used with the community at large. There is also a national expert on schizophrenia—Dan Fischer who has a compassion training module that helps people get a feel for what it is like to hear voices etc. It could be used for first responders.</p>			
	<ul style="list-style-type: none"> • For kids at first break be sure to work with them to obtain employment, and/or other meaningful activities in the community. 			
	<ul style="list-style-type: none"> • Provide a coordinated constellation of group interventions at multiple sites in a non-stigmatizing format—community-based organizations, schools and health clinics: <ul style="list-style-type: none"> ○ Depression, ○ Anxiety ○ Dual diagnosis ○ Trauma 	<p>If we had true HHS coordination with Community Health Clinics, we would have better health outcomes, reduced hospitalizations, better cost-containment.</p>		
	<ul style="list-style-type: none"> • <u>Need a liaison</u> to help people “on the margins” navigate and obtain services 			
	<ul style="list-style-type: none"> • <u>Peer Support Groups</u> Peers can provide acceptance and safety net 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	for each other at low cost.			
	<ul style="list-style-type: none"> • <u>Employ individuals who have mental illness</u> to be peer support specialists or coordinators. This helps them heal by giving-back to the community and provides them with a means of support at the same time it provides hope and support to young adults at early onset. • <u>Have peers sit with early onset patients in crisis at hospital.</u> 			
	<ul style="list-style-type: none"> • <u>Peer support (sponsors, mentors).</u> Can take a variety of forms, but peer supporters need to be trained about how to do it effectively. Having peer support available during transports really helped. This approach could also help the children of mentally ill parents. These children may lack for friends because of the odd behavior of their parents. In addition, child is frightened and needs someone to explain what is happening, worried about having the same problem. 			
	<ul style="list-style-type: none"> • <u>Cognitive behavioral therapy</u>—short-term for Jr. High & High School suffering from social anxiety, OCD and some depressions 			
	<ul style="list-style-type: none"> • <u>Cognitive therapy</u> for children of families in 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	which there is mental illness or dual diagnosis			
	<ul style="list-style-type: none"> • <u>Mental Health professional to accompany law enforcement</u>—when picking up a mentally ill individual. 			
	<ul style="list-style-type: none"> • <u>Pre-Crisis House</u> .—a safe place where people can go when they are on the edge and get motivated to get help—like the Light House in Clearlake. • <u>One-stop center</u> in each community for information, peer support, socialization, and other services. Could include money-making, self-supporting projects for the centers that the clients participate in. 			
<i>Screening</i>	<ul style="list-style-type: none"> • Use Zoy’s CAARMs screening tool for identifying early onset 			
	<ul style="list-style-type: none"> • <u>Outreach, assessment & services to home-schooled youth</u> 			
<i>Crisis</i>	<ul style="list-style-type: none"> • Need 24/7 crisis facility/capacity <ul style="list-style-type: none"> ○ Mental health ○ Domestic violence ○ Homelessness 			
	<ul style="list-style-type: none"> • Need a better crisis response—Law 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p>Enforcement can't babysit people who are having some kind of mental health problem, and now Mental Health has no one to do that either, so there is no capacity to enable the person to sober up or be watched to monitor their status before they are out on the street again.</p>			
	<ul style="list-style-type: none"> • Establish a Mental Health 211 line—answers covering the gamut from facts and information to crisis services. 			
	<ul style="list-style-type: none"> • <u>Children and adults in crisis on coast</u>—Need post-hospitalization services, and services to help with issues below level of crisis leading to hospitalization. 			
	<p>Homeless with mental health issues need a special, quicker way to get crisis services and medications.</p>			
	<ul style="list-style-type: none"> • <u>Suicide Prevention</u> A 24-hour line with a continuum—from information (warm line) to crisis. Could be staffed by peers who are well-trained. 			
	<ul style="list-style-type: none"> • Mental health crisis services for developmentally delayed clients 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
<i>School-based</i>	<ul style="list-style-type: none"> Provide Prevention and Early Intervention services on school sites and employ leadership training with kids to de-stigmatize. 			
<i>American Indians</i>	<ul style="list-style-type: none"> <u>Youth in jail</u>. “drop-out” from CTHP –go into jail and don’t access CTHP services afterward until next big crisis. Need discharge and after care services for the youth and the family. 			
	<ul style="list-style-type: none"> <u>Tribal police</u> at Coyote Valley, Hopland, Coto and Sherwood could <u>develop relationship with behavioral health</u> programs for Native Americans. 			
	<ul style="list-style-type: none"> <u>Outreach and information to underserved cultural groups</u> 			
<i>Probation</i>	<ul style="list-style-type: none"> For Probation clients—used to have a mental health “caseload” with a Probation Officer assigned—worked well. They could monitor meds and ensure they stayed on them. 			
	<ul style="list-style-type: none"> Kids in Juvenile Hall—many showing mental health symptoms or are already receiving some level of mental health care—either lose continuity of care while in JH or are at first break—no adequate mental health service 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	for these kids or their families. Need a “mental health bridge” between juvenile hall and home—continuity of services			
	<ul style="list-style-type: none"> • Discharge services and aftercare services to families of youth who are in juvenile hall or jail. 			
	<p><u>FOR INCARCERATED</u> They bounce in and out of jail. Would help to have <i>a Mental Health clinician at the jail again</i> to do really good discharge planning with these folks to keep them from being incarcerated again</p> <ul style="list-style-type: none"> ○ Medical follow-up ○ Housing ○ Get assessment and case manager ○ Help them obtain SSI or GA 			
	<u>Mental Health counselors at juvenile hall and jail.</u>			
<i>Spanish-speaking</i>	<ul style="list-style-type: none"> • <u>Outreach and information to underserved cultural groups</u> 			
<i>Co-occurring</i>	<ul style="list-style-type: none"> • <u>Folks with co-occurring alcohol and drug abuse and mental illness</u>—need means/expertise to sort through and address both. Need to include and educate whole family about what is going on with their family member. 			

