Mental Health Services Act

COMMUNITY SERVICES AND SUPPORTS PLAN

Submitted to
The California Department of Mental Health

April 20, 2009

EXHIBIT 1: PROGRAM AND EXPENDITURE PLAN FACE SHEET

MENTAL HEALTH SERVICES ACT (MHSA)
THREE-YEAR PROGRAM AND EXPENDITURE PLAN

COMMUNITY SERVICES AND SUPPORTS
FISCAL YEARS 2008-09, 2009-10, 2010-11, AND 2011-12

County: **Tri-City** Date: **April 27, 2009**

Tri-City Executive Director

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TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

A Proposal to the California Department of Mental Health
in Accordance with the Mental Health Services Act

April 2009

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COMMUNITY SERVICES AND SUPPORTS PLAN

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COMMUNITY SERVICES AND SUPPORTS PLAN

INTRODUCTION

Tri-City Mental Health Center (Tri-City MHC) is a municipal Joint Powers Authority established by legislation in 1960 to provide Short-Doyle and Short-Doyle/Medi-Cal outpatient mental health services to residents of Claremont, La Verne, and Pomona. The services provided by Tri-City MHC historically included the following: adult outpatient services, children's outpatient services, emergency services and crisis intervention, psychosocial rehabilitative programs, mental health support services, pre-vocational programs, job placement services, AB2034 programs with transitional housing, and a client drop-in center and club house, Boredom Is A Cop Out (BIACO).

In February 2004, after being a community provider for over 40 years, Tri-City MHC filed for bankruptcy protection under Chapter 9 of the bankruptcy code. The number of staff members shrank from over 300 to fewer than 50. The budget was reduced by over 75%, from $21 million to $5 million. It is hard to overstate the trauma that Tri-City's bankruptcy has had on the three cities. Remaining Tri-City staff did everything they could to insure an effective transition for the many clients that they no longer could serve. Other providers stepped up to shoulder some of the responsibilities. Each of the three cities developed various responses to the sudden disappearance of mental health funds. Such efforts notwithstanding, however, there simply was no easy or comprehensive solution for the loss of millions of dollars and hundreds of staff.

In August 2006, as Tri-City MHC worked with the California and Los Angeles County Departments of Mental Health to develop a plan to emerge from bankruptcy, the Tri-City Governing Board initiated an extensive community visioning process. The purpose of this process was to begin reestablishing trust and working relationships between Tri-City and its community partners and stakeholders, and to develop a shared vision for a renewed system of mental health care across the three cities.

This year-long effort, described in greater detail in the Community Program and Planning Proposal approved by the California Department of Mental Health (CA DMH) in October 2008, reached hundreds of people across the three cities, and culminated in an intensive stakeholder process with 41 delegates meeting throughout the summer of 2007. The stakeholders ultimately reached consensus on a broad range of recommendations for the Tri-City Governing Board, including recommendations that:

1. Tri-City Mental Health Center expand its focus from overseeing a clinic that directly provides mental health services, to partnering with a wide array of community and public organizations to manage a system of care throughout the three cities.

2. Tri-City MHC conduct all of its efforts in accordance with the following core values:

- A commitment to recovery and wellness;
- A commitment to build a service system that is client-driven and family-focused;
- A commitment to cultural competence and appropriateness in delivering mental health services;
- A commitment to address disparities in access to mental health services;
- A commitment to achieve positive outcomes for people who receive services and their families;
- A commitment to financial accountability and responsibility to the community and all of Tri-City's funders;
- A commitment to deliver and/or contract out services of the highest quality possible, consistent with the commitment to accountability for positive outcomes for as many people as possible; and
- A commitment to honor and engage people receiving services, family members, clinical and administrative staff, and community stakeholders as partners in building and transforming the system of care.

In October 2007, the Governing Board adopted all of the consensus recommendations from the delegates' process, as well as a recommendation to expand the membership of the Governing Board.[1] This was an historic change for Tri-City; it was now committed to building a system of care with its community partners and allies, rather than trying to deliver, by itself, all of the mental health services for residents in the three cities.

As part of this transformation, the Governing Board asked all members of the Mental Health Commission to resign, so that the new Board could recruit a new Commission aligned with the vision of managing a system of care.

The new Governing Board was seated in January 2008, and the new Commission several months later. Tri-City emerged from bankruptcy just as the first stakeholder process was concluding, and immediately began to develop a staffing structure consistent with the vision of managing a mental health system of care.

We submitted the Community Program Planning proposal in September 2008 to secure the funds needed for our Community Services and Supports planning process. In that proposal, approved by the California Department of Mental Health (CA DMH) in October 2008, we wrote:

> The goodwill and hopefulness that now surrounds Tri-City MHC could not be more different from the environment two years ago. While no one would have *planned* for Tri-City MHC to wait until the fall of 2008 to start its MHSA planning efforts, it is now—finally—positioned to convene a community-wide dialogue about how to transform mental health services, and promote mental health, for the residents of the three cities.

[1] As a Joint Powers Authority, the recommendation to change the composition of the Board had to be approved by a majority of each of the three City Councils. The City Councils approved this change to the Governing Board structure through a series of meetings in November and December 2007.

We believe that the mental health system now emerging in the Tri-City area will ultimately be stronger and more effective than anything that has gone before. We know we are not there yet, but with the steps we have taken to date, including the generation and submission of this CSS plan, we believe we are on our way to creating a transformed system of care for the residents of Claremont, La Verne, and Pomona. We are excited to share with you the CSS plan that has emerged through our planning efforts over the past six months.

Context for the CSS Plan

Tri-City Mental Health System is submitting this Community Services and Supports (CSS) plan in accordance with California Department of Mental Health Letter 05-05, dated August 1, 2005. As one of six plans required by CA DMH under the Mental Health Services Act (MHSA), the CSS plan must reflect five core principles:

- Community collaboration;
- Cultural competence;
- Consumer- and family-driven systems of care for all age groups;
- Wellness focus, including the concepts of recovery for adults and resiliency for children; and
- Integrated service experiences for consumers and their families.

The CSS plan must prioritize services for adults and older adults who suffer serious and persistent mental illness (SMI), and children and youth who suffer severe emotional disturbances (SED). Specifically, the plan must organize services around four age groups:

- Children and youth between the ages of 0 and 15, including their families;
- Transition age youths (TAY) between the ages of 16 and 25;
- Adults between the ages of 26 and 59; and
- Older adults 60 years and older.

CA DMH requires counties to invest in three kinds of services—full service partnerships, systems development, and outreach and engagement—to effect positive outcomes for people who receive services, including helping them to:

- Develop meaningful uses of their time and capabilities;
- Secure and/or maintain safe housing;
- Develop and/or strengthen supportive networks of relationships;
- Develop ways to easily and appropriately access assistance during a mental health crisis;
- Suffer fewer number of incarcerations; and
- Experience a reduction in (and hopefully elimination of) the number of involuntary mental health treatments.

Our proposed CSS plan projects services to begin in June 2009 (this fiscal year), and continue through June 30, 2012. The State has made available to Tri-City MHC the following allocations to support our CSS plan:

- FY 2006-07: $1,907,890 (to be spent/legally obligated by June 30, 2009)
- FY 2007-08: $3,586,800 (to be spent/legally obligated by June 30, 2010)
- FY 2008-09: $3,721,400 (to be spent/legally obligated by June 30, 2011)
- FY 2009-10: $4,989,000 (to be spent/legally obligated by June 30, 2012)
- FY 2010-11: yet to be forecast by CA DMH
- FY 2009-10: yet to be forecast by CA DMH

The proposed CSS plan divides these allocations into two types of funding: (1) on-going funds to finance mental health services and supports that we expect to continue year after year, and (2) non-recurring funds to finance mental health expenditures on a one-time basis.

With this introduction as context, we now turn to the specific questions and instructions outlined in California Department of Mental Health Letter 05-05, dated August 1, 2005.

PART I: PUBLIC PLANNING AND PLAN REVIEW PROCESSES

PART I, SECTION I: Public Planning Processes

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

CA DMH expects counties to conduct extensive community outreach for their CSS planning efforts to insure meaningful exploration of diverse perspectives, including those of people who receive services and families. This engagement should also incorporate the views of people who receive services and family members who are not part of organized advocacy groups, as well as members of unserved or underserved population groups across all four age groups.

In our Community Program Planning (CPP) proposal, we outlined four inter-related strategies for meaningfully involving individuals receiving mental health services and family members. These strategies included: (1) conducting media outreach and public education; (2) establishing a strong referral base; (3) organizing a consumer support and advocacy network; and (4) conducting periodic assessments among consumers and families about the effectiveness of these outreach strategies.

NAMI Pomona Valley has an active presence in the tri-city area and a rich history of activism on behalf of families who have members with mental health issues. As active as NAMI is, however, we know that many family members from mono-lingual homes, and from traditionally unserved and underserved ethnic communities, have traditionally not participated in NAMI.

We have one consumer-operated clubhouses in the tri-city area: Boredom Is A Cop Out (BIACO), located at the Tri-City directly operated clinic, with approximately 80 members. Currently there is no active network of consumer leaders and advocates.

Two strategies outlined in the CPP plan were designed to immediately engage people who receive services and their family members in the CSS planning process. These were: (1) conducting media outreach and public education; and (2) strengthening networks of relationships for consumers and families to connect with each other and to the process.

Strategy #1: *Conducting media outreach and public education*

One of our first tasks was to increase public awareness about the MHSA planning processes and the current and emerging system of care across the three cities. We not only wanted to increase *general* public knowledge about MHSA; we also wanted to increase specific understanding of MHSA and the CSS plan, particularly among people who are currently receiving services, or could be receiving services, and their families. Throughout these efforts we stressed the vital role of consumers and family members,

and sought to identify new consumers and family members to join the process. We also solicited existing staff members and community partners for ideas about how to spread the word to consumers and families, especially from underserved and underrepresented populations.

Through the course of our planning process, we issued press releases to community newspapers—the Daily Bulletin, Inland Valley News, and the Tribune—and to La Voz, a Spanish newspaper (See Part IV, Attachment 1 for a sample article). We also posted the schedule of delegates' meetings and related materials on the Tri-City MHC website.

Below is a list of individuals and organizations we engaged through presentations and 1:1 meetings prior to posting the draft plan, reflecting a total of 56 different entities involving well over 1000 individuals:

Name	Description and Notes	# of Attendees
Consumer, Family Member, and Under-Represented Groups		
BIACO Clubhouse	Individuals receiving services	26
BRIDGES, Inc.	Helping individuals with developmental disabilities. 1:1 meeting to encourage outreach to others	1
Cal Poly Pomona Gay/Lesbians	Presentation to encourage outreach to others	15
NAMI Pomona Valley chapter	National Alliance for Mental Illness, family members, monthly meetings	65
Pacific Clinics	Individuals receiving services	4
Services Center for Independent Living	Provides services for disabled people of all ages. 1:1 meeting to encourage outreach to others	1
TAY consumer	1:1 meeting to encourage outreach to others	1
Vietnamese American Community	Community leader in 1:1 meeting to encourage outreach to others	1
Vietnamese Cultural House	Community leader in 1:1 meeting to encourage outreach to others	1
Ohlone Costanoan Rumsen Wellness Center	Community center providing support to Native American people in the tri-city area	10
Coalitions		
Claremont Youth and Family	Representing 15 committee members and 99 community partners	13
Homeless Fair	Sponsored by Project Homeless Connect. People of all ages and ethnic groups attended, including people who are homeless or at risk of homelessness, providers, family members, advocates, etc.	431 + 50 service providers
Human Services Mental Health Collaborative, Claremont	Representing 20 different agencies	15
Pomona Continuum of Care, Homelessness in Pomona	Monthly updates to members from non-profit, governmental, and faith-based agencies	30
Pomona Youth & Family Services	City supported coalition representing 90 agencies	1
Project Homeless Connect, Steering Committee	Monthly meetings with representatives from LA County Dep'ts —e.g., DPSS, DCFS, etc.	15
Sexual Assault Response Teams	Collaboration among law enforcement, community agencies, family members, and survivors	22

Name	Description and Notes	# of Attendees
Faith-Based Organizations		
Community Services Center	Organization in West Covina (bordering the tri-city area) that provides support services; 1:1 meeting to encourage outreach to others	1
Homeless Education Support	1:1 meeting to encourage outreach to others	1
Joselyn Senior Center	Staff members to explain connection between CSS and Older Adults	3
Neighborhood Partnership	1:1 meeting to encourage outreach to others	1
Veterans Administration	1:1 meeting to encourage outreach to others	1
Weed and Seed	Gang involvement safe havens for children and youth, 5 agencies and large parent constituency	2
Youth Employment Services	1:1 meeting to encourage outreach to others	1
Faith-Based Organizations		
Catholic Charities	Meeting to encourage outreach to others	2
City of Knowledge	Islamic K-6 School, PTA meeting with parents	25
Inland Valley Hope Partners	1:1 meeting to encourage outreach to others	1
Inter-faith Council	Diverse faith-based organizations	14
Pomona United Methodist	1:1 meeting to encourage outreach to others	1
Pomona Valley Christian Ministry	1:1 meeting to encourage outreach to others	1
Temple Beth Israel	1:1 meeting to encourage outreach to others	1
Colleges		
Mt. San Antonio College	1:1 meeting to encourage outreach to others	1
Hospitals and Health Care Providers		
East Valley Hospital	1:1 meeting to explain basics of CSS plan	1
FAP Foothill Aids Project	1:1 meeting to explain basics of CSS plan	1
Ideal Care and Health Services	1:1 meeting to explain basics of CSS plan	1
Pomona Community Health Center	1:1 meeting to explain basics of CSS plan	1
Pomona Valley Family Health Ctr	1:1 meeting to explain basics of CSS plan	1
Mental Health Service Providers		
Arcadia Mental Health	1:1 meeting to explain basics of CSS plan	1
Aurora Behavioral Health Care, Charter Oak Hospital	1:1 meeting to explain basics of CSS plan	1
Bonita Family Center	1:1 meeting to explain basics of CSS plan	1
David and Margaret Youth and Family Services	1:1 meeting to explain basics of CSS plan	1
House of Ruth	Women and children affected by domestic violence. Mtg w/ staff to explain basics of CSS plan.	4
Landmark Medical Center	Institution of Mental Disease (IMD) 1:1 meeting to explain basics of CSS plan.	1
LeRoy Haynes Center for Children and Family Services	Residential and educational facility. 1:1 meeting to explain basics of CSS plan.	1
LA County Department of Mental Health	Service Area 3. Presentation to discuss emerging CSS plan and implications for SA 3.	40
McKinley Children's Center	Residential and mental health programs. 1:1 meeting to explain basics of CSS plan.	1
Prototypes Advisory Council	Presentation on the emerging CSS plan.	38
Tri-City Clinic	Presentation to line staff re: emerging CSS plan.	40

Name	Description and Notes	# of Attendees
Substance Abuse Treatment		
American Recovery	1:1 meeting to explain basics of CSS plan	1
Havenly Homes	1:1 meeting to explain basics of CSS plan	1
Help the People Foundation	1:1 meeting to explain basics of CSS plan	1
River Community, Social Model Recovery System Inc.	Residential treatment for adults	1
Sober Living Network	Approximately 27 organizations providing support for substance abuse and co-occurring disorders	1
Social Model Recovery	Presentation on emerging CSS plan	42
Political Constituencies		
City Hall meetings with all 3 cities	Claremont and Pomona city hall meetings	95
City Managers	1:1 meetings with City Managers from all 3 cities	3
Mental Health Task Force	Sponsored by Congresswoman Grace Napolitano. Presentation to explain basics of the CSS plan.	45

The presentations listed above are only those conducted by Tri-City MHSA and Outreach staff. In addition, there were many more meetings conducted by *delegates* as they discussed the emerging plan with their constituencies (see table on page 10 for a list of delegates and their constituencies).