EXHIBIT H2
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Early Intervention—Transition Age Youth

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> • Program to serve the substance use and mental health needs of clients with co-occurring issues. 			
	<p><u>FOR DUAL DIAGNOSIS</u></p> <ul style="list-style-type: none"> • Need collaboration with AODP to provide a good dual diagnosis group <i>to include clinical staff as well as peer support.</i> • Would be good to have an <i>AOD clinician to plug into Crisis Unit</i> and Adult Mental Health Services in general for dual diagnosis clients 			
<i>Coast</i>	<ul style="list-style-type: none"> • Other-than crisis services for children and adults on the coast—including services to client and families post-hospitalization. There are no such services on coast now 			

EXHIBIT H3
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention & Early Intervention—Older Adults 60+

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
<u>Older Adults Prevention</u>	<ul style="list-style-type: none"> Meeting place for Spanish-speaking Srs.—reduce isolation & identify MH issues 			
	<ul style="list-style-type: none"> <u>Go to Senior Centers and Grange Meetings.</u> Seniors go to these places for free food and socialization and because they're used to meeting there. These would be excellent venues for providing education and de-stigmatization information and suicide prevention information. Meals on Wheels does not reach everyone. 			
<u>Prevention/Early Intervention</u>	<ul style="list-style-type: none"> <u>Expansion of suicide prevention model utilizing Meals on Wheels drivers</u> to conduct screenings for depression —has United Way funding that could be leveraged also would continue the service when United Way funding is gone. It constitutes an outreach program to these older adults and can link them to services they would otherwise not access. <u>Expand and enhance the Meals on-Wheels Suicide Prevention Program</u>—train more volunteers to recognize mental health issues and who to refer to 			
	<ul style="list-style-type: none"> <u>Increase Peer Counselors</u>—there is always a waiting list. They can be excellent primary prevention/early intervention resource. They 			

EXHIBIT H3
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention & Early Intervention—Older Adults 60+

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	are in the home and can see how older adults are living, vs. what they say. Trained to recognize mental health and medication mis-use or non-use issues. Peer counselors are trained in “wellness survey” and “depression scale”.			
	<ul style="list-style-type: none"> • <u>Education/training of in-home health providers</u> to recognize and report mental health concerns they see in their clients 			
	<ul style="list-style-type: none"> • <u>Expand (or bring back) the Sr. Companion Program</u>—these companions can take seniors to medical appointments and other places that peer counselors can't 			
	<ul style="list-style-type: none"> • <u>Expand and enhance Sr. Center Outreach programs</u>. Provide substantive training program so that current structure can be utilized more effectively—professional who oversees paraprofessionals who oversee and train a host of volunteers—built on food programs. This is low-cost, constant service to a fragile population. Could select the best outreach person at each senior center to train others. 			
	<ul style="list-style-type: none"> • <u>Service to manage the medications</u> of older 			

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NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p>adults who are unable to do so. This means helping them obtain their medications, organize them, use them appropriately, and remember to take them. Could contract with for a nurse to check on the medications of specifically identified clients. Can do this now through MSSP, but this is only for Medi-Cal patients who fit MSSP criteria. Could also set up a phone tree to remind forgetful patients to take their medications at right times.</p>			
	<ul style="list-style-type: none"> • <u>Training for GPs about psychiatric medications for seniors.</u> 			
	<ul style="list-style-type: none"> • <u>Service to coordinate with multiple physicians of seniors.</u> 			
	<ul style="list-style-type: none"> • <u>Go to service groups such as the Soroptimists & Lions Clubs</u> These are good venues for providing education, suicide prevention and de-stigmatization efforts. Lots of Seniors participate. In addition, they might help fund some prevention or early intervention projects. 			
	<ul style="list-style-type: none"> • <u>Check out Redwood Coast Medical Services.</u> They have a “Living Well” Program for seniors that includes assessments and interventions that are 			

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STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention & Early Intervention—Older Adults 60+

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	working.			
	<ul style="list-style-type: none"> Establish a partnership in each community—between Community Health Clinics and other service providers in that community. Need to conduct assessments that sort out the mental health vs. medical issues. Clinic would do that for the clients they already have, and then could provide many of the mental health services at the clinics. But people could also be referred or drop in for service in which case the clinics would need a link to refer the person for the appropriate service. 	Minimal. Some training/education at each clinic; establishing protocols. Most already equipped to do assessments and all but Anderson Valley have mental health component.	Community health clinics reach all of the outlying areas of Mendocino County. They can't turn anyone away. They serve a large proportion of our population	
<i>American Indians</i>	<ul style="list-style-type: none"> Provide services to Native Americans in the <u>outlying areas</u>—they could spill over into the rest of the Native American community. 			
Early Intervention	<ul style="list-style-type: none"> <u>Coordinator and trainer for outreach workers & Sr. Peer counselors</u>—how to conduct screening for depression and other mental health issues 			
	<ul style="list-style-type: none"> <u>Children and adults in crisis on coast</u>—Need post-hospitalization services, and services to help with issues below level of crisis leading to hospitalization. 			

EXHIBIT H3
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Prevention & Early Intervention—Older Adults 60+

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> • <u>In-home psychological, psychiatric services on the Coast.</u> Essential that the services be available in home as seniors will not got to Mental Health even if they are able. Also, home is “an open book”. The patients life situation is clear. 			
	<ul style="list-style-type: none"> • Day Care Center at all Senior Centers 			
	<ul style="list-style-type: none"> • Provide a coordinated constellation of group interventions at multiple sites in a non-stigmatizing format—community-based organizations, schools and health clinics: <ul style="list-style-type: none"> ○ Depression, ○ Anxiety ○ Dual diagnosis ○ Trauma 	<p>If we had true HHS coordination with Community Health Clinics, we would have better health outcomes, reduced hospitalizations, better cost-containment.</p>		
<i>Co-occurring</i>	<ul style="list-style-type: none"> • <u>Folks with co-occurring alcohol and drug abuse and mental illness</u>—need means/expertise to sort through and address both. Need to include and educate whole family about what is going on with their family member. 			
	<ul style="list-style-type: none"> • Program to serve the substance use and mental health needs of clients with co-occurring issues—any age group. 			