Following the posting of the draft plan, we trained a team of 15 people, including people receiving services, family members, advocates and staff, to make presentations to explain the essentials of the draft plan and to seek feedback and support. This team, including Tri-City Outreach and Engagement staff and consultants, made presentations and held conversations with dozens more organizations and entities, reaching more than 1200 people between March 16 and the public hearing on April 16, 2009. Please see the details below. [2]

Strategy #2: *Strengthening networks of relationships for consumers and families to connect with each other and to the process*

We have acted on this strategy in several ways to date. First, we recruited seven people currently receiving services to participate as delegates in the CSS planning process. Staff met regularly with members of this group, both individually and collectively, to help prepare them for the meetings and solicit their feedback on emerging issues. These

[2] Although it will occur after the public hearing, Tri-City MHC is sponsoring a movie night on Friday, April 24, 2009 to showcase the movie, *The Soloist.* This movie is based on the true story of Los Angeles Times journalist Steve Lopez and his relationship with Nathaniel Ayers, whom Lopez met on Skid Row. A musical prodigy, Ayers developed symptoms of schizophrenia during his second year at Juilliard School and ended up homeless in Los Angeles. The movie illustrates the many relationships that supported Ayer's journey of recovery. Tri-City MHC purchased tickets for the entire Laemmle theater (250 seats) for this event. A one-hour reception for guests preceding the showing will promote increased awareness about mental health issues, the emerging CSS plan, and the upcoming MHSA planning efforts focused on the Prevention and Early Intervention plan and others.

members regularly engaged BIACO members and other people receiving services through the Tri-City clinic, sharing with them what they were learning in the process. One of these consumers actively participated in the subcommittee process (described below) and is emerging as a potential consumer leader for the next phases of the MHSA planning effort.

Several NAMI members were also members of the delegates, and regularly briefed NAMI members on the plan and its progress, both at regular NAMI meetings and in small group conversations between meetings.

As indicated in the community outreach table, staff have also reached out to consumers, family members, and community leaders across the region, building relationships that are already beginning to generate contacts fomr people from traditionally unserved and under-served ethnic groups and others who are interested in participating in the next phases of the process, or who want to find out about supports that may be available to them.

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

A representative process

A total of 48 delegates participated in the CSS planning processes, representing a wide array of constituencies and stakeholders. We solicited applications for the delegate positions through early outreach efforts, particularly targeting representation from unserved and underserved constituencies. We also publicized the application through local newspapers to help attract candidates who might not already have a relationship with Tri-City Mental Health Center (Tri-City MHC). We analyzed the final roster of nominations to maximize diversity of representation before submitting it to the Tri-City Governing Board for approval.

The table on the next page documents the various constituencies represented by the 48 delegates. The abbreviations used are as follows:

- Constituency: Consumer=persons who have received services; GLBT=gay, lesbian, bisexual, or transgender; MH Commission=Tri-City Mental Health Commission; Congress Ofc=Local Congressional Office; Governing Board=Tri-City MHC Governing Board

- Ethnicity: W=White; AA=African American; L=Latino; API=Asian Pacific Islander; NA=Native American; and N/A=not answered.

- City: C=Claremont; LV=La Verne; P=Pomona; W=Whittier; SD=San Dimas; LA=Los Angeles

#	Primary Constituency	Other Constituency	Gender	Ethnicity	City	Non-English Language
1	Consumer	Family member, persons affected by domestic violence	F	W	C	
2	Consumer	MH Commission, homeless persons	M	W	LV	Spanish
3	Consumer		F	W	P	
4	Consumer	Family member, MH Commission	M	AA, L	P	
5	Consumer		F	AA	P	
6	Consumer	Family member	F	W	LV	
7	Consumer		F	API	P	Tagalog
8	Family member	Consumer, older adults	F	W	C	
9	Family member	Persons w/ co-occurring disorders and other disabilities	F	W	P	
10	Family member	NAMI, faith-based org.	M	W	P	
11	Family member	Children, TAY, NA community	M	NA, L	P	Spanish
12	Family member	NAMI, Claremont Mental Health Consortium	M	W	C	
13	Family member	Regional Center, TAY	M	W	LV	
14	Advocate	Claremont Committee on Aging, older adults	F	W	C	
15	Advocate	LA County Office of Education, victims of domestic violence	F	AA	P	
16	Provider	American Recovery, substance abuse	M	AA	P	
17	Provider	Pacific Clinics, immigrants	M	API	P	Mandarin, Taiwanese
18	Provider	Pilgrim Place, Joslyn Senior Ctr, older adults, persons w/ disabilities	F	N/A	C	
19	Provider	Governing Board, persons affected by substance abuse	M	W	C	
20	Provider	Pacific Clinics	F	L, AA	P	Spanish
21	Provider	Prototypes, women, persons affected by substance abuse	F	AA	P	
22	County Dep'ts serving TC area	LA County Probation Department	F	W	W	
23	County Dep'ts serving TC area	LA County Board of Supervisors	F	L	P	
24	County Dep'ts serving TC area	LA Department of Mental Health	M	L	LA	
25	Congress Ofc		M	L	SD	
26	Law Enforcement	Claremont PD, MH Commission	M	N/A	C	
27	Law Enforcement	La Verne PD	M	W	LV	
28	Law Enforcement	Pomona PD	M	W	P	
29	City employee	Claremont	F	W	C	
30	City employee	La Verne	M	L	LV	
31	City employee	Pomona	M	W	P	
32	School	Bonita School District	F	N/A	LV	
33	School	Claremont Unified School District	F	W	C	
34	School	Pomona Unified School District, family member, NAMI	F	L	P	Spanish

#	Primary Constituency	Other Constituency	Gender	Ethnicity	City	Non-English Language
35	Health services		F	L	P	Spanish
36	Health services	Pomona Valley Hospital	F	W	P	
37	Colleges	Cal Poly Pomona, TAY	F	N/A	P	
38	Colleges	University of La Verne, TAY	F	N/A	LV	
39	Faith-based Org.	Clinibell Institute	F	N/A	C	
40	Faith-based Org.	Catholic Charities, persons who are homeless	F	API	P	Tagalog
41	TC Clinic staff	GLBTQ community	F	W	P	
42	TC Clinic staff	Individuals with disabilities	M	W	P	
43	TC Clinic staff		F	L	P	Spanish
44	TC Clinic staff	Pomona Urban League, vocational educational programs, persons who are unemployed	F	AA	P	
45	MH Commission		F	AA	LV	
46	Governing Board	Pomona City Council	F	W	P	
47	Governing Board	Claremont City Council	F	W	C	
48	Governing Board	La Verne community, family member	F	AA	LV	

Of the 48 delegates:

- At least 17% had received mental health services, and at least 21% were family members;
- 19% were African American, 6% were Asian and/or Pacific Islander, 21% were Latino, 1 delegate was Native American, and 46% were White;
- 6 delegates were fluent in Spanish, 2 in Tagalog, and 1 in Chinese Mandarin and Taiwanese;
- 35% were men and 65% were women;
- 52% lived in Pomona, 23% in Claremont, 19% in La Verne, and 6% lived outside the three cities; and
- 4 were children's advocates, 4 were TAY advocates, and 3 were older adult advocates.

Other constituencies represented included persons with co-occurring disorders, and persons who are homeless, unemployed, immigrant, disabled, or gay, lesbian, bisexual, or transgender. City and county departments represented included law enforcement, probation, LA County Board of Supervisors, LA County Department of Mental Health, and Congressman David Dreier's office.

In addition, approximately 25 observers attended the delegates meetings, including representatives from Catholic Charities, the League of Women Voters, NAMI Pomona Valley, and staff from the Tri-City Clinic and two recovery and wellness centers from nearby communities. Four members of the Ohlone Costanoan Rumsen Native American community, and a high school student writing a school paper about the planning process, also regularly attended meetings as observers.

A comprehensive process

Delegates met for a total of eight meetings between mid-December and early March. Meetings were held in the evenings from 5:00-9:00 p.m. to insure that people who work could attend. We served dinner at each gathering, and were prepared to offer child care and translation services if any delegate or observer required them (none did during this process). In between the meetings, delegates were encouraged to meet regularly with their constituencies to get their feedback and to bring back their feedback at the next meeting.

The delegates' meetings were announced through e-mails, letters, and the outreach efforts described earlier. Observers were also invited to attend the delegates' meetings. Orientations were provided prior to delegates' meetings and greeters welcomed new participants at each meeting. Observers were encouraged to provide comments during meetings and to participate in the priority-setting processes. They were, however, not part of the decision-making processes in recognition of the higher commitment needed to effectively deliberate on the complex issues presented within the CSS Plan.

We began the delegates' process with a mini-seminar—spanning two meetings—that introduced participants to the concepts of recovery, wellness and resiliency, the concept of a system of care, and the history and evolution of the Mental Health Services Act. We then shared data about community needs and the current services in the Tri-City area, inviting delegates to supplement the formal data with stories from their own experiences and perceptions. We then asked delegates to prioritize needs and potential investments to address the most urgent issues in the community, informed by the realities of existing budgets and the MHSA guidelines and allocations.

At this point in the process, delegates authorized a subcommittee to review the data that had emerged to that point, and then to develop program and budget options for the delegates to consider. The subcommittee's twelve members represented a cross section of the delegates, including people who receive services and family members. Subcommittee members met four times (over sixteen hours) during February to develop proposals for delegates to review.

The delegates then met for three additional meetings to refine and revise the proposals that had emerged from the subcommittee.

The decision-making process

Throughout the process, delegates were introduced to practices and principles that promote the emergence of collective wisdom. Rather than debate and compromise, delegates were introduced to the skills of dialogue and discernment. Delegates were encouraged to welcome divergent perspectives, treating such perspectives as neutral data rather than opposing views that people had to choose between.

For any major decision taken by the group, no voting took place. Instead, each delegate was polled using a tool called the Gradients of Agreement. (Part IV, Attachment 2) Delegates faced no pressure to agree with each other, or to develop convergent recommendations for the Tri-City Governing Board. Had the deliberations ultimately resulted in irreconcilable differences, the areas of convergence and divergence would have been fully documented and shared with the Tri-City Governing Board in the final report. In this case, however, every delegate fully endorsed the structure and budget of the CSS plan. The plan submitted to the Tri-City Governing Board for final approval represents *a complete consensus* among the delegates.

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

Tri-City MHC staff and consultants with primary responsibilities for the CSS planning process included the following:

1. Rimmi Hundal, MA, MHSA Coordinator, dedicated 100% of her time, and Gilbert Saldate, Community Outreach Coordinator, dedicated approximately 65% of his time to this effort. They collaborated closely to fulfill the following responsibilities:
   - Gathering data to support the analysis required for the CSS Plan;
   - Conducting outreach to a broad spectrum of community stakeholders, including consumers, family members, and ethnic populations;
   - Organizing the logistics for the delegates' meetings and welcoming all stakeholders;
   - Facilitating presentations, orientations, and trainings in support of effective outreach and engagement of stakeholders in the CSS planning process and future MHSA planning processes;
   - Updating Tri-City MHC staff members, Board members, and Tri-City Mental Health Commission members as needed; and
   - Collaborating closely with external consultants to help insure timely progress on all benchmarks.

2. Nancy Day, Executive Administrative Assistant, dedicated approximately 15% of her time to provide on-going administrative and clerical support, including coordination of logistics for delegates meetings.

3. Jesse Duff, Executive Director, devoted approximately 40% of his time to providing oversight of key budgetary, policy, staff, and programmatic considerations.

4. Toni Navarro, LMFT, Director of Clinical Services, dedicated approximately 40% of her time to the following responsibilities:
   - Sharing clinical, programmatic, and budgetary expertise with delegates as appropriate;
   - Actively supporting delegates as needed to help them accomplish key objectives;
   - Recruiting and engaging relevant community partners in the planning processes;

- Planning for implementation issues such as training, staffing requirements, contract administration, and provider selection;
- Designing and delivering training for staff to support the recovery model; and
- Participating in the delegates' subcommittee.

5. Margaret Harris, Chief Financial Officer, devoted approximately 15% of her time to help educate the delegates about budgetary issues and to provide oversight of all budgetary projections.

6. Nancy Gill, BA, Director of Operations, devoted approximately 20% of her time to begin developing the information technology, billing, and reporting structures needed to effectively implement the CSS Plan.

7. The following four staff members devoted approximately 10% of their time to participate as delegates and to provide support to consumer delegates as appropriate:
   - Mary Baron, LCSW, Program Manager for Specialized Clinical Services;
   - Paul Crane, LMFT, Program Manager for Children's Outpatient Services;
   - Regina Ortega, Mental Health Specialist; and
   - Rosalind Watson, Employment Outreach Coordinator.

8. The following three staff members devoted approximately 5% of their time to help conduct community outreach and engagement efforts:
   - Toshi Koramatsu, LCSW, Program Manager;
   - Elizabeth Owens, IMF, Pre-License MFT, Quality Assurance Manager; and
   - Al Chin, MSW Program Supervisor.

9. In addition, John Ott, JD and Rose Pinard, PhD were lead consultants for this process, devoting approximately 40% of their time to the following responsibilities:
   - Designing the overall CSS planning processes;
   - Designing and leading trainings for individuals who receive services and family members about how to participate in this process and training staff trainers to continue this effort as needed;
   - Designing and leading training on the basic elements of the MHSA, community engagement strategies, and other process topics;
   - Facilitating delegates' and subcommittee meetings;
   - Helping compile and analyze the research data required by the CSS Plan; and
   - Translating the stakeholder agreements into the CSS plan format required by CA DMH.

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

The training process began with orientation sessions for delegates, front-line staff, Mental Health Commission members, Governing Board members, and others. These sessions introduced participants to the basic elements of the MHSA, and to the core

concepts of recovery and wellness, outcomes, cultural competency, and a system of care. These sessions also provided an overview of demographic, prevalence, and service utilization data.

We also provided delegates with on-going training about how to create effective collaborative planning processes. The specific topics of these sessions included:

- Effective communication;
- Strategies and skills for building consensus; and
- Creating a safe learning environment for exploring new issues and generating innovative solutions.

In addition, Tri-City Clinic staff members received training to develop a deeper understanding of the principles of recovery, resiliency, and wellness, and the related commitments to outcomes and cultural competency. These sessions focused on preparing for the Full Service Partnerships and related components of the CSS plan, as well as key concepts of systems transformation. Similar trainings were provided to members of the Coastanoan Native American tribe, members of NAMI, and members of the Inter-faith Council.

Staff members are now developing training for staff members of other community providers, and for community leaders—e.g., teachers, child welfare workers, probation officers, and others. These trainings will be provided over the next several months as we prepare to implement the CSS plan.

PART I, SECTION II: Plan Review Processes

1) Provide a description of the CSS Plan Review process to ensure that the draft plan was circulated to representative stakeholder interests and any interested party who requested it.

From March 16, 2009, when we posted the plan, until April 16, 2009 when we held our public hearing, we participated in over 40 community meetings, reaching almost 1200 people in the three cities, to inform them about the draft CSS plan. These presentations included people who currently receive or could receive services, family members, staff and providers, community leaders, elected officials, community advocates, city managers and staff members, and many others. We invited feedback to the plan, and encouraged participation in the public hearing and in the next phases of the MHSA planning effort. Some of the groups we presented to included:

- BIACO Clubhouse
- Multiple groups of consumers from Tri-City Clinic
- California State Polytechnic University students and faculty
- Claremont City Hall staff
- Claremont Human Services Dep't
- Claremont Youth Activity Center staff and members
- Claremont Unified School District principals and teachers
- Claremont Unified School District

- House of Ruth
- Kiwanis Club of Pomona Valley
- Claremont Mental Health Collaborative
- NAMI of Pomona Valley
- Community meetings for mono-lingual Spanish and Vietnamese speaking residents
- Service Area 3 Council
- Pomona Homeless Coalition
- Pomona Interfaith Council
- Pomona Valley Hospital residents, staff, and patients
- River Community Program
- Pomona Valley Public Health Board
- Tri-City Clinic staff
- Trinity United Methodist Church
- University of La Verne
- Constituency meetings held by Pomona City Council members
- Pomona Youth and Family Master Plan Council
- Claremont Coordinating Council
- La Verne Interfaith Council
- Costanoan/Ohlone tribe members

In addition to these presentations, we conducted a local cable interview, and wrote an article advertising the public hearing that appeared in all the local newspapers. Additionally, we posted the plan on the Tri-City website (in both English and Spanish), and posted hard copies in both languages at all public libraries in the area. Interested individuals were able to email, fax, or mail feedback to us for review and consideration.

2) Provide documentation of the public hearing by the mental health commission.

The public hearing we held on April 16, 2009 was the culmination of an aggressive outreach effort that began in November 2008. Over 100 people attended the public hearing, including people who receive services and family members, representatives from community organizations and agencies, representatives from the three cities, Tri-City Mental Health Center staff, and a range of other interested stakeholders, including clergy, representatives from LA DMH and other county departments, and many others. We offered translation services in three languages—Spanish, Vietnamese, and sign language.

One of our objectives for this public hearing was to attract many people who had not yet been engaged in the process: more than 60 people indicated in their small groups that the public hearing was either their first formal meeting about the CSS plan (36 people), or that they had attended only a few meetings on the plan (32 people).

Participants in the public hearing had three opportunities to be heard: first, through small group conversations following a brief presentation about the plan; second through individual comment sheets made available to every participant; and third, through public comment during the large group discussion. Delegates from the planning process facilitated the small group discussions.

The table discussions and the large group dialogue revealed enthusiastic support for every aspect of the plan (see Part IV, Attachment 3 for a summary of the feedback). The following comments were typical:

- We like the flexibility and the attitude of "whatever it takes" in Full Service Partnerships.
- My aunt is ill. After hearing about the plan, I want her to move here to get help.
- This hearing and whole process has had a rare level of participation.
- Good that older people will have services brought to them.
- Wellness Center will hopefully help people stick to medication courses and plans.
- Really like focus on helping young people who are severely mentally ill. The Center where young people can come and "hang out" is a really good idea.
- I like the commitment to culturally appropriate services. Need to be delivered in partnership with community leaders.
- Really like the special focus on TAY in the Wellness and Recovery Center
- The focus on crisis services is important.

The questions that people asked about the plan focused primarily on *how* and *who* issues. For example:

- How will we insure that TAY won't fall between the cracks?
- Who can qualify for these services?
- How will Full Service Partnerships connect with field capable services for older adults?

Note that these questions reflect support for the intention of the plan, focusing on how it will achieve its ends. The suggestions for additional action focused primarily on engaging additional constituencies—e.g., health providers, schools—and funding additional services—e.g., housing. These suggestions will be addressed in our next planning efforts focused on the remaining non-recurring CSS funds, and the Housing and Prevention and Early Intervention plans.

At the end of the hearing, first Mental Health Commission members, and then Governing Board members, voted unanimously to recommed the plan to CA DMH for approval.

We are proud of the work we have done to craft the Community Services and Supports Plan, and to engage a broad cross-section of communities in the process. We firmly believe that the CSS plan is a vital next step in our efforts to transform the mental health services system in the tri-city area.

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

Residents of the tri-city area had multiple opportunities to comment on the plan. We received no substantive recommendations for change to the plan.

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

We received no substantive recommendations for change to the plan.

PART II: PROGRAM AND EXPENDITURE REQUIREMENTS

PART II, SECTION I: Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

In this section, CA DMH requires counties to describe how they plan to reduce long-term adverse impacts of untreated mental health illness and serious emotional disorders in their communities. As a first step, counties must identify which of the key issues outlined by CA DMH are priority concerns that, if they addressed, can make a significant contribution to the mental health of their community members.

1) Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years.

CA DMH identified a number of priority community issues by age group for counties to consider in their planning efforts. These issues included:

- For children and TAY: inability to be in a mainstream school environment, school failure, hospitalization, peer and family problems, out-of-home and out-of-area placement, and involvement in the child welfare and juvenile justice systems.
- For adults, older adults, and some transition age youth (TAY): homelessness, frequent hospitalizations, frequent emergency medical care, inability to work, inability to manage independence, isolation, involuntary care, institutionalization, and incarceration.

Tri-City delegates and stakeholders highlighted most of these issues as concerns to address through the CSS Plan, specifically prioritizing the following:

- A significant decline in intensive services, leading to the threat of increased homelessness, frequent hospitalizations, frequent emergency care, and increased involuntary care, institutionalization, and incarceration.
- A lack of community resources to promote independence, wellness, recovery, and resiliency, and increased employment and education;
- A lack of support for TAY struggling with mental health issues, leading to increased isolation, risk of homelessness, and risk of institutionalization;
- A lack of field capable services for older adults, leading to increased isolation, diminished capacity, and risk of institutionalization; and
- A lack of appropriate housing options for people with mental health issues in various stages of recovery.

Issue: *A significant decline in intensive services and crisis services for all age groups*

This decline began, tragically and precipitously, with Tri-City MHC's bankruptcy. In February 2004, after being a community provider for over 40 years, Tri-City MHC filed for bankruptcy protection under Chapter 9 of the bankruptcy code. The number of staff members declined from over 300 to fewer than 50. The budget was reduced by over

75%, from $21 million to $5 million. It is hard to overstate the trauma that this bankruptcy had on the three cities. Remaining Tri-City staff did everything they could to ensure an effective transition for the many clients whom they could no longer serve. Other providers stepped up to shoulder some of the responsibilities. Each of the three cities developed various responses to the sudden disappearance of mental health funds. Such efforts notwithstanding, however, there simply was no easy or comprehensive solution for the loss of millions of dollars and hundreds of staff.
One of the many remarkable achievements by Tri-City MHC staff during the bankruptcy was the continuation of its highly successful AB2034 program. Tri-City MHC was one of the original sites for the AB34 pilot projects, and for the statewide AB2034 program that followed. Positive outcomes from the AB2034 services included significant reductions in rates for hospitalization, incarceration, and institutionalization and increased ability to quality for benefits and employment. Indeed, AB2034 was the model for the Full Service Partnerships required to be provided under the CSS plan. Tri-City MHC was able to consistently achieve outcomes within the top 30% of all state providers and even achieved the second highest outcome for education.

In June 2008, however, Tri-City MHC was forced to end this program, along with every other county in the state, because Governor Schwarzenegger zeroed out the program as part of his final FY 2007-08 budget.[3]

The loss of this program has hit the three cities hard. Several hundred individuals had been enrolled in the program since its inception, with an average annual enrollment of approximately 100. Each enrolled individual received intensive support, including 24-hour access to case managers. Supports included transitional housing (e.g., loans to cover move-in costs, community housing at 4 dedicated locations) and assistance to help secure part-time and full-time education and employment (e.g. college enrollment, GED testing, and vocational skills training). With the end of the AB2034 program, these supports went away. Hundreds of people who were benefitting from the program had to do with far less help and support.

Another result of the bankruptcy was a significant decline in local crisis services after hours and on weekends for the three cities. While the Tri-City directly operated clinic, and other providers in the area, offer 24/7 crisis support for *people they currently serve,* people who are not currently receiving services who suffer a crisis during the evening or on weekends must rely on Los Angeles County's Psychiatric Mobile Response Team (PMRT). Response times can sometimes take hours, given the location of the three cities on the eastern edge of the county. Such long response times before a clinician is available to support the person in crisis and his/her family increases the likelihood that the situation will deteriorate, resulting in a 5150, the person being sent to an emergency room, or the person being incarcerated. Preliminary data from LA DMH and local police

[3] State funding actually ended July 1, 2007, but Tri-City reallocated general funding from other programs and used operating reserves to continue services for another year, allowing time to facilitate transitions to other programs and supports for the individuals who had been enrolled in the program.

departments suggests a significant increase in the number of 5150 calls since the bankruptcy and the termination of the AB 2034 program. Specifically, the number of 5150 and 5585 incidents more than doubled between FY 2005-06 and calendar year 2008, from 475 to almost 1000.

Moreover, responding police officers can be detained for hours, taking them away from their normal patrol duties. This is a significant issue for all three cities, and particularly for the city of La Verne. Given the size of its police force, even a single 5150 call can expose La Verne residents to extended periods of minimal police protection.

Issue: *A lack of community resources to promote independence, increased wellness, recovery, and resiliency, and increased employment and education*

Facing declining budgets and increased need, area providers—including Tri-City's clinic, Prototypes, Pacific Clinics, David and Margaret Home, and others—are doing what they can to provide 1:1 counseling, group counseling, medications support, and other traditional mental health services. Without a strong presence of services and other resources to promote recovery, resiliency, and wellness, however, people currently receiving services can stall on their path to independence, thereby maintaining their reliance on traditional mental health services and preventing other people from being able to access the increasingly stretched traditional mental health services.

Issue: *a lack of support for TAY struggling with mental health issues, leading to increased isolation, and increased risks of homelessness and institutionalization*

The population of children and TAY is increasing dramatically in the three-city area, particularly in the city of Pomona. Delegates and myriad stakeholders we interviewed decried the lack of services and supports for TAY struggling with mental health issues. Many delegates had personal experiences with TAY who could not get timely access to services and supports. School officials and others interviewed as part of the outreach effort echoed these sentiments. As vital as the BIACO club house is, for example, adults are its most frequent participants; TAY often feel out of place in such environments. TAY who emerge from the juvenile justice system, or from the foster care system, also often lack support to make a successful transition to independence.

Issue: *a lack of field capable services for older adults, leading to increased isolation, diminished capacity, and risk of institutionalization*

Older adults are the fastest growing population in the cities of Claremont and La Verne. While a number of programs provide health and social supports for older adults, there are few services to meet the mental health needs of this population. Older adults, especially frail elders, need mental health services provided at locations that are convenient to them—e.g., in their homes, senior centers, and medical facilities.

Issue: *a lack of appropriate housing options for people with mental health issues in various stages of recovery*

Homelessness has plagued the tri-city area for decades. Several collaboratives have emerged over the past 20 years to address the needs of homeless people and the need for affordable housing in the San Gabriel Valley, including the cities of Pomona, La Verne, and Claremont. Current estimates of homeless people in the three cities range into the thousands. The loss of the AB2034 program exacerbated the threat of homelessness for some of the most seriously mentally ill people living in the tri-city area. A recent report on homelessness in the San Gabriel Valley (the LA County region that includes the three cities) included the following analysis:

> While inefficiencies in the current system should be addressed, there exists an insufficient number of both short-term housing beds and permanent supportive housing units available in the San Gabriel Valley to address the current need. Regardless of how coordinated the system is, without sufficient capacity to facilitate the movement of individuals and families out of homeless and into permanent housing and self- sufficiency, the system will not achieve meaningful outcomes nor decrease the number of homeless persons. This fact, and weakness in the current system, was reported by a majority of service providers as well as many city officials throughout the San Gabriel Valley.
>
> The valley lacks an adequate number of emergency shelter and transitional housing programs that enable temporarily homeless individuals and families to quickly stabilize their lives and end their homelessness. In addition, a subset of the homeless population suffering from mental and physical disabilities and other barriers to housing stability require longer term support to stabilize their lives and end their homelessness. … Data collected through this study reveals that 30% of adult clients in short-term housing programs in the San Gabriel Valley reported their previous residence to be another short term housing program. Similarly, 22% of adult clients leaving short-term housing programs were discharged into another short term housing program. The San Gabriel Valley lacks an adequate supply of permanent supportive housing to meet the needs of this sub-population. …[4]

2) Please describe what factors or criteria led to the selection of the issues identified above to be the focus of MHSA services over the next three years. How were issues prioritized for selection?

Given the history of the bankruptcy, and the current economic crisis confronting the state and cities, the fabric of support for people suffering mental health issues has been profoundly rent. As one delegate commented during the planning process: "We have a

[4] San Gabriel Valley Regional Homeless Services Strategy Phase I Report, October 10, 2008, p. iii.

target rich environment here. We can select almost any issue and it would be a high priority issue."

In selecting the priority issues for the CSS plan to address, delegates focused on several strategic considerations, including:

- Making investments to construct and strengthen a system of care across the three cities, rather than funding isolated services;
- Working to leverage existing community resources and collaborations;
- Making investments that clearly demonstrate a commitment to wellness, resiliency, and recovery;
- Learning from the experiences of other counties' CSS implementation efforts;
- Taking advantage of the relative flexibility of the MHSA funds compared to other funding sources (e.g., Medi-Cal) to address some of the community's most intractable issues and most vulnerable populations; and
- Remaining aware of the scope and focus of future MHSA plans (e.g., Prevention and Early Intervention) and prioritizing investments that only are possible through the CSS plan.

To guide their decision-making in accordance with these strategic considerations, delegates received a detailed overview of the MHSA, the CSS Plan requirements, funding allocations, and a system of care model describing key components organized from intensity of care through increasing levels of independence. They also discussed core values such as recovery, resilience, and cultural competence, and reviewed data about the current accessibility and availability of mental health services for the four age groups.

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

Our analysis of such disparities is hampered by a significant absence of data specific to the three cities. Many data sources—e.g., juvenile justice data, child protective services data—are compiled at a County or Service Planning Area level, preventing any meaningful analysis for the tri-city area. Moreover, throughout the planning process, we were often forced to rely on less than current data, or to extrapolate from incomplete data and/or data from different years. The data we gathered required extensive outreach efforts, and frequent extrapolations. One of our intentions in building a system of care in the three cities is to develop reliable sources of area-specific data that can guide future planning efforts.

As listed in the previous section, the five priority community issues identified through our planning process include:

- A significant decline in intensive services, leading to the threat of increased homelessness, frequent hospitalizations, frequent emergency care, and increased involuntary care, institutionalization, and incarceration.
- A lack of community resources to promote independence, wellness, recovery, and resiliency, and increased employment and education;
- A lack of support for TAY struggling with mental health issues, leading to increased isolation, and increased risks of homelessness and institutionalization;
- A lack of field capable services for older adults, leading to increased isolation, diminished capacity, and risk of institutionalization; and
- A lack of appropriate housing options for people with mental health issues in various stages of recovery.

Given our incomplete data sets, the following analysis applies to all five of these issues. The current penetration rates for mental health services within the three cities are extremely low. Self-reported data from providers in the three cities suggests that just over 2,000 people are receiving publicly funded mental health services *of any kind or intensity.* This number represents only about 25% of the number of people living in the three cities below the 200% federal poverty threshold projected to be suffering from SMI or SED:

ESTIMATE OF PEOPLE WITH SMI/SED UNDER 200% OF FEDERAL POVERTY THRESHOLD IN TRI-CITY AREA				
Age Groups	**SMI/SED prevalence rate for < 200% Poverty**	**Tri-City Pop < 200% Poverty**	**Estimated Pov Pop w/SMI/SED**	**% of Total**
0-15	8.97%	31,380	2,815	40.11%
16-25	8.72%	15,386	1,342	19.12%
26-59	8.66%	27,818	2,409	34.33%
60-60+	6.83%	6,619	452	6.44%
Totals		81,203	**7,018**	100.00%
Sources: CA DMH, 2000 US Census + extrapolation				

ESTIMATE OF PEOPLE WITH SMI/SED UNDER 200% OF FEDERAL POVERTY THRESHOLD RECEIVING NO PUBLIC MENTAL HEALTH SERVICES				
Age Groups	**Estimated Pov Pop w/SMI/SED**	**# Receiving some mental health service**	**# Receiving no services**	**% Receiving no services**
0-15	2,815	437	2,378	84.47%
16-25	1,342	392	950	70.79%
26-59	2,409	1219	1,190	49.39%
60-60+	452	37	415	91.81%
Totals	**7,018**	**2085**	**4,933**	**74.71%**
Sources: CA DMH, 2000 US Census, provider self-reports, extrapolation				

Almost 75% of the people living under 200% of the federal poverty threshold who likely suffer from SMI/SED are receiving no services. This number is clearly much higher if we extend the analysis to include the working poor, people who may be living at 300% or

400% of the federal poverty threshold. The need for mental health services of all kinds, including those that promote independence, increased wellness, recovery, and resiliency, and increased employment and education, is made clear by these numbers.

Focusing specifically on intensive mental health services, the total number of Full Service Partnerships currently available in the three cities (funded by providers under contract with LA DMH) is 62: 40 partnerships for children, 14 for TAY, 8 for adults, and 0 for older adults. Given these small numbers, the need for intensive mental health services clearly affects all age groups and all ethnic populations. A more detailed analysis of this issue is offered in the next section analyzing the mental health needs in the community.

PART II, SECTION II: Analyzing Mental Health Needs in the Community

CA DMH defines three population groups for analyzing mental health needs. The ***unserved population*** includes individuals who are experiencing symptoms of serious mental illness who are not currently receiving mental health services.[5] A statewide study has been underway to determine the unserved populations in California so individual counties are not required to provide detailed estimates of this group. Counties are, however, required to provide general descriptions of their unserved population using locally available data with particular attention to ethnic disparities.

The ***fully served population*** represents individuals who have been diagnosed with SMI or SED and are receiving mental health services through individualized service plans that support wellness and recovery goals. Such services are also delivered in a manner permitting both the individual and their service providers to agree that the services are both wanted and needed. Specific examples of this type of service include AB 34 and AB 2034 programs for adults and wraparound programs for children within a comprehensive system of care.

The ***underserved or inappropriately served population*** includes individuals diagnosed with SMI or SED who receive some services, but who do not have the needed support and opportunities to pursue wellness and recovery goals. This group also includes individuals so poorly served that they are at risk of becoming homeless, institutionalized, incarcerated, or being placed in settings outside their homes.

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

[5] The formal language differs by age group. Adults and older adults are described as having severe and persistent mental illness (SMI); children and youth are described as suffering severe emotional disturbances (SED).

As noted previously, throughout the planning process, we were often forced to rely on less than current data, or to extrapolate from incomplete data and/or data from different years. The analysis for this section follows that pattern. Disparities between tables in this section often reflect different data sources, or data from different years. We have always used the most current data available. Again, one of our intentions in building a system of care across the three cities is to develop reliable sources of area-specific data that can guide future planning efforts.