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STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention & Early Intervention—Older Adults 60+

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p><u>FOR DUAL DIAGNOSIS</u></p> <ul style="list-style-type: none"> • Need collaboration with AODP to provide a good dual diagnosis group <i>to include clinical staff as well as peer support.</i> • Would be good to have an <i>AOD clinician to plug into Crisis Unit</i> and Adult Mental Health Services in general for dual diagnosis clients 			
	<ul style="list-style-type: none"> • <u>Need to de-couple mental health issues from other diagnoses.</u> Could provide mental health services that prevent or treat their mental health issues as well as their other problems. 			
<i>American Indians</i>	<ul style="list-style-type: none"> • <u>Someone to provide direct services in Round Valley and other tribal areas—LCSW at least.</u> (There are 3000 people living in Round Valley Reservation.) Person should be in community every day and be able to recognize and address mental health issues and dual diagnosis. 			
	<ul style="list-style-type: none"> • <u>Provide services to Native Americans in the outlying areas—they could spill over into the rest of the Native American community.</u> 			

EXHIBIT H3
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention & Early Intervention—Older Adults 60+

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> • Culturally relevant interventions such as “<u>At home</u>” program and <u>supplemental counseling for Native Americans and Latinos</u> who are substance abusers and/or have dual diagnosis 			
Latinos	<ul style="list-style-type: none"> • Culturally relevant interventions such as “<u>At home</u>” program and <u>supplemental counseling for Native Americans and Latinos</u> who are substance abusers and/or have dual diagnosis 			
	<ul style="list-style-type: none"> • <u>Spanish-speaking clinician and service providers</u> 			

EXHIBIT H4
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
Prevention Services-- Youth	<ul style="list-style-type: none"> • Kids 0-5—FRCs can use First 5 funds to match & provide MH services in natural settings such as in-home or in play groups 			
	<ul style="list-style-type: none"> • Utilize primary care providers (Community Health Clinics) to assess issues & provide proven programs aimed at the general population such as Project Impact which targets depression, and/or • Provide a coordinated constellation of group interventions at multiple sites in a non-stigmatizing format—community-based organizations, schools and health clinics: 			
	<ul style="list-style-type: none"> • Teachers, therapists, other professionals—funding to enable them to screen and refer middle school and high school aged kids (age 11—24). 			
	<ul style="list-style-type: none"> • Expand “Raise & Shine”—use a Raise and Shine-like approach for older kids. 			
	<ul style="list-style-type: none"> • Coordinate mental health services with law enforcement to address “out-of-control” adolescents. 			
	<ul style="list-style-type: none"> • Kids with poor attendance—utilize “Attendance Improvement Monitoring” 			

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STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	program			
	<ul style="list-style-type: none"> • Counseling & Intervention for foster parents (kids 0-18); Spanish-speaking parents(kids 0-18, but especially 0-5) And child care providers (kids age 0-13) 			
	<ul style="list-style-type: none"> • Psycho-social education for providers, parents, youth themselves 			
	<ul style="list-style-type: none"> • Get to parents of young children—a campaign about how their response to their children today determines behaviors they have to deal with tomorrow 			
	<ul style="list-style-type: none"> • Provide counseling and support services and Behavior Intervention Training to child care providers and parents—provide through community based agencies and child care settings. Make it bi-lingual 			
	<ul style="list-style-type: none"> • Utilize evidence-based practices addressing impulse control. 			
	<ul style="list-style-type: none"> • Provide prevention services that reconnect youth in outlying areas and teach them life skills, address health and education and substance use. 			