The total population for the tri-city area is approximately 229,473 residents. Nearly equal numbers of individuals live in the cities of La Verne and Claremont. Pomona has more than twice the population of the other two cities combined.

TOTAL POPULATION BY CITY				
	La Verne	Claremont	Pomona	Tri-City area
Total population	35,614	36,561	157,298	**229,473**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley				

The following tables indicate the total population by age group and ethnicity:

TOTAL POPULATION BY AGE GROUP					
City: / Age group:	La Verne	Claremont	Pomona	Tri-City area	% by age
0-15	7,524	6,191	46,910	60,625	26.42%
16-25	4,734	4,854	21,884	31,472	13.71%
26-59	16,124	17,341	68,084	101,549	44.25%
60+	7,232	8,175	20,420	35,827	15.61%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley + extrapolation					

TOTAL POPULATION BY ETHNICITY					
City: / Ethnicity:	La Verne	Claremont	Pomona	Tri-City area	% by ethnicity
African American	1,155	1,774	11,735	14,664	6.39%
Asian Pacific Islander	2,474	4,479	10,634	17,587	7.66%
Latino	8,790	6,338	110,330	125,458	54.67%
Native American	156	94	634	884	0.39%
White	22,243	22,886	21,822	66,951	29.18%
Other	46	93	149	288	0.13%
Two or more races	750	897	1,994	3,641	1.58%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley					

TOTAL POPULATION BY ETHNICITY BY AGE GROUP FOR THE TRI CITY AREA						
Age group: / Ethnicity:	0-15	16-25	26-59	60+	Total	% by ethnicity
African American	3,874	2,011	6,489	2,289	14,663	6.39%
Asian Pacific Islander	4,646	2,412	7,783	2,746	17,587	7.66%
Latino	33,145	17,206	55,519	19,587	125,457	54.67%
Native American	234	121	391	138	884	0.39%
White	17,688	9,182	29,628	10,453	66,951	29.18%
Other	1,038	539	1,740	614	3,931	1.71%
Totals	**60,625**	**31,471**	**101,550**	**35,827**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley + extrapolation						

An estimated 35% of the residents or 81,203 individuals live in households earning below 200% of the Federal Poverty threshold. The following tables detail the poverty population for each of the three cities by the four age groups and by ethnicity.

INDIVIDUALS LIVING BELOW 200% OF THE FEDERAL POVERTY THRESHOLD BY AGE GROUP					
City: / Age group:	La Verne	Claremont	Pomona	Tri-City area	% of total by age
0-15	921	1,283	29,176	31,380	38.64%
16-25	1,089	1,074	13,223	15,386	18.95%
26-59	1,701	2,147	23,971	27,818	34.26%
60-60+	681	664	5,274	6,619	8.15%
Totals	4,392	5,168	71,643	**81,203**	100.00%
Source: 2000 US Census + extrapolation					

INDIVIDUALS LIVING BELOW 200% OF THE FEDERAL POVERTY THRESHOLD BY ETHNICITY BY AGE GROUP						
Age group: / Ethnicity:	0-15	16-25	26-59	60 and older	Total	% by ethnicity
African American	2,818	1,382	2,498	594	7,293	8.98%
Asian Pacific Islander	2,132	1,045	1,890	450	5,516	6.79%
Latino	20,023	9,817	17,750	4,223	51,814	63.81%
Native American	506	248	448	107	1,308	1.61%
White	3,903	1,914	3,460	823	10,100	12.44%
Other	1,999	980	1,772	422	5,172	6.37%
Totals	**31,381**	**15,386**	**27,818**	**6,619**	**81,203**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley + extrapolation						

As noted in the previous section, we estimate that 7,018 residents living under 200% of the federal poverty threshold are suffering from serious mental illness (SMI/SED).

ESTIMATE OF PEOPLE WITH SMI/SED UNDER 200% OF FEDERAL POVERTY THRESHOLD IN TRI-CITY AREA				
Age Groups	**SMI/SED prevalence rate for < 200% Poverty**	**Tri-City Pop < 200% Poverty**	**Estimated Pov Pop w/SMI/SED**	**% of Total**
0-15	8.97%	31,380	2,815	40.11%
16-25	8.72%	15,386	1,342	19.12%
26-59	8.66%	27,818	2,409	34.33%
60-60+	6.83%	6,619	452	6.44%
Totals		81,203	**7,018**	100.00%
Sources: CA DMH, 2000 US Census + extrapolation				

Just over 2000 people, however, are receiving publicly funded mental health services of any kind. This means that almost 5,000 people living under 200% of the federal poverty threshold who suffer from serious mental illness are receiving no publicly funded mental health services. The following table shows the distribution of people receiving no publicly funded mental health services across the four age groups:

ESTIMATE OF PEOPLE WITH SMI/SED UNDER 200% OF FEDERAL POVERTY THRESHOLD RECEIVING NO PUBLIC MENTAL HEALTH SERVICES				
Age Groups	**Estimated Pov Pop w/SMI/SED**	**# Receiving some mental health service**	**# Receiving no services**	**% Receiving no services**
0-15	2,815	437	2,378	84.47%
16-25	1,342	392	950	70.79%
26-59	2,409	1219	1,190	49.39%
60-60+	452	37	415	91.81%
Totals	**7,018**	**2085**	**4,933**	**74.71%**
Sources: CA DMH, 2000 US Census, provider self-reports, extrapolation				

These numbers are likely even greater now, given the number of people becoming unemployed as a result of the unfolding recession, and would certainly be greater if we included people living at 300% or 400% of federal poverty thresholds.

The question of disparities by ethnicity in the unserved populations requires the completion of Chart A below, and will be answered as part of the next set of questions.

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

When reading Chart A, please keep in mind the following qualifications:

- For the purposes of this chart, we define *Fully Served* as those individuals who are enrolled in a full service partnership or equivalent service. Given the de-funding of AB2034, the only residents in the three cities who are currently being fully served are enrolled in full service partnerships from providers who have contracts with LA DMH.

- For the purposes of this chart, we have re-named the category *Underserved and/or Inappropriately Served* to *Less than Fully Served.* This category includes individuals who are receiving *any* service less than a full service partnership. We have made this modification for several reasons:

    - First, we have no data from which to make principled determinations of clients who are underserved and/or inappropriately served. For example, we have only limited data on the numbers of people in Board and Cares and Institutes of Mental Disease (IMDs) in the area, much less the quality of their experience, despite repeated outreach to these institutions.

    - Similarly, we have no data to determine the numbers of people who repeatedly rely upon emergency room services, or who have received a 5150 or 5585 designation where such results might have been avoided.

    - We also have no principled way of determining whether someone who is receiving simple medications support or limited 1:1 counseling is receiving sufficient support to promote their wellness and recovery.

    - The purpose of Chart A is to map the patterns of service among ethnic groups. We believed the most defensible way of demonstrating these patterns was to regard anyone receiving services other than a full service partnership as less than fully served.

- We were not able to obtain the gender of individuals in the three cities who are receiving full service partnerships funded by LA DMH. We were also able to gather only partial data related to the gender of individuals receiving other kinds of services. This lack of consistent data made any coherent analysis about gender patterns impossible, so we deleted the gender columns from the chart. We do provide some analysis of gender service patterns based on available data from the Tri-City directly operated clinic.

- Finally, please note: the total numbers served indicated in the Chart A tables below are 307 individuals lower than indicated in prior tables. This is because one of the local providers could not provide data on the ethnicity of their clients.

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Chart A: Estimates of Service Utilization by Race/Ethnicity

Children and Youth (Ages 0-15)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	3	55	58	21%	2,818	9%	3,874	6%
Asian Pacific Islander	6	1	7	3%	2,132	7%	4,646	8%
Latino	28	144	172	62%	20,023	64%	33,145	55%
Native American	0	1	1	0%	506	2%	234	0%
White	3	30	33	12%	3,903	12%	17,688	29%
Other	0	5	5	2%	1,999	6%	1,038	2%
Totals	**40**	**236**	**276**	100%	**31,381**	100%	**60,625**	100%
Sources: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

Transition Age Youths (Ages 16-25)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	1	60	61	18%	1,382	9%	2,011	6%
Asian Pacific Islander	3	4	7	2%	1,045	7%	2,412	8%
Latino	8	220	228	66%	9,817	64%	17,206	55%
Native American	0	3	3	1%	248	2%	121	0%
White	2	40	42	12%	1,914	12%	9,182	29%
Other	0	2	2	1%	980	6%	540	2%
Totals	**14**	**329**	**343**	100%	**15,386**	100%	**31,472**	100%
Sources: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

Adults (Ages 26-59)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	0	233	233	21%	2,498	9%	6,489	6%
Asian Pacific Islander	3	38	41	4%	1,890	7%	7,783	8%
Latino	4	434	438	39%	17,750	64%	55,519	55%
Native American	0	30	30	3%	448	2%	391	0%
White	1	349	350	31%	3,460	12%	29,628	29%
Other	0	23	23	2%	1,772	6%	1,739	2%
Totals	**8**	**1,107**	**1,115**	**100%**	**27,818**	**100%**	**101,549**	**100%**
Sources: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

Older Adults (Ages 60 and older)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	0	5	5	14%	594	9%	2,289	6%
Asian Pacific Islander	0	0	0	0%	450	7%	2,746	8%
Latino	0	14	14	40%	4,223	64%	19,587	55%
Native American	0	1	1	3%	107	2%	138	0%
White	0	12	12	34%	823	12%	10,453	29%
Other	0	3	3	9%	422	6%	614	2%
Totals	**0**	**35**	**35**	**100%**	**6,619**	**100%**	**35,827**	**100%**
Sources: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

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

Given the data in Chart A, and the data in the tables on pp. 24-26, we offer the following observations about service patterns among the different ethnic and age groups in the tri-city area:

- Significant percentages of people of all ages who likely qualify for publicly funded services are not receiving any service: 84.47% of children, 70.79% of TAY, 49.39% of adults, and 91.81% of older adults (see table at the bottom of p. 26).

- The Asian Pacific Islander ethnic population is underrepresented in the mental health system across all age groups. Asian and Pacific Islanders comprise almost 8% of the total population, and 7% of the population under 200% of the federal poverty threshold, but are only 3% of the population receiving children's services, 2% of the population receiving TAY services, 4% of the population receiving adults services, and currently receive no older adult services.

- Latino children and TAY are being served at rates almost equal to their percentage representation within the 200% Federal Poverty population. Latino adults and older adults, however, are proportionately underrepresented in the mental health system. Latino adults are 64% of the adult federal poverty population, but only 39% of the adults receiving mental health services. For Latino older adults, the percentages are 64% and 40% respectively.

- African American representation within the mental health system is consistently higher for all age groups than the group's representation among the population below 200% of Federal Poverty guidelines. These higher utilization rates may

suggest that African Americans are currently receiving disproportionate referrals to the mental health system, or are being inappropriately served.

- African American adults are 21%, and white adults are 31%, of the adult population receiving mental health services in the tri-city area. According to the 2008 San Gabriel Valley Regional Homeless Services Strategy Phase I Report, however, African-Americans comprise 36%, and Whites 37%, of the homeless population in the region that includes Claremont, La Verne, and Pomona.[6] This data suggests that, taking homelessness into account, African American and White adults may actually be underserved.

- Native Americans represent a small percentage of the 200% poverty population in the tri-city area, approximately 2%. Frequently, however, Native Americans are significantly underreported or misreported in the census data. For example, many Native Americans identify themselves as Hispanic thereby understating the Native American population. Interestingly, the Los Angeles metropolitan area is home to the largest urban concentration of Native Americans in the United States,[7] and Pomona is one of six cities in Los Angeles County with the highest clusters of Native Americans in Los Angeles.[8] These bits of information suggest that there may be more Native Americans in the tri-city area than captured by current census data. Even at 2% of the area's 200% poverty population, however, only Native American adults are receiving commensurate services at 3%. The total *number* of Native Americans receiving services across all other age groups was only 7 individuals: 3 children, 3 TAY, and 1 older adult.

While we had incomplete data for any systematic analysis about service patterns by gender, the data provided by the Tri-City Clinic suggests areas for further inquiry as we continue our MHSA planning and implementation efforts. In both the general population and the 200% federal poverty population, males and females are represented more or less equally across all age groups. In 2008, however, Tri-City Clinic provided substantially more services to boys 0-15 than girls (71% to 29%), and more services to male youth and young adults 16-25 than to females in the same age group (60% to 40%), reflecting, among other things, referral patterns from local schools. Interestingly, the pattern is reversed for the adult and older adult populations. For these populations, the percentages were: 43% male and 57% female for adults, and 39% male and 61% female for older adults.

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

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[6] San Gabriel Valley Regional Homeless Services Strategy Phase I Report, October 10, 2008, p. 85.
[7] Report to the Annie E. Casey Foundation by the National Urban Indian Family Coalition, Seattle, WA, 2008, p. 10-11.
[8] Los Angeles County Children's Planning Council, *Ethnic Community Profiles: Planning for a New Los Angeles.* Los Angeles, 1996.

The data in Chart A suggests several significant disparities in access to services by ethnic groups, particularly for Asian and Pacific Islanders across all age groups, Latino adults and older adults, and Native Americans, among others. Access to services can be even more difficult when the primary language of the individual or family seeking services is not English.

Understanding this, we have set ambitious targets for our Full Service Partnerships to reach people of all ethnic groups, including people for whom English is not a primary language. Specifically, we will conduct persistent outreach into the Vietnamese and Latino communities to ensure that monolingual individuals who suffer from SMI/SED can benefit from full service partnerships and the other services funded by the CSS plan. We will develop selection criteria to ensure that providers chosen to deliver full service partnerships demonstrate an active commitment to cultural competency, and will sponsor regular trainings for staff members from providers throughout the three cities to continually strengthen the cultural competency across the system.

The other components of our plan—community navigators, the wellness and recovery center, the supplemental crisis services, and field capable services for older adults—all reflect a commitment to engage unserved and underserved ethnic populations and other groups (see discussion of these plan components in Part II, Section VI below).

PART II, SECTION III: Identifying Initial Populations for Full Service Partnerships

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

Given the large numbers of people who are unserved in the tri-city area, and the amount of MHSA funds available to us through this plan, we cannot fully serve *any* population. Our intention is to fully serve individuals, and in some cases their families, across all age groups. The plan specifically embraces the initial populations recommended by CA DMH in California Department of Mental Health Letter 05-05, consistent with the commitments articulated above to engage unserved and under-served ethnic populations and other groups.

Age group: *Children 0-15*
Consistent with CA DMH recommendations, we will provide full service partnerships to children and youth experiencing severe emotional disorders and their families (including Special Education pupils) who are unserved or underserved, specifically including:

- Children and their families who are uninsured, under-insured and/or youth not eligible for Medi-Cal because they are detained in the juvenile justice system;
- Children and youth who are homeless, or at risk of homelessness;
- Children and youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements; and/or
- Children and youth who are at risk of out-of-home placement.

Age group: *Transition Age Youth (TAY) 16-25*
Consistent with CA DMH recommendations, we will provide full service partnerships to transition age youth between the ages of 16 and 25, who are currently unserved or underserved who have severe emotional disorders, specifically including youth:

- With a co-occurring substance abuse disorder and/or health condition;
- Who are homeless or at imminent risk of homelessness;
- Who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems;
- Involved in the criminal justice system;
- At risk of involuntary hospitalization or institutionalization; and/or
- Who have experienced a first episode of major mental illness.

Age group: *Adults 26-59*
Consistent with CA DMH recommendations, we will provide full service partnerships to adults between the ages of 26 and 59 with serious mental illness who are unserved or seriously underserved, specifically including adults:

- With a co-occurring substance abuse disorder and/or health condition;
- Who are homeless or at risk of homelessness;
- Involved in the criminal justice system (including adults with child protection issues), or at risk of criminal justice involvement;
- Who are frequent users of hospital and emergency room services; and/or
- At risk of institutionalization.

Age group: *Older adults 60 years and older*
Consistent with CA DMH recommendations, we will provide full service partnerships to adults who are 60 years and older with serious mental illness who are unserved or seriously underserved, and who have a reduction in personal or community functioning, specifically including older adults who are:

- Homeless or at risk of homelessness; and/or
- At risk of institutionalization, nursing home care, hospitalization and emergency room services.

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

Given the substantial numbers of residents across the three cities within all age groups who likely can qualify for full service partnerships, delegates believed that the recommended populations by CA DMH accurately reflected the populations in greatest need. Delegates also felt that selecting these initial populations was consistent with the strategic considerations that guided the development of the entire CSS plan, including:

- Making investments to construct and strengthen a system of care across the three cities, rather than funding isolated services;
- Working to leverage existing community resources and collaborations;
- Making investments that clearly demonstrate a commitment to wellness, resiliency, and recovery;
- Learning from the experiences of other counties' CSS implementation efforts;
- Taking advantage of the relative flexibility of the MHSA funds compared to other funding sources (e.g., Medi-Cal) to address some of the community's most intractable issues and most vulnerable populations; and
- Remaining aware of the scope and focus of future MHSA plans (e.g., Prevention and Early Intervention) and prioritizing investments that only are possible through the CSS plan.

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

The data examined previously in this plan (Part II, Section II) suggests several significant disparities in access to services by ethnic groups, particularly for Asian and Pacific Islanders across all age groups, Latino adults and older adults, and Native Americans, among others. Access to services can be even more difficult when the primary language of the individual or family seeking services is not English.

Understanding these dynamics, we have set ambitious targets for our Full Service Partnerships to reach people of all ethnic groups, including people for whom English is not a primary language. Specifically, we will conduct persistent outreach into the Vietnamese and Latino communities to ensure that monolingual individuals who suffer from SMI/SED can benefit from full service partnerships and the other services funded by the CSS plan. We will develop selection criteria to ensure that providers chosen to deliver full service partnerships demonstrate an active commitment to cultural competency, and will sponsor regular trainings for staff members from providers throughout the three cities to continually strengthen the cultural competency across the system.

PART II, SECTION IV: Identifying Program Strategies

1) If your county has selected one or more strategies to implement with MHSA funds that are not listed in this section, please describe those strategies in detail in <u>each</u> applicable program work plan including how they are transformational and how they will promote wellness/recovery/resiliency and are consistent with

the intent and purpose of the MHSA. No separate response is necessary in this section.

All strategies chosen by Tri-City MHC are listed in this section.

PART II, SECTION V: Assessing Capacity

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

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

For this section we rely only on data about staff from Tri-City Mental Health Center, including administrative staff and staff that work for the directly operated clinic. It was not possible to obtain data documenting the ethnic composition of other providers' staff. We do have anecdotal evidence that the patterns we describe for Tri-City Clinic are consistent with other providers in the three cities.

The first table compares the ethnic composition of Tri-City MHC staff to the ethnic composition of the general population in the three cities, and the population living at or below the 200% federal poverty threshold. The second table compares the percentages of people in the three cities who speak languages other than English to percentages of Tri-City MHC staff who speak languages other than English.

COMPARISON OF POPULATION ETHNICITY WITH ETHNICITY OF TRI-CITY MHC STAFF

Ethnic Population	Tri-City Area Population		200% Poverty Population		Tri-City MHC Staff	
	#	%	#	%	#	%
African American	14,664	6.39%	7,293	8.98%	7	9.46%
Asian Pacific Islander	17,587	7.66%	5,516	6.79%	9	12.16%
Latino	125,458	54.67%	51,814	63.81%	35	47.30%
Native American	884	0.39%	1,308	1.61%	1	1.35%
White	66,951	29.18%	10,100	12.44%	22	29.73%
Other/Two or more races	3929	1.71%	5,172	6.37%	0	0.00%
Totals	**229,473**	**100.00%**	**81,203**	**100.00%**	**74**	**100.00%**

Source: United Way 2007 Zip Code Data Book San Gabriel Valley + Tri-City MHC 01/2009 data

COMPARISON OF NON-ENGLISH LANGUAGES IN GENERAL POPULATION WITH NON-ENGLISH LANGUAGES SPOKEN BY TRI-CITY MHC STAFF				
Non-English Languages Spoken	**Tri-City Area Population**		**Tri-City MHC Staff**	
	#	**%**	**#**	%
Spanish	**96,379**	**42%**	**31**	**42%**
API languages	**13,768**	**6%**		**18%**
Tagalog			2	
Hindi			3	
Punjabi			3	
Vietnamese			1	
Japanese			1	
Mandarin			2	
Taiwanese			1	
European	**4,589**	**2%**		**3%**
French			1	
Italian			1	
Other	**2,295**	**1%**		**1%**
American Sign			1	
Totals	**116,941**	**51%**	**47**	**64%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley + Tri-City MHC 01/2009 data + extrapolations				

Several conclusions emerged from analyzing the data in these tables, including:

- The ethnic representation of Tri-City MHC staff is generally proportionate to the ethnic representation of the general population within the tri-city area, and of the population living at or below 200% of the federal poverty threshold.

- The percentages of Tri-City MHC center staff who speak a language other than English are also reflective of, or higher than, the equivalent percentages in the general population.

- As Tri-City MHC hires staff and contracts with providers to deliver services under this CSS plan, it will work to continually strengthen the system's capacity to effectively engage unserved and underserved ethnic populations, with a particular focus on people who speak languages other than English as their primary language. Specifically, we will likely need to increase the number of staff and/or contractors who speak Vietnamese and Spanish as we focus on outreach to these communities.

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

Some of the challenges we can anticipate as we work to re-construct and transform a system of care across the three cities include:

- Many potential community partners and leaders remain wary of Tri-City, due in large part to the trauma of the bankruptcy, and in part to wounds and conflicts that preceded the bankruptcy and remain unhealed. Many other potential partners are simply unaware of the progress made over the past few years, despite substantial outreach and engagement efforts. "Didn't Tri-City go out of business?" is still a question that arises in our public forums. Much more work will be required to earn the trust and inspire creative collaboration among community leaders and potential partners. We will continue to build upon our efforts of the last several years—developing a sound plan for emerging out of bankruptcy, hiring new staff, conducting two expansive and well-regarded stakeholder processes, beginning the MHSA planning effort—to earn the trust and engagement of our partners.

- Ensuring that staff members at all levels of the system—both within Tri-City's staff and within our community partners—are grounded in and committed to the fundamental principles of recovery requires on-going work. We have already begun offering trainings to Tri-City Clinic staff, and will expand these trainings into the larger community in the coming months.

- Ensuring that staff members at all levels of the system—both within Tri-City's staff and within our community partners—are grounded in and committed to the fundamental principles of cultural awareness and competency also requires on-going effort. Staff members at the Tri-City clinic regularly receive training on issues of cultural competency, and related trainings will likely be a major component of our Workforce Education and Training (WET) plan.

- Housing is often a major barrier to support an individual or family's recovery. We anticipate having a substantial amount of non-recurring funding from FY 2009-10 due to lag times in start-up. Although delegates have not yet developed a plan for these dollars, they have already signaled an interest in devoting a substantial portion of these dollars to housing, augmenting the $2.4 million dollars that is available to Tri-City through the MHSA housing program.

- One of the major investments we will make through this CSS plan is for a new Wellness and Recovery Center. Creating this prominent center will likely encounter challenges in the permitting process, and possibly from residents who live near the proposed site (whenever that is chosen). Fortunately, the Governing Board includes representatives from the three city councils, and Executive Director Jesse Duff, a former City Manager, has very good working relationships with the City Managers and staff from all three cities. These relationships, and our on-going outreach and engagement efforts, will serve us well as we navigate the building process.

- Creating trusting relationships with people from some of the focal populations for our Full Service Partnerships—e.g., transition age youth, people with severe and persistent mental illnesses who are not within any current system, monolingual residents of the Vietnamese and Latino communities, Native American residents—will pose a substantial challenge in the early months of our Full Service Partnership work. We will begin outreach and engagement well in advance of the development of FSP contracts to begin identifying potential FSP recipients in these communities.

- Designing and implementing an effective information and technology system that will allow us to effectively track outcomes and other critical performance measures will present another substantial challenge to implementing the CSS Plan. As noted throughout this document, there is currently no system for effectively tracking mental health data across all three cities. This will be a major focus of our administrative efforts in the coming year.

PART II, SECTION VI: Developing Work Plans with Timeframes, Budgets and Staffing Projections

Sub-section I. Summary Information on Programs to be Developed or Expanded

1) Please complete Exhibits 1, 2, and 3, providing summary information related to the detailed work plans contained in the Program and Expenditure Plan.

Exhibits 1, 2 and 3 have been completed and are attached.

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

Attachment 2 contains a summary budget for our requests. We estimate that 51% of the funds in FY 2008-09 will go to Full Service Partnerships (beginning startup); 67% in FY 2009-10; 63% in FY 2010-11; and 63% in FY 2011-12.

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

Please see Exhibit 6 for the detailed calculations supporting these projections:

- **In FY 2008-09,** we project one month of services to be delivered in June, with no enrollments in Full Service Partnerships (too soon), and 20 people receiving services and supports through our Systems Development investments.

- **In FY 2009-10,** the first full year of FSP implementation, we project that 212 people will receive Full Service Partnerships, and 1,255 people will receive services and supports through our Systems Development investments.

- **In FY 2010-11,** we project that 304 people will receive Full Service Partnerships, and 2,035 people will receive services through our Systems Development investments.

- **In FY 2010-11,** we project that 304 people will receive Full Service Partnerships, and 2,120 people will receive services through our Systems Development investments.

We have no way to readily estimate how many of the people receiving Full Service Partnerships will also receive services and supports through our Systems Development investments. We certainly expect that a number of people who enroll in Full Service Partnerships will first be engaged by our community navigator teams or by our field capable services for older adults. They also may require support from the supplemental crisis services. We expect that many of them will, over time, benefit from the many programs and supports available through the Wellness and Recovery Center. Given that well over 60% of our CSS allocation will go to Full Service Partnerships, however, we have not recalculated our Exhibit 2 projections to try to incorporate these additional percentages.

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

Our community navigator teams will conduct regular outreach and engagement efforts, reaching people who may have a range of formal and informal support and services needs, including Full Service Partnerships. We estimate that these teams will reach:

- 20 people in FY 2008-09 (June 2009);
- 950 people in FY 2009-10;
- 1200 people in FY 2010-11; and
- 1200 people in FY 2011-12.

In addition, the Full Service Partnership providers will conduct outreach and engagement efforts on their own to identify potential FSP recipients. The combination of these efforts will produce the following FSP numbers (cumulative, not unduplicated):

- 0 people in FY 2008-09 (one month);
- 212 people in FY 2009-10;
- 304 people in FY 2010-11; and
- 304 people in FY 2011-12.

5) For children, youth and families, the MHSA requires all counties to implement Wraparound services, pursuant to W&I Code Section 18250, or provide substantial evidence that it is not feasible in the county, in which case, counties should explore collaborative projects with other counties and/or appropriate alternative strategies.

Although wraparound services exist in Service Area 3, the LA County region that includes Claremont, La Verne, and Pomona, we are not aware of these services being delivered in the three cities. We project the largest number of Full Service Partnerships funded under this plan to go to children (183 out of 304 when fully implemented).

PART 2, SECTION VI: Developing Work Plans With Timeframes And Budgets/ Staffing Projections

Sub-section II: Programs to be developed or expanded—the following information is required for <u>each</u> program. Since the review process may approve individual program work plans separately, it is critical that a complete description is provided for each program. If a particular question is not applicable for the proposed program, please so indicate.

The Tri-City Mental Health System's CSS Plan consists of six programs:

- TC-01: Full Service Partnerships
- TC-02: Community Navigators
- TC-03: Wellness and Recovery Center
- TC-04: Supplemental Crisis Services
- TC-05: Field Capable Services for Older Adults
- TC-06: Administration

FULL SERVICE PARTNERSHIPS

The Tri-City CSS Plan invests in Full Service Partnerships for all four age groups: children 0-15, transition age youth (TAY) 16-25, adults 26-59, and older adults age 60 and older. All of these full service partnerships are part of **workplan TC-01**. For budget purposes, we created separate budgets for each age group, and labeled each age group as a separate sub-workplan as follows:

- TC-01a: Children Full Service Partnerships
- TC-01b: TAY Full Service Partnerships
- TC-01c: Adult Full Service Partnerships
- TC-01d: Older Adult Full Service Partnerships

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

a) A brief description of the program;

b) Identification of the age and situational characteristics of the priority population to be served in this program;

c) Identification of strategies for which you will be requesting MHSA funds for this program; and

d) Identification of the funding types that will be used and the age group of the priority populations to be served for each strategy.

Please see Exhibit 4, workplan TC-01.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The August 1, 2005 guidelines issued by CA DMH contain the following description of Full Service Partnerships:

> Each individual identified as part of the initial full service population must be offered a partnership with the county mental health program to develop an individualized services and supports plan. The services and supports plans must operationalize the five fundamental concepts identified at the beginning of this document. They must reflect community collaboration, be culturally competent, be client/family driven with a wellness/recovery/ resiliency focus, and they must provide an integrated service experience for the client/family. Under Full Service Partnerships:
>
> - The county agrees to work with the individual and his/her family, as appropriate, to provide all necessary and desired appropriate services and supports in order to assist that person/family in achieving the goals identified in their plan.
> - Individuals will have an individualized service plan that is person/child-centered, and individuals and their families will be given sufficient information to allow them to make informed choices about the services in which they participate.
> - All fully served individuals will have a single point of responsibility—Personal Service Coordinators (PSCs)[9]—with a caseload that is low enough so that: (1) their availability to the individual and family is appropriate to their service needs, (2) they are able to provide intensive services and supports when needed, and (3) they can give the individual served and/or family member considerable personal attention. Services must include the ability of PSCs or team members known to the client or family member to respond to clients and family members 24 hours a day, 7 days a week. This 'best practice' service strategy is intended to provide immediate 'after-hours' interventions that will reduce negative outcomes for individuals including but not limited to unnecessary hospitalizations, incarcerations and evictions. For transition age youth, adults and older adults this service must include the ability to respond to landlords and or law enforcement. For children and youth it must include the ability to respond to persons in the community identified by a child's family.
> - Personal Service Coordinators (PSCs) must be culturally competent, and know the community resources of the client's racial or ethnic community.
> - Services should also include linkage to, or provision of, all needed services or benefits as defined by the client and or family in

[9] We received word from the Los Angeles County Service Area 3 District Chief that CA DMH will no longer allow un-licensed case managers to assume PSC responsibilities for children in Full Service Partnerships. Given this understanding, we chose to eliminate the language about case managers from this quote from the CA DMH regulations to avoid confusion. If our information is not accurate, we will make adjustments accordingly in the RFPs that we issue for children's full service partnerships.

> consultation with the PSC. This includes the capability of increasing or decreasing service intensity as needed. Community Support Services, consistent with the individual service plan may only be funded by MHSA funds when funding under any other public or private payor source or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services pursuant to Medi-Cal and Special Education Programs.[10]

The Tri-City MHC CSS plan fully endorses this description of full service partnerships as the overarching framework for the development of these partnership services.

Focus: Recommended target populations for Full Service Partnerships

Consistent with CA DMH recommendations, we will provide full service partnerships to the following target populations:

Children ages 0-15[11] who have severe emotional disorders and their families (including Special Education pupils) who are unserved or underserved, including:

- Children and their families who are uninsured, under-insured and/or youth not eligible for Medi-Cal because they are detained in the juvenile justice system;
- Children and youth who are homeless, or at risk of homelessness;
- Children and youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements; and/or
- Children and youth who are at risk of out-of-home placement.

Transition age youth ages 16-25 who are currently unserved or underserved who have severe emotional disorders, including youth:

- With a co-occurring substance abuse disorder and/or health condition;
- Who are homeless or at imminent risk of homelessness;
- Who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems;
- Involved in the criminal justice system;
- At risk of involuntary hospitalization or institutionalization; and/or
- Who have experienced a first episode of major mental illness.

Adults ages 26-59 with serious mental illness who are unserved or seriously underserved, including adults:

- With a co-occurring substance abuse disorder and/or health condition;

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[10] California Department of Mental Health Letter 05-05, dated August 1, 2005, pp. 22-23.

[11] The first draft of the CSS guidelines issued by the State set the age range for children at 0-15. In subsequent versions of the guidelines, including the final guidelines, the State established the age range for children at 0-18, creating an overlap with Transition Age Youth. We have opted to keep the age range for children at 0-15, and to address the issues of transition between the two age groups through our RFPs and other implementation structures.

- Who are homeless or at risk of homelessness;
- Involved in the criminal justice system (including adults with child protection issues), or at risk of criminal justice involvement;
- Who are frequent users of hospital and emergency room services; and/or
- At risk of institutionalization.

Older adults 60 years and older with serious mental illness who are unserved or seriously underserved, and who have a reduction in personal or community functioning, specifically including older adults who are:

- Homeless, or at risk of homelessness; and/or
- At risk of institutionalization, nursing home care, hospitalization and emergency room services.

Focus: Recommended outcomes for Full Service Partnerships

The Tri-City MHC CSS plan endorses the outcomes for all age groups specified by the State's August 1, 2005 guidelines, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including during times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

3) Describe any housing or employment services to be provided through the Full Service Partnerships for all age groups.