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STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> AODP services for youth. 			
	<ul style="list-style-type: none"> Treatment for child victims or children exposed to domestic violence—and/or information about existing treatment & services. 			
	<ul style="list-style-type: none"> Establish a Mental Health 211 line—answers covering the gamut from facts and information to crisis services. Fund the education of teachers, therapists, and other professionals about how to screen for mental health issues and where to refer clients for services. 			
	<ul style="list-style-type: none"> Bring elders and youth together to provide mental health services across the generations—more impact on whole community 			
	<ul style="list-style-type: none"> Link prevention services to community resources. 			
	<ul style="list-style-type: none"> Utilize SARB to identify and refer children and their families to various mental health services. 			
	<ul style="list-style-type: none"> Suicide Prevention A 24-hour line with a continuum—from information (warm line) to crisis. Could be staffed by peers who are well-trained. 			

EXHIBIT H4
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> • Outreach to families—especially those of youth who are no longer attending school. 			
	<ul style="list-style-type: none"> • Referral & Assessment of kids/families who are isolating themselves—independent study, poor attendance—perhaps utilize SARB 			
	<ul style="list-style-type: none"> • Referral & Assessment of young elementary school-aged kids who are showing mild issues 			
	<ul style="list-style-type: none"> • Peer support groups for parents & kids and/or therapeutic groups—linked to services 			
	<ul style="list-style-type: none"> • Services for teens and their parents—would be good to have a phone number to call for general information about teens and a class or group to refer them to 			
	<ul style="list-style-type: none"> • <u>Behavior Intervention Support Services</u>—education and training of day care providers about how to utilize 			
	<ul style="list-style-type: none"> • <u>Child Find curriculum</u>—helps child care providers recognize and address a variety of special needs 			
	<ul style="list-style-type: none"> • <u>Net Program</u>—assessment that can be 			

EXHIBIT H4
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	utilized by child care providers			
	<ul style="list-style-type: none"> • <u>NCO</u> provides a <u>training series</u> for new child care providers—<u>could include information about mental health issues and services.</u> Any program for child care providers or parents they serve would have to be offered on <u>weekends or in the evenings</u>—may need to do on-site, in-home Helps to provide <u>stipends/gift certificates</u> to get parents and providers to training 			
	<ul style="list-style-type: none"> • Outreach services to families and child care providers 			
	<ul style="list-style-type: none"> • Provide a mental health professional to come and observe specific children in preschool settings and in schools when teachers are concerned that the child may have mental health issue. 			
	<ul style="list-style-type: none"> • Peer Support Groups Peers can provide acceptance and safety net for each other at low cost. 			
	<ul style="list-style-type: none"> • Play rooms at schools Latency aged kids 			
	<ul style="list-style-type: none"> • SARB—focus on younger kids and parents— Ft Bragg has dropped SARB for teens because it is too late. 			

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STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> • <u>Outreach, assessment & services to home-schooled youth</u> 			
<i>Teen Parents</i>	Parenting skills, mental health services for teen and young parents of young children in outlying areas			
	<ul style="list-style-type: none"> • Teen Pregnancy Prevention program that includes mileage, supplies and a person to talk to the teens—especially Latino teens. 			
	<ul style="list-style-type: none"> • Couples Counseling for teen parents 			
	<ul style="list-style-type: none"> • Support groups for youth and young parents –how to cope with life, rules to live by—engage older parents to mentor younger ones 			
<i>School-based</i>	<ul style="list-style-type: none"> • Behavior Specialist Services—parent training on behavior management. Addressed the <i>family system</i>. Behavior is now the #1 challenge for schools. This program worked with parents with very high stress index and kids aged 0-5—services that were not Medi-Cal billable. Used BA level person working under a Board certified person, but First 5 \$ was cut. Need this kind of program for all levels. 			