We anticipate providing housing and employment services through Full Service Partnerships for all age groups under the "whatever it takes" commitment that defines these services.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Based on data from Los Angeles County providers and providers in surrounding counties (e.g., San Bernadino, Riverside), we have developed the following estimates for our full service partnerships:

ESTIMATED COSTS/FSP SLOT BY AGE GROUP			
Fund type / Age group	Funds for services billable to Medi-Cal	Flex funds for services not billable to Medi-Cal	Total per slot
Children	$ 16,000	$ 850	$ 16,850
TAY	$ 13,000	$ 4,530	$ 17,530
Adults	$ 11,000	$ 4,999	$ 15,999
Older Adults	$ 12,000	$ 3,000	$ 15,000

We anticipate leveraging Medi-Cal and EPSDT[12] funds for our children FSPs, Medi-Cal and EPSDT funds for our TAY FSPs (EPSDT where possible), and Medi-Cal funds for adult and older adult FSPs. Please note, however, that we have reserved 25% of our FSP allocation to fund full service partnerships for people who do not qualify for any other funding source.

When our FSP program is fully implemented, we project the following numbers of matched (using leveraged funds for allowable services) and unmatched (using only MHSA funds) FSP slots for each age group:

PROJECTED FSP SLOTS BY AGE GROUP AND FUNDING SOURCE					
Age group / Funding source	Children	TAY	Adult	Older Adults	Totals
Matched (MHSA + leveraged $)	173	22	58	19	272
No match (MHSA $ only)	10	5	13	4	32
Totals	**183**	**27**	**71**	**23**	**304**

With a base allocation of $2,041,185 in MHSA funds for full service partnerships (out of an FY 2008-09 allocation of $3,721,400),[13] we have used the following table to estimate the total funds we would leverage for Full Service Partnerships (assuming that we were fully implemented at the $2,041,185 figure).

PROJECTED LEVERAGED REVENUES ON $2,041,185 ALLOCATION FOR FULL SERVICE PARTNERSHIPS					
Fund source / Age group	FFP[14]	SGF[15]	Total Gov $ match	MHSA Funds	Total Funds
Children	1,384,000	1,024,160	2,408,160	675,749	3,083,909
TAY	143,000	-	143,000	324,531	467,531
Adults	319,000	-	319,000	813,619	1,132,619
Older Adults	114,000	-	114,000	227,286	341,286
Total	**$1,960,000**	**$1,024,160**	**$2,984,160**	**$2,041,185**	**$5,025,345**

[12] Early Periodic Screening, Diagnosis, and Treamtment (EPSDT) is the child component of Medi-Cal.

[13] The FY 2008-09 CSS allocation to Tri-City is $3,721,400. The FY 2009-10 allocation is $4,989,000. Given revenue projections for the next several years, and the Governor's proposed FY 2009-10 budget proposal, we felt it prudent to use the $3,721,400 figure as the target for our FY 2009-10 plan, even though we have a higher allocation for that fiscal year.

Some notes about this projection:

- We used $2,041,185 as an initial projection for our MHSA allocation for full service partnerships. None of our Exhibit 2 projections, however, actually show this figure. This is because in the first year of implementing FSPs (FY 2009-2010), we expect start-up time to take at least 6 months. In subsequent years, when we project full funding, we added 3% cost of living allowances (COLAs).

- The allocation of MHSA funds by age groups reflects a decision by the delegates to use the following percentages: children 33%, TAY 16%, adults 40%, and older adults 11%. Delegates used a combination of population, poverty, and prevalence data to arrive at these percentages.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and reinforced.

Full Service Partnerships are grounded in a commitment to recovery. Full Service Partnerships are voluntary, and begin with a plan that is co-created with the person who is receiving services and his or her family where appropriate. Training in the principles of recovery, wellness, and resiliency will be regularly provided to providers of Full Service Partnerships and related community-based organizations. We will also track outcomes regularly and work with providers to ensure constant improvement in realizing our commitment to recovery and wellness.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

We expect people who receive services and family members to be integral members of the staffs of the organizations who deliver Full Service Partnerships.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

[14] FFP is an abbreviation for Federal Financial Participation, the Federal Government's portion of the Medi-Cal matching funds.

[15] SGF is an abbreviation for State General Fund, the source of the State's portion of the matching funds for children's Medi-cal services.

We expect providers of Full Service Partnerships to develop meaningful collaborations with myriad community-based organizations who serve the various focal populations for Full Service Partnerships. This will be one of several essential criteria in assessing the strength of a potential provider's application to deliver Full Service Partnership services.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what strategies will be used to meet their needs.

We expect providers of Full Service Partnerships to demonstrate a history of delivering culturally appropriate and culturally competent services, including having staff that are fluent in the language(s) of the focal populations, and excelling in other measures of cultural competence. This will be one of several essential criteria in assessing the strength of a potential provider's application to deliver Full Service Partnership services.

We will also provide training to FSP providers and their staffs that will include evidence-based practices, promising practices, and community-defined research related to effective engagement of different ethnic and racial groups.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

We expect providers of Full Service Partnerships to demonstrate a history of delivering evidenced-based services that are sensitive to sexual orientation and gender issues, and reflect the differing psychologies and needs of women and men, boys and girls. This will be one of several essential criteria in assessing the strength of a potential provider's application to deliver Full Service Partnership services.

We will also provide training to FSP providers and their staffs that will include evidence-based practices, promising practices, and community-defined research related to sexual orientation and gender identity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

13) Please provide a timeline for this work plan, including all critical implementation dates.

Calendar year: 2009	
April-May	• Develop consensus among delegates on initial provider selection and program design criteria for FSPs • Work with consultants, attorneys and others to develop RFP process • Begin research on FSP waiting lists for other providers in the area who are under contract with LA DMH
June	• Finalize and issue RFP • Hold information sessions for potential providers
July	• Recruit and train proposal review teams • Train Community Navigators on outreach strategies for FSPs • Receive proposals from potential providers
August	• Convene review teams to review proposals • Select potential providers
September	• Work with chosen providers to develop contracts • Execute contracts
October-December	• Providers begin hiring staff, conducting outreach and engagement efforts
Calendar year: 2010	
January-June	• Begin services • Providers continue enrolling individuals, providing services, and developing and strengthening FSP infrastructure • Conduct regular meetings with providers to assess progress on key benchmarks related to community engagement, cultural- and gender-competence, and progress toward recovery
July	• Program Fully Operational • Conduct evaluation of program to date; make improvements and adjustments

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Budget worksheets have been completed on each of the four Full Service Partnerships and are included in Exhibit 5.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Tri-City MHC is requesting funding.

SYSTEMS DEVELOPMENT INVESTMENTS

TC-02: Community Navigators

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

a) A brief description of the program;

b) Identification of the age and situational characteristics of the priority population to be served in this program;

c) Identification of strategies for which you will be requesting MHSA funds for this program; and

d) Identification of the funding types that will be used and the age group of the priority populations to be served for each strategy.

Please see Exhibit 4, workplan TC-02.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

One of the foundational premises of the Tri-City CSS plan is a belief that professionally delivered, publicly funded human services, by themselves, cannot deliver the outcomes we seek for all people who struggle with mental health needs.

More specifically, the data regarding unmet need, and the current budget and economic realities confronting the state and counties, make it clear: public mental health budgets, even with the addition of MHSA funds, will not be sufficient to meet the needs of all people in our communities who struggle with mental health issues. Therefore, if we are committed to achieving the outcomes of the MHSA for all people who struggle with mental health issues, we must develop infrastructure to fully and effectively leverage all available community supports, including informal supports as well as professional services. This is the analysis driving the proposal for community navigators.

Community navigators and their teams will be a crucial structure to help people find the formal and informal supports they need. The navigators will help build teams of volunteers and staff from other organizations and community groups, including people who have received services, family advocates, family members, and leaders of unserved and under-served communities.

Community navigators will regularly visit community organizations, emerging and well-established health and mental health programs, law enforcement agencies, schools, courts, residential facilities, NAMI chapters, self-help groups, client advocacy groups, and others. This model provides the beginning infrastructure to implement a system of care that is responsive to the local needs of communities, people who receive services, and families.

Some of the specific responsibilities of the community navigators and their teams will include:

- Engaging people who need services and their families to help them quickly identify currently available services, including formal and informal supports and services tailored to their particular cultural, ethnic, age, and gender identities;

- Recruiting community-based organizations, faith-based organizations, and other community groups to become part of an active and ever growing locally-based support network for people in the three-cities, including groups and organizations in communities most challenged by mental health issues;

- Following-up with people with whom they have engaged to ensure that they have connected with support structures and received the help they needed;

- Using information technology and other means to map and keep up to date about the current availability of services and supports within the tri-city area; and

- Promoting awareness about mental health issues, and the commitment to recovery, wellness, and self-help that lies at the heart of the Mental Health Services Act.

3) Describe any housing or employment services to be provided.

The program will develop and maintain information on employment and housing services in the three cities, and will actively recruit employers and housing providers to become an integral part of the support network in the three cities.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Not applicable

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program supports the CSS plan's overarching commitment to recovery, resiliency, and wellness. Beyond helping people find the supports and services they need to achieve and sustain wellness, recovery, and resiliency, Community Navigators, their team members, and their community partners will regularly receive training on the principles and practices of recovery, resiliency, and wellness. Staff's commitment to these principles, as well as knowledge of practical tools for putting this commitment into practice, will be regularly addressed during supervision, team meetings and

performance evaluations. Of critical importance will be the increased use of self-help groups both for training staff and for the provision of recovery-focused support services. As previously noted, peer and family advocates will participate as members of the Navigation teams and in doing so will bring the richness of their life experiences to the program.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Clients and family members will participate as members of the Navigator teams in each city and will be responsible for ensuring that individuals and their families are informed of, have access to, and receive appropriate community based and client run services and supports, in addition to professional services.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

As detailed above, the Community Navigator teams will promote collaboration with community stakeholders in myriad ways, including: inviting stakeholders to participate on the Navigation teams; organizing and participating in various community planning, assessment, and engagement efforts; maintaining current information about available services and supports; and others. Some of the indicators of success will include:

- The diversity of and expansiveness of the Community Navigator teams;
- The diversity of community organizations and other supports that become available through Community Navigator teams; and
- The number of people engaged by the Community Navigators who report having received the support they needed.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Through the outreach and collaboration described above, the Community Navigator teams will develop competency in understanding the diverse cultural and linguistic needs of their communities and the current resources available to meet those needs. Promoting the development of additional resources for unserved and underserved

populations, including the recruitment and training of culturally representative volunteers, will be a key role of the Navigator teams. Training for Navigator teams and their partners will focus on evidence-based practices, promising practices, and community-defined research related to effective engagement of different ethnic and racial groups.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Community Navigator teams will reflect a diversity of experiences and skills to ensure that services and supports identified to assist clients are sensitive to and responsive to their individual needs. This includes identifying services and supports that are sensitive to differing needs based on gender and sexual orientation. Training for Navigator teams and their partners will focus on evidence-based practices, promising practices, and community-defined research related to sexual orientation and gender identity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Community Navigator teams will be available to assist with referrals and linkages to resources for tri-city residents who have been placed out of the area and are planning to return.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

13) Please provide a timeline for this work plan, including all critical implementation dates.

Calendar year: 2009	
April-May	• Develop job descriptions and qualifications for four community navigator positions • Begin advertising community navigator positions • Identify and interview potential candidates • Extend offers to candidates to begin work June 1 or sooner, contingent upon CA DMH approval of CSS plan
June-September	• Navigators begin work • Focus of their efforts in first few months: outreach and engagement to begin connecting with people in un-served and underserved communities; building relationships with community organizations across the three cities to build their volunteer teams; becoming familiar with service mapping technologies in the three cities.

October - December	• Navigators and teams begin partnering with FSP providers to identify potential recipients of FSPs • Continue their other community outreach and engagement work • Identify sources of training and support for community members
Calendar year: 2010	
January	• Full implementation underway • Conduct assessment of first six months; identify needed improvements
February -	• Continue implementation • Decide on need for fifth navigator before CSS plan update submission

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Budget worksheets for this workplan are included in Exhibit 5.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Tri-City MHC is requesting funding.

TC-03: Wellness and Recovery Center

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

a) A brief description of the program;

b) Identification of the age and situational characteristics of the priority population to be served in this program;

c) Identification of strategies for which you will be requesting MHSA funds for this program; and

d) Identification of the funding types that will be used and the age group of the priority populations to be served for each strategy.

Please see Exhibit 4, workplan TC-03.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

We will create a new wellness and recovery center that will promote recovery, resiliency, and wellness for people confronting mental health issues. Staff located at this site, including peer advocates, family members, clinical staff, and others, will provide a

range of culturally competent, person– and family-centered services and supports designed to promote increasing independence and wellness for people of all ages.

The center will be open 6-7 days a week, and for extended hours on many days. It will be open to anyone who wants to participate in its programs and offerings. Staff and volunteers will welcome people of all ages. Programming will focus as much on strengthening a sense of identity and connections to natural communities of support as it will on providing education and technical information.

The center will not offer intensive counseling, medications, or other more traditional mental health services. Other providers in the community do that. Instead, the center will support people who have struggled with mental health issues accelerate their movement toward independence, recovery, and wellness. We expect that many participants in Full Service Partnerships will engage with the center, but again, the center is for anyone who wants to benefit from the activities there.

Some of the specific activities and supports that will be offered through the center include:

- Self-help groups, and other peer and family support services: Peers and family members will be on site, both as paid staff and volunteers, to offer a wide range of supports and services, including mentoring, peer advising, self-help groups, skills classes, classes on how to navigate the system, classes and mentoring on effective advocacy and leadership, vocational counseling, and many others.

- Services to promote increasing independence: People coming to the center will be able to access a range of support services to help them move to increasing levels of independence, including help with pursuing additional education, employment, and/or housing. These services and supports will also include leadership and workforce development training, helping participants develop effective communication, advocacy, and other related skills.

- Educational resources: People who come to the center will have access to a resource library, a computer lab, and classes focused on culturally-appropriate, evidence-based, and promising practices and therapies.

- Recreational and cultural activities: The center will offer a range of recreational and cultural activities, including exercise classes, social networking classes, classes in cultural art and music, and many others. Frequently led by peers, family members, and/or leaders and teachers from different communities, these activities will be designed to strengthen a sense of cultural identity and belonging.

- Assessment and linkage services: The site will be open to anyone who wants to participate in its programs and supports. As it becomes known in the three cities, we expect that people who may be averse to traditional mental health clinics

may come to find support or help. We will have clinical staff and others on site who can engage people new to the mental health system, helping them determine the type of supports they would need. Staff will work closely with the Community Navigator teams to help facilitate access to a wide variety of mental health and other services and supports, including referrals to traditional mental health services if such referrals are warranted and desired.

- Specialized supports and services for TAY: A special section of the site with a separate entrance (or a separate site very near the center) will be dedicated to transition age youth. This part of the site will be staffed primarily by highly skilled peers who have life experience relevant to young people struggling with mental health issues. Professional staff will support the peer staff. Staff will offer a range of support and transition services to TAY. This part of the center will be open after-hours to provide a safe place for TAY to come who may have no place else to go. Staff will work to develop trusting relationships with these youth in order to support them in accessing the help they need.

Over time, we expect that most staff and management of the center will be a diverse array of people who have received services and family members. The center will also be guided by an advisory council whose members will come from diverse communities in the three cities, particularly unserved and underserved communities.

3) Describe any housing or employment services to be provided.

People coming to the center will be able to access a range of support services to help them move to increasing levels of independence, including help with pursuing additional education, employment, and/or housing. These services and supports will also include leadership and workforce development training, helping participants develop effective communication, advocacy, and other related skills.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Not applicable

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program supports the CSS plan's overarching commitment to recovery, resiliency, and wellness. Too often in the current mental health system, people stall on their pathway to recovery because there are not sufficient community supports and structures to help them achieve greater levels of independence, and decrease their dependence on more intensive mental health services. For children and TAY, often the

stigma associated with mental health services can discourage them from getting the help they need. The Wellness and Recovery Center seeks to address these gaps in the current system head-on. The majority of staff and volunteers at the center will be people who have received services or family members from a diverse array of communities. The center will welcome all who want to come, and will focus on *wellness*, not *illness.* It will not seek to create dependency among people who come to the center, but instead will facilitate connections among participants to more sustaining and natural communities of support.