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STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> • Work with and support parents through the schools. • Provide services on school campuses or other community settings • Provide Prevention and Early Intervention services on school sites and employ leadership training with kids to de-stigmatize 			
	<ul style="list-style-type: none"> • Services that take place at school or pre-school (most pre-school-aged kids are attending pre-school)—could be after school programs, but on school campus. 			
	<ul style="list-style-type: none"> • Programs or counselors that “follow” at risk or troubled kids all the way through school—especially transitions from Elementary to Middle School to High School. Schools no longer have enough school counselors or school psychologists to do the job and Middle and High School teachers have too many students to give time to these kids. 			
	<ul style="list-style-type: none"> • Having mental health clinicians in the schools worked. 			
	<ul style="list-style-type: none"> • PIPs worked—Primary Intervention Program—pre-school through grade 2. Was funded through DMH—EMHI. Not happening now. Each school district must apply for 			

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Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p>funds each year and they require matching funds.. Addressed kids with risk factors, but not extremely high risk.</p> <ul style="list-style-type: none"> • Bring back the PIP program—mental health staff on campuses. • Leverage funding and bring back the Primary Prevention Program (PIP) at each school site. • Bring back the PIP—mental health clinicians on campus—de-stigmatizes mental health services. 			
	<ul style="list-style-type: none"> • <u>Need school-based counselors again.</u> This allows counselors to observe the dynamics, build trust with the kids, and stop problems from becoming worse; It is a “natural setting” for both kids and parents; Both Native Americans and Latinos resist availing themselves of therapy/counseling in the traditional settings of therapists’ offices or Mental Health. More willing to access help at schools; Can do individual and small-group work at schools; use creative ways to engage kids—drama, games, peer counseling/helpers. 			
	<p>Mendocino College has a “college coaching program” run by Catherine Rosoff—brief</p>			

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Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p>interventions with students referred by teachers usually. She assesses them and refers them to Mental Health and elsewhere for service. It would be good to <i>have a Catherine Rosoff-type service at high schools to catch kids younger.</i></p>			
	<ul style="list-style-type: none"> • Need a baseline curriculum at all schools that addresses mental health and suicide prevention. It could include topics that focus on key self-esteem issue such as body imaging. 			
	<ul style="list-style-type: none"> • Schools could offer peer groups or empowerment groups for kids that address issues such as their parents abusing substances, domestic violence, suicide, peer bullying, gender identity etc. The group would have to be named and operated in a way that would not stigmatize those attending. The group could include peer mentors. • Engage Soroptimists or other service groups in providing college scholarships to kids who attend or become peer mentors. 			
	<ul style="list-style-type: none"> • Utilize community health clinics for prevention. Girls go to these clinics for birth control. Many kids go for sports exams. These are occasions when the child is not accompanied by a parent. Nurse 			

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Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<p>practitioners can ask kids key questions about their emotions, home lives and lifestyles. Are already equipped to do assessment of depression which can lead to other assessments. This could provide gateway to peer groups or empowerment groups at the schools.—and to other services. Therapists at clinics could provide therapy for those kids who need it.</p> <ul style="list-style-type: none"> • Every community would need a place to send the children who needed support 			
	<ul style="list-style-type: none"> • High School-age kids need program that helps them learn how to deal with the realities of life—basic coping and life skills. Prevents anxiety and depression later on. 			
	<ul style="list-style-type: none"> • Prevention efforts for youth need to engage troubled parents. Need means to do this that does not single them out as deficient. Parents likely to get engaged around kids. Could be some kind of fun social event that includes information about mental health, suicide, substance abuse etc., (Chili Cook-off etc.) 			
<i>American Indians</i>	<ul style="list-style-type: none"> • <u>Covelo/Round Valley</u> : Would like to see additional clinicians to facilitate groups: <ul style="list-style-type: none"> ○ Grief counseling ○ Domestic violence 			

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Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	<ul style="list-style-type: none"> ○ Sexual abuse ○ Depression & anxiety ○ Substance abuse 			
	<ul style="list-style-type: none"> • Need parenting education, outreach and in-home assistance with emotional & behavioral & relationship issues 			
	<ul style="list-style-type: none"> • <u>Youth</u>—school drop-out rate. Need outreach to these families by someone equipped to recognize and address mental health issues and dual diagnosis—at least LCSW level. 			
	<ul style="list-style-type: none"> • <u>Youth in jail</u>. “drop-out” from CTHP –go into jail and don’t access CTHP services afterward until next big crisis. Need discharge and after care services for the youth and the family. 			
	<ul style="list-style-type: none"> • Someone to provide direct services in Round Valley and other tribal areas—LCSW at least. (There are 3000 people living in Round Valley Reservation.) Person should be in community every day and be able to recognize and address mental health issues and dual diagnosis. 			
	<ul style="list-style-type: none"> • Tribal police at Coyote Valley, Hopland, Coto 			

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Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	and Sherwood could develop relationship with behavioral health programs for Native Americans.			
	<ul style="list-style-type: none"> Provide services to Native Americans in the outlying areas—they could spill over into the rest of the Native American community. 			
	<ul style="list-style-type: none"> Mini grant for youth in Pinoleville. Expand program they have that provides services to youth in Juvenile Hall and accompany children to IEPs 			
	<u>Outreach and information to underserved cultural groups</u>			
<i>Domestic Violence</i>	<p><u>Saturation campaign</u> to end all violence in local community as a social priority; provide education about the effects of violence on brain development, future relationships etc. This could involve kids and parents in all our systems—CWS, Probation, Mental Health, Youth Project.</p> <p><u>Services related to exposure to violence</u> Link saturation campaign to support groups for children and parents. Include peer support, and parent partners to reach out to families.</p>			
<i>Probation</i>	<ul style="list-style-type: none"> 13-18-year olds—Expand and do more with 			

EXHIBIT H4
STRATEGY IDEAS FROM FOCUS GROUPS & CONSULTATIONS
Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
<i>Youth</i>	Probation’s “Impact Program”—fund counselor and Probation officers, and add Probation Officer training as per the Napa County model			
	<ul style="list-style-type: none"> • Mentoring program for teens in general and those in Juvenile Hall—include activities that keep them busy. 			
	<ul style="list-style-type: none"> • Utilize “grandparents” to interact with kids in juvenile hall—could serve to help older adults who are isolated and the kids at the same time—working well now with a grandmother who visits kids at juvenile hall. Kids with abandonment issues get the most out of this service 			
	<ul style="list-style-type: none"> • Youth in jail. “drop-out” from CTHP –go into jail and don’t access CTHP services afterward until next big crisis. Need discharge and after care services for the youth and the family. 			
<i>GLBTQ Youth</i>	<ul style="list-style-type: none"> • A shelter for homeless youth of this group who have been kicked out of their homes because of their orientation; 			
	Need to collaborate—the various GLBTQ			

EXHIBIT H4
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Prevention—Youth 0-17

NEED/ POPULATION	STRATEGY	COST ESTIMATE	PROJECTED IMPACT	LEVERAGING POSSIBILITY
	support groups and non-profits to consolidate resources to provide support mutually, ensure sustainability. <i>Should NOT be run by County.</i>			
<i>Spanish-speaking</i>	<ul style="list-style-type: none"> • Mental Health counselor at Nuestra Casa—bi-lingual/bi-cultural available evenings and weekends. 			
	<ul style="list-style-type: none"> • Outreach to kids who are not attending school—some are afraid to go. 			
	<ul style="list-style-type: none"> • <u>Outreach and information to underserved cultural groups</u> 			
<i>Co-occurring</i>	<ul style="list-style-type: none"> • Provide curriculum to address self-esteem and co-occurring disorders for 5th, 6th & 7th graders 			
<i>Coast</i>	<ul style="list-style-type: none"> • Children in crisis on coast—Need post-hospitalization services, and services to help with issues below level of crisis leading to hospitalization 			