Staff and volunteers will receive on-going training and support on the principles and practices of recovery, wellness, and resiliency. They will regularly engage in self-assessments of the effectiveness of the center and its offerings, and will regularly seek feedback from the Advisory Council and from other community leaders to help continually improve the impact of the center.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

People who receive services and their family members will be integral parts of all aspects of the Center, including management, staff, volunteers, and the Advisory Council.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Wellness and Recovery Center will collaborate with communities and organizations throughout the three cities, identifying volunteers, teachers, and others who can provide classes and offer other supports to center participants. Center staff and volunteers will also cultivate relationships with providers and other service organizations so that they can refer participants as warranted and desired. We expect that community leaders from many communities in the three cities, including the Native American community and other ethnic communities, will help Center staff design culturally appropriate programming for center participants, including activities to introduce participants to traditional healing practices. The center's success will lead to more people in the tri-city area who struggle with mental health issues finding the supports they need to live more fully independent lives.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The recruitment of a diverse staff and volunteer corps of family members and people who have received services, and the collaboration with leaders from Native American and ethnic communities in the three cities, will help the Center reflect an on-going commitment to culturally and linguistically diverse communities. Such programming and collaborations will help to establish trusting relationships with traditionally underserved and unserved communities, leading over time to greater support for these communities. As with the Community Navigator teams, training for Center staff and volunteers will include evidence-based practices, promising practices, and community-defined research related to effective engagement of different ethnic and racial groups.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The staff and volunteers of the Wellness and Recovery Center will reflect a diversity of experiences and skills to ensure that services and supports offered through the Center are sensitive to and responsive to participants' individual needs. This includes organizing supports and activities that are sensitive to differing needs based on gender and sexual orientation. As with the Community Navigator teams, training for Center staff and volunteers will also include evidence-based practices, promising practices, and community-defined research related to sexual orientation and gender identity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

13) Please provide a timeline for this work plan, including all critical implementation dates.

Calendar year: 2009	
April-May	• Identify architects and others to help with site selection process • Begin research on potential sites for the Center • Develop outline of Conditional Use Permit process for each city
June	• Convene delegates workgroup to review potential sites and make recommendation to the Governing Board • Governing Board chooses preferred site • Begin conditional use permit process
July-December	• Complete purchase of site if buying • Finalize physical plans for center • Complete conditional use permit process • Delegates workgroup begins research on best practices and possible programs for the Center • Begin recruiting members of the Advisory Council
Calendar year: 2010	
January-June	• Vision finalized for Center • Construction of new site/rehab of existing site begins • Begin recruiting staff • Staff hired in last quarter; begin work with Advisory Council on initial program offerings • Staff and others prepare for moving into the center • Community Navigators and Advisory Council members begin publicizing Center
July-December	• Center opens and activities begin • Assessment of center after 6 months of operation.

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Budget worksheets for this workplan are included in Exhibit 5.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Tri-City MHC is requesting funding.

TC-04: Supplemental Crisis Services

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

a) A brief description of the program;

b) Identification of the age and situational characteristics of the priority population to be served in this program;

c) Identification of strategies for which you will be requesting MHSA funds for this program; and

d) Identification of the funding types that will be used and the age group of the priority populations to be served for each strategy.

Please see Exhibit 4, workplan TC-04.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

As explained in the community issues section, one result of Tri-City's bankruptcy was a significant decline in local crisis services after hours and on weekends for the three cities. While the Tri-City clinic, and other providers in the area, offer 24/7 crisis support for *people they are serving,* people who are not currently receiving services who suffer a crisis during the evening or on weekends must rely on Los Angeles County's Psychiatric Mobile Response Team (PMRT). Given that the three cities are on the eastern edge of the county, response times can sometimes take hours. Such long response times before a clinician is available to support the person in crisis and his/her family increases the likelihood that the situation will deteriorate, resulting in a 5150, the person being sent to an emergency room, or the person being incarcerated.

While Tri-City MHC cannot afford to reconstruct its own after-hours system to replace LA County's after-hours PMRT, we propose to supplement this after-hours system with clinical support. Specifically, we intend to contract with several clinicians who will provide coverage after-hours and on weekends.

These clinicians will not be LPS qualified; they will not have be able to write 5150s or 5585s. What they will be able to do is respond to police calls, meet the police at the location of the crisis, and offer support to police, the person in crisis, and others present. they would also be able to travel with police and the person to another location if such movement might help diffuse the situation. If ultimately a 5150 has to be issued, the clinician will wait with the person and the officer until the PMRT arrives. We believe that such clinical support will likely diffuse many situations and ultimately avoid a 5150, an emergency room referral, or incarceration. These after-hour clinicians will also be connected to the Community Navigator teams, so that if referrals for the person in crisis are needed, they will have up-to-date information about services and supports that are available. This program advances the goals of the MHSA by avoiding unnecessary involuntary commitments, incarcerations, or hospital stays.

3) Describe any housing or employment services to be provided.

Not applicable

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Not applicable

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

By intervening in crises and helping to avoid unnecessary involuntary commitments, incarcerations, or hospital stays, this program makes it more likely that persons with mental health issues will be able to receive referrals and supports that will help them move toward recovery, resiliency, and wellness.

Clinicians will receive on-going training and support on the principles and practices of recovery, wellness, and resiliency. We will conduct regular assements with the clinicians, representatives of the police departments from the three cities, and community leaders to ensure the ongoing effectiveness of this programs.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

It may be that the clinicians hired to provide these services are people who have received services or family members; we may not know that, however, unless candidates choose to self-disclose.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

We will work closely with the police departments from the three cities, NAMI, the Mental Health Commission, and leaders from other community groups to assess the effectiveness of this program and pursue continuous improvement. Staff will also

regularly review every incident responded to by the Supplemental Crisis clinicians to assess what improvements could be made in future situations.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The Community Navigators and other staff of Tri-City will regularly engage leaders from ethnic and other traditionally unserved and underserved communities to solicit their feedback on the effectiveness and appropriateness of services in this plan, including supplemental crisis services. As with the Community Navigator teams, training for supplemental crisis clinicians will include evidence-based practices, promising practices, and community-defined research related to effective engagement of different ethnic and racial groups.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

As with the Community Navigator teams, training for supplemental crisis clinicians will also include evidence-based practices, promising practices, and community-defined research related to sexual orientation and gender identity.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

13) Please provide a timeline for this work plan, including all critical implementation dates.

Calendar year: 2009	
June-July	• Develop job description and RFP • Issue RFP and hold information sessions
August-September	• Receive proposals and/or applications • Review and make decision
October-December	• Services begin • Begin incident review process

Calendar year: 2010	
January-June	• Implementation continues • Convene assessment process with police departments, NAMI, Mental Health Commission, community leaders • Make adjustments in program as necessary

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Budget worksheets for this workplan are included in Exhibit 5.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Tri-City MHC is requesting funding.

TC-05: Field-Capable Service for Older Adults

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

a) A brief description of the program;

b) Identification of the age and situational characteristics of the priority population to be served in this program;

c) Identification of strategies for which you will be requesting MHSA funds for this program; and

d) Identification of the funding types that will be used and the age group of the priority populations to be served for each strategy.

Please see Exhibit 4, workplan TC-05.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

As explained in the community issues section, older adults are the fastest growing population in the cities of Claremont and La Verne. While a number of programs provide health and social supports for older adults, there are few services to meet the mental health needs of this population. Older adults, especially frail elders, need more accessible mental health services provided at locations convenient to them—e.g,, in their homes, senior centers, and medical facilities.

Tri-City Mental Health system will hire or contract with one or more clinicians (equal to 1.0 FTE) with expertise in older adult mental health issues. This clinician (or clinicians) will spend much of his/her time engaging with seniors who have serious mental health issues in their homes, in senior centers, and other places where seniors are present. They will integrate their work with other providers of senior services in the Tri-City area, and with the Community Navigator teams.

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3) Describe any housing or employment services to be provided.

The clinician or clinicians may offer possible referral for housing or employment support services if warranted and desired.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Not applicable

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Older adults are frequently invisible to mental health systems, often because they cannot get to the services and supports available to them. Creating field-capable services solves this problem, and brings to seniors supports and services that can promote their recovery.

The clinician (or clinicians) chosen to provide these services will have expertise in older adult mental health issues. They will receive on-going training and support on the principles and practices of recovery and wellness as applicable to older adults. We will conduct regular assessments with the clinician(s), representatives of the local senior services centers, and community leaders to ensure the ongoing effectiveness of this program.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

It may be that the clinician hired to provide these services is someone who has received services and/or a family member; we may not know that, however, unless potential candidates choose to self-disclose.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

We will work closely with the senior centers, other senior service providers, NAMI, the Mental Health Commission, and leaders from other community groups to assess the effectiveness of this program and pursue continuous improvement.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The Community Navigators and other staff of Tri-City will regularly engage leaders from ethnic and other traditionally unserved and underserved communities to solicit their feedback on the effectiveness and appropriateness of services in this plan, including field capable services for older adults. As with the Community Navigator teams, training for this clinician will include evidence-based practices, promising practices, and community-defined research related to effective engagement of older adults of different ethnic and racial groups.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

As with the Community Navigator teams, training for this clinician will also include evidence-based practices, promising practices, and community-defined research related to sexual orientation and gender identity for older adults.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

13) Please provide a timeline for this work plan, including all critical implementation dates.

Calendar year: 2009	
June-July	• Develop job description and RFP • Issue RFP and hold information sessions
August-September	• Receive proposals and/or applications • Review and make decision
October-December	• Services begin
Calendar year: 2010	
January-June	• Implementation continues • Convene assessment process with senior centers, NAMI, Mental Health Commission, community leaders, and others • Make adjustments in program as necessary

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Budget worksheets for this workplan are included in Exhibit 5.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Tri-City MHC is requesting funding.

ADMINISTRATION

We are allocating fifteen percent (15%) of our CSS allocation to administration. It is hard to overstate the importance or significance of this investment. Tri-City MHC has just emerged from bankruptcy. Prior to the bankruptcy, Tri-City MHC employed over 300 employees; it now has less than 80. The silver lining of this tragedy has been that other providers have emerged to provide services and meet the needs of people in the three cities. Unfortunately, there is no real system in place to coordinate these various providers and their services; no data system to support planning, billing, and to track outcomes; no contract monitoring infrastructure to allow straightforward subcontracting of services. All of this infrastructure will have to be created. We will begin to create this infrastructure through the CSS plan, and continue its development through the PEI plan, WET plan, and others.

That the delegates approved this allocation by consensus and with great enthusiasm speaks volumes about the trust that Tri-City MHC has begun to re-build with its community partners and stakeholders.

NON-RECURRING FUNDS

In addition to recommendations for programs funded with on-going CSS dollars, delegates also reached consensus on a number of investments with available non-recurring funds. We calculated the non-recurring funds available to support the Tri-City CSS plan as follows:

- In FY 2006-07, Tri-City MHC was allocated **$1,907,890** for CSS services. We funded no CSS services in FY 2006-07, so this amount becomes available as non-recurring funds, required to be expended by June 30, 2009.

- In FY 2007-08, Tri-City MHC was allocated **$3,586,800** for CSS services. We funded no CSS services in FY 2007-09, so this amount becomes available as non-recurring funds, required to be expended by June 30, 2010.

- In FY 2008-09 (this fiscal year), Tri-City MHC was allocated $3,721,400 for CSS services. We project expending $70,745 on on-going services in June 2009, leaving a balance of **$3,650,656** available as non-recurring funds, required to be expended by June 30, 2011.

- For FY 2009-10, Tri-City has been allocated $4,989,000 for CSS services. We project a budget of $2,386,796 for this fiscal year, leaving a balance of **$2,602,204** available as non-recurring funds, required to be expended by June 30, 2012.

- Total projected non-recurring funds through FY 2009-10: **$11,747,550**

We have developed a budget as part of Exhibit 2 that indicates how we want to allocate a substantial portion of these funds by fiscal year. The list of these non-recurring investments includes:

- TCNR-01: Community Program Planning funds
- TCNR-02: Prudent Reserve
- TCNR-03: Operational Reserve
- TCNR-04: FSP non-recurring expenses
- TCNR-05: Community navigator non-recurring expenses
- TCNR-06: Crisis and field-capable services non-recurring expenses
- TCNR-07: Wellness and Recovery Center non-recurring expenses
- TCNR-08: Administration non-recurring expenses

What follows is a narrative summary of these proposed investments of non-recurring funds, all endorsed unanimously by the delegates.

TCNR-01: Community Planning Program

CA DMH approved Tri-City MHC's Community Planning Program proposal for **$250,000** in October 2008. Tri-City has already received these funds, and used them to pay for the planning process that produced this plan. CA DMH took portions of this allocation from Tri-City's FY 2006-07 and FY 2007-08 allocations.

TCNR-02: Prudent Reserve

CA DMH has issued regulations permitting counties to invest up to 50% of the current fiscal year's allocation into a prudent reserve. For Tri-City MHC this amount equals **$1,860,700** ($3,721,400 * 50%).

TCNR-03: Operational Reserve

CA DMH has also issued regulations permitting counties to invest up to 10% of the current fiscal year's allocation into an operational reserve. For Tri-City MHC this amount equals **$372,140** ($3,721,400 * 10%).

TCNR-04: FSP Non-Recurring Expenses

Providers who are chosen to provide Full Service Partnerships under this plan may incur non-recurring expenses needed to successfully implement their programs—e.g., building renovations, vehicle purchases, equipment and technology purchases, and other costs. Delegates recommend setting aside **$200,000** in non-recurring funds to be available for providers chosen to deliver Full Service Partnerships. Providers will submit applications for a portion of these funds when they submit their proposals to deliver Full Service Partnerships.

TCNR-05: Community Navigator Non-Recurring Expenses

To support the Community Navigators and their teams, delegates approved a recommendation of **$30,000** in non-recurring funds. These funds would be used to pay for software to more effectively link databases among the three cities to track available services and supports, and for computers, phones, and other equipment to support this workplan.

TCNR-06: Supplemental Crisis Services and Field-Capable Service for Older Adults Non-Recurring Expenses

Delegates approved a recommendation of **$4,000** in non-recurring funds to pay for computers and other equipment to support this workplan.

TCNR-07: Wellness and Recovery Center Non-Recurring Expenses

Delegates approved a recommendation of **$4,000,000** in non-recurring funds to support this workplan. The budget for these non-recurring funds was developed in consultation with staff from the three cities, and includes the following:

Expense Category	Amount	Notes
Building		
10,000 sq ft building	2,300,000	Assumes $230/sq ft either to purchase the building for, or build, the Center
Design and rehab/construction of interior of the building	950,000	Assumes $95/square foot to rehab or to construct the interior of the building
Professional fees	215,000	Space planning, architect, attorneys, etc.
Contingency reserve	325,000	Reserve 10% of building purchase and rehab costs
Sub-total building	**3,790,000**	
Furnishings and other equipment		
Furniture + recreational equipment	120,000	
Van	35,000	
Computers, phones, copiers, etc.	55,000	Includes computers for computer lab
Sub-total furnishings	**210,000**	
Total request	**$ 4,000,000**	

TCNR-08: Administration Non-Recurring Expenses

Delegates approved a recommendation of **$360,400** in non-recurring funds to support the Administration component of this workplan. The budget for these non-recurring funds includes the following:

Expense Category	Amount	Notes
Staff set-up costs	15,700	Computers, equipment for new staff
Contracts administrator—Consultant	97,500	To help set up monitoring system
Audit/Compliance/QA—Consultant	72,000	To help set up compliance system
Legal costs—contracting/compliance	120,000	Contracts development with community providers
RFP development	25,000	For FSPs and other workplans
Software development costs	20,200	
Supplies + other costs	10,000	
Total request	**$ 360,400**	

We propose expending these funds over two fiscal years: $60,900 in FY 2008-09 and $299,500 in FY 2009-10. Note that this proposal relies on several consultants to support administrative staff in establishing systems for contract administration and compliance, and for RFP development. Once we learn what these systems will take to manage on an on-going basis, we will include these costs as part of a proposal for on-going administration funds associated with the Prevention and Early Intervention plan.

Remaining Non-Recurring Funds Through FY 2009-10

-

The requests approved by the delegates for non-recurring funds total **$7,077,240** out of an available **$11,747,550,** leaving **$4,670,310** of non-recurring funds yet to be allocated, assuming all proposed budgets are approved by CA DMH. Delegate will convene again in May or June 2009 to develop a plan for these remaining non-recurring funds, once we have secured CA DMH approval for the CSS plan.

PART III: REQUIRED EXHIBITS

Exhibit I: Plan Face Sheet
Exhibit 2: County Program Work Plan Listing and Summary Budget by Fiscal Year
Exhibit 3: Full Service Partnership Population
Exhibit 4: Program Work Plan Summary
Exhibit 5: Budget and Staffing Detail Worksheets[16]
Exhibit 6: Quarterly Progress Reports

PART IV: ADDITIONAL DOCUMENTS

Attachment 1: Article from Inland Valley Bulletin about the planning process
Attachment 2: Gradients of Agreement tool used to test for consensus

[16]We have developed budget and staffing detail worksheets for each workplan. We have substituted the new Exhibit F1(b) budget form for the old Exhibit 5 budget forms, but still organized all of the budget and staffing documents under Exhibit 5.

TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

EXHIBIT 2

COUNTY PROGRAM WORK PLAN LISTING AND SUMMARY BUDGET BY FISCAL YEAR

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

County:	**Tri-City**
Fiscal Year:	**FY 2008-09**

(Assumes funds are available 6/1/2009)

		TOTAL FUNDS REQUESTED By Type				FUNDS REQUESTED By Age Group			
#	Program Work Plan	FSP	SD	O&E	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
TC-01	Full Service Partnerships								
TC-02	Community Navigators		9,538	9,538	19,076	6,295	3,052	7,630	2,098
TC-03	Integrated Wellness+Recovery Ctr								
TC-04	Supplemental Crisis Services								
TC-05	Field capable services for OA								
TC-06	Administration	36,169	7,750	7,750	51,669	17,051	8,267	20,668	5,684
		36,169	17,288	17,288	70,745	23,346	11,319	28,298	7,782

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

County:	**Tri-City**
Fiscal Year:	**FY 2009-10**

		TOTAL FUNDS REQUESTED By Type				FUNDS REQUESTED By Age Group			
#	Program Work Plan	FSP	SD	O&E	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
TC-01	Full Service Partnerships	1,305,888			1,305,888	537,270	184,318	452,195	132,105
TC-02	Community Navigators		112,250	112,250	224,500	74,085	35,920	89,800	24,695
TC-03	Integrated Wellness+Recovery Ctr		181,238		181,238	59,809	28,998	72,495	19,936
TC-04	Supplemental Crisis Services		58,500		58,500	19,305	9,360	23,400	6,435
TC-05	Field capable services for OA		58,500		58,500				58,500
TC-06	Administration	305,319	199,752	53,099	558,170	184,196	89,307	223,268	61,399
		1,611,207	610,240	165,349	2,386,796	874,665	347,903	861,158	303,070

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

County:	**Tri-City**
Fiscal Year:	**FY 2010-11**

		TOTAL FUNDS REQUESTED By Type				FUNDS REQUESTED By Age Group			
#	Program Work Plan	FSP	SD	O&E	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
TC-01	Full Service Partnerships	2,091,521			2,091,521	690,202	334,643	836,608	230,067
TC-02	Community Navigators		115,618	115,618	231,235	76,308	36,998	92,494	25,436
TC-03	Integrated Wellness+Recovery Ctr		758,569		758,569	250,328	121,371	318,599	68,271
TC-04	Supplemental Crisis Services		80,340		80,340	26,512	12,854	32,136	8,837
TC-05	Field capable services for OA		80,340		80,340				80,340
TC-06	Administration	314,479	231,788	28,648	574,915	189,722	91,986	229,966	63,241
		2,406,000	1,266,655	144,266	3,816,920	1,233,071	597,853	1,509,803	476,192

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

County:	**Tri-City**
Fiscal Year:	**FY 2011-12**

		TOTAL FUNDS REQUESTED By Type				FUNDS REQUESTED By Age Group			
#	Program Work Plan	FSP	SD	O&E	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
TC-01	Full Service Partnerships	2,155,816			2,155,816	705,570	345,173	863,215	241,858
TC-02	Community Navigators		119,087	119,087	238,173	78,597	35,726	97,651	26,199
TC-03	Integrated Wellness+Recovery Ctr		781,326		781,326	257,838	125,012	328,157	70,319
TC-04	Supplemental Crisis Services		82,750		82,750	27,308	13,240	33,100	9,103
TC-05	Field capable services for OA		82,750		82,750				82,750
TC-06	Administration	323,913	238,742	29,507	592,163	195,414	94,746	236,865	65,138
		2,479,729	1,304,655	148,594	3,932,978	1,264,726	613,897	1,558,988	495,367

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

County:	**Tri-City**
Fiscal Year:	**FY 2008-09 - FY 2009-10**

(Assumes funds are available on or before 6/1/2009)

#	Program Work Plan	TOTAL FUNDS REQUESTED By Fiscal Year				
		FY 2006-07: 1,907,890	**FY 2007-08: 3,586,800**	**FY 2008-09: 3,650,656**	**FY 2009-10: 2,602.204**	**Total Request**
	NON-RECURRING					
TCNR-01	CPP funds (already disbursed by CA DMH)	95,000	155,000			250,000
TCNR-02	Prudent Reserve (50% of FY 2008-09 allocation)	1,812,890	47,810			1,860,700
TCNR-03	Operational Reserve (10% of FY 2008-09 allocation)		372,140			372,140
TCNR-04	FSP non-recurring expenses		200,000			200,000
TCNR-05	Community navigator non-recurring expenses		30,000			30,000
TCNR-06	Supplemental crisis and field-capable services non-recurring expenses		4,000			4,000
TCNR-07	Wellness+Recovery Center non-recurring expenses		2,777,850	1,222,150		4,000,000
TCNR-08	Administration non-recurring expenses			360,400		360,400
	Total Request for FY 08-09	1,907,890	3,586,800	1,582,550	0	**7,077,240**
	Balance remaining to be allocated	0	0	2,068,106	2,602,204	**4,670,310**

Notes

1. CA DMH has already released the CPP planning funds to Tri-City.
2. The prudent and operational reserves should be allocated by program type in the same percentages as the on-going CSS plan.
3. With the CPP planning funds and the Prudent Reserve, we have fully allocated our FY 2006-07 allocation.
4. The amount of non-recurring funds for FY 2008-09 is the difference between the allocation (3,721,400) and the amount to be used for on-going services and supports in June 2009: 70,745.
5. The amount of non-recurring funds for FY 2009-10 is the different between the allocation (4,989,000) and the projected FY 2009-10 budget: 2,386,796.

TRI-CITY MENTAL HEALTH SYSTEM'S
COMMUNITY SERVICES AND SUPPORTS PLAN

EXHIBIT 3

FULL SERVICE PARTNERSHIP POPULATION

EXHIBIT 3: FULL SERVICE PARTNERSHIP POPULATION – OVERVIEW

Number of individuals to be fully served: (see Note 1)

FY 2008-09: Children and Youth: 0	**Transition Age Youth: 0**	**Adult: 0**	**Older Adult: 0**	**TOTAL: 0**
FY 2009-10: Children and Youth: 91	**Transition Age Youth: 27**	**Adult: 71**	**Older Adult: 23**	**TOTAL: 212**
FY 2010-11: Children and Youth: 183	**Transition Age Youth: 27**	**Adult: 71**	**Older Adult: 23**	**TOTAL: 304**
FY 2011-12: Children and Youth: 183	**Transition Age Youth: 27**	**Adult: 71**	**Older Adult: 23**	**TOTAL: 304**

PERCENT OF INDIVIDUALS TO BE FULLY SERVED

	% Unserved								%Underserved								TOTALS #/%	
	%Male				%Female				%Male				%Female					
Race/Ethnicity	**Total #/%**		**Non-English Speaking (Note 5)**		**Total #/%**		**%Non-English Speaking (Note 5)**		**Total #/%**		**%Non-English Speaking (Note 5)**		**%Total**		**%Non-English Speaking (Note 5)**			
2009-10																		
African American	4	2%			6	3%			4	2%			5	2%			**19**	**9%**
Asian/Pac Island	8	4%	2	1%	11	5%	2	1%									**19**	**9%**
Latino	32	15%	4	2%	36	17%	6	3%	32	15%	4	2%	38	18%	3	3%	**138**	**65%**
Native American	2	1%			2	1%											**4**	**2%**
White	4	2%			7	3%			4	2%			8	4%			**23**	**11%**
Other	2	1%			2	1%			2	1%			3	1%			**9**	**4%**
Totals	**25**	25%	3	3%	**30**	30%	4	4%	**20**	20%	2	2%	24	24%	3	3%	**212**	**100%**
2010-11																		
African American	6	2%			9	3%			6	2%			6	2%			**27**	**9%**
Asian/Pac Island	12	4%	4	1%	15	5%	4	1%									**27**	**9%**
Latino	46	15%	6	2%	52	17%	9	3%	46	15%	6	2%	52	17%	9	3%	**196**	**64%**
Native American	3	1%			3	1%											**6**	**2%**
White	6	2%			10	3%			6	2%			10	3%			**32**	**11%**
Other	4	1%			4	1%			4	1%			4	1%			**16**	**5%**
Totals	**77**	24%	10	3%	**93**	32%	13	4%	**62**	20%	6	2%	**72**	24%	9	3%	**304**	**100%**
2011-12																		
African American	6	2%			9	3%			6	2%			6	2%			**27**	**9%**
Asian/Pac Island	12	4%	4	1%	15	5%	4	1%									**27**	**9%**
Latino	46	15%	6	2%	52	17%	9	3%	46	15%	6	2%	52	17%	9	3%	**196**	**64%**
Native American	3	1%			3	1%											**6**	**2%**
White	6	2%			10	3%			6	2%			10	3%			**32**	**11%**
Other	4	1%			4	1%			4	1%			4	1%			**16**	**5%**
Totals	**77**	24%	10	3%	**93**	32%	13	4%	**62**	20%	6	2%	**72**	24%	9	3%	**304**	**100%**

Notes

1. We project our first services to be delivered in this fiscal year (June 2009), but FSPs will not begin until the third quarter of FY 2009-10.
2. The unmet need in the Tri-City area, even with new MHSA funds, will far exceed the numbers we will reach through this plan.
3. Demographic data suggest that boys and young men receive more services than girls and young women (ages 0-25), though we have no data to suggest a disproportionate prevalence of mental illness in boys. Moreover, across all age groups there is essentially a 50/50 split between males and females in the three cities. Therefore, we are creating slightly higher targets for girls and young women than boys and young men.
4. Demographic data indicate Asian and Pacific Islander (API) residents across all age groups receive fewer services than their population numbers would indicate; so too for Latino adults and older adults. White and African Americans residents receive more services than their population numbers would indicate, though unmet need is substantial across all populations. Therefore, we are creating slightly higher targets for API residents across all age groups, and Latino adults and older adults, than their population numbers would indicate.
5. The numbers and percentages for non-speaking people are included in the totals for each gender, and therefore do not separately contribute to the total for each category.

TRI-CITY MENTAL HEALTH SYSTEM'S
COMMUNITY SERVICES AND SUPPORTS PLAN

EXHIBIT 4

PROGRAM WORK PLAN SUMMARY

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Tri-City	Program Work Plan Name: **Full Service Partnerships**
Program Work Plan #: TC-01	Estimated Start Date: October 1, 2009
Description of Program *Describe how this program will help advance the goals of the MHSA*	Full service partnerships are the heart of the Community Service and Supports plan. Full service partnerships are individualized services grounded in a "whatever it takes" commitment. Each enrolled individual, and where appropriate his or her family, participates in the development of a culturally appropriate plan focused on recovery and wellness. The plan can include all needed services, including but not limited to traditional mental health services, so long as the services and supports contribute to the outcomes of well-being defined in the plan, including: meaningful use of time and capabilities; safe housing; a network of supportive relationships; timely access to services; reductions in incarceration; and reductions in involuntary services. Each enrolled individual has a personal services coordinator (PSC), and is supported by a staffing structure that insures 24/7 support.
Priority Populations *Describe the situational characteristics of the priority population.*	**Children and youth (0-15)** who have serious emotional disorders and their families (including Special Education pupils) who are unserved or seriously underserved, specifically including: ❖ Children and their families who are uninsured, under-insured and/or youth who are not eligible for Medi-Cal because they are detained in the juvenile justice system; ❖ Children and youth who are homeless, or at risk of homelessness; ❖ Children and youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements; and/or ❖ Children and youth who are at risk of out-of-home placement. **Transition age youth** (16-25) who are currently unserved or seriously underserved who have severe emotional disorders, specifically including youth: ❖ With a co-occurring substance abuse disorder and/or health condition (recommendation from the subcommittee); ❖ Who are homeless or at imminent risk of being homeless; ❖ Who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems; ❖ Involved in the criminal justice system; ❖ At risk of involuntary hospitalization or institutionalization; and/or ❖ Who have experienced a first episode of major mental illness.

	Adults (26-59) with serious mental illness who are unserved or seriously underserved, specifically including adults: ❖ With a co-occurring substance abuse disorder and/or health condition; ❖ Who are homeless or at risk of homelessness; ❖ Involved in the criminal justice system (including adults with child protection issues), or at risk of criminal justice involvement; ❖ Who are frequent users of hospital and emergency room services; and/or ❖ At risk of institutionalization. **Older adults** (60 years and older) with serious mental illness who are unserved or seriously underserved, and who have a reduction in personal or community functioning, specifically including older adults who are: ❖ Homeless, or at risk of homelessness; and/or ❖ At risk of institutionalization, nursing home care, hospitalization and emergency room services.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Full Service Partnerships	X			X	X	X	X
Any and all appropriate strategies under a "whatever it takes" commitment, including age and culturally appropriate and competent services, including but not limited to:							
❖ Assessment services;							
❖ 24/7 crisis services;							
❖ Support for housing, employment, and educational needs;							
❖ Peer support services;							
❖ Integrated substance abuse and mental health services; and							
❖ Whatever other services and supports are necessary to promote and sustain resiliency, recovery, and wellness.							

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Tri-City	Program Work Plan Name: **Community Navigators**
Program Work Plan #: TC-02	Estimated Start Date: June 1, 2009
Description of Program *Describe how this program will help advance the goals of the MHSA*	Community navigators will be a crucial structure to help people find the formal and informal supports they need. The navigators will help build teams of volunteers and staff from other organizations and groups, including community workers, people who have received services, family advocates, family members, and mental health professionals. While the precise design of these teams will vary across the three cities, reflecting each city's particular local character, ethnic composition, and needs, each team will recruit members who together have substantial familiarity and expertise with all age groups, including the particular challenges facing those age groups and the distinct characteristics of the support networks for each. Community navigators and their volunteer teams will: ❖ Engage with people who need services and their families to help them quickly identify currently available services, including formal and informal supports and services tailored to the particular cultural, ethnic, age, and gender identity of those seeking them; ❖ Recruit community-based organizations, faith-based organizations, and other community groups to become part of an active and ever growing locally-based support network for people in the three-cities, including those most challenged by mental health issues; ❖ Follow-up with people with whom they have engaged to ensure that they have connected with support structures and received the help they need; ❖ Use information technology and other means to map and keep up to date about the current availability of services and supports in the Service Area; and ❖ Promote awareness of mental health issues, and the commitment to recovery, wellness, and self-help that lies at the heart of the Mental Health Services Act.
Priority Population *Describe the situational characteristics of the priority population.*	All people with mental health issues in the three cities, with an initial focus on the focal populations for the Full Service Partnerships for all four age groups, un-served and under-served ethnic communities, special populations, and others.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Community area navigators		X	X	X	X	X	X
❖ The four teams will reflect the needs of each city with a balance of community-based skills, lived experience and professional skills. Teams will be especially familiar with community-based supports and services.							
❖ Supports service integration through linkages to mental health and supportive services, including formal and informal community-based supports and services.							
❖ Collaboration with the Full Service Partnership agencies in the Service Area to appropriately outreach, engage and refer appropriate individuals to these agencies							

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Tri-City	Program Work Plan Name: **Wellness and Recovery Center**
Program Work Plan #: TC-03	Estimated Start Date: April 1, 2010
Description of Program *Describe how this program will help advance the goals of the MHSA*	A new integrated services and supports site will focus on promoting recovery, resiliency, and wellness for people of all ages struggling with serious mental health issues and their families. Staff located at this site, including counselors, peer advocates, and others, will provide a range of culturally competent, person– and family-centered services and supports designed to promote increasing independence and wellness for people of all ages. Over time, we expect that most staff and management of the center will be people who have received services and family members. It will also be guided by an advisory council whose members will be predominantly people who have received services and family members. A special section of the site with a separate entrance, or a separate site very close by, will be dedicated to transition age youth. This part of the site will be staffed primarily by highly skilled peers who have life experience relevant to young people struggling with mental health issues. Professional staff will support the peer staff. Staff will offer a range of support and transition services to TAY. It will be open after-hours to provide a safe place for TAY to come who may have no place else to go. Staff will work to develop trusting relationships with these youth in order to support them in accessing the help they need.
Priority Population *Describe the situational characteristics of the priority population.*	All people with mental health issues in the three cities, with an initial focus on the priority focal populations for the Full Service Partnerships for all four age groups, un-served and under-served ethnic communities, special populations, and others.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Wellness and Recovery Center		X		X	X	X	X
❖ Assessment services				X	X	X	X
❖ Self-help groups and other peer-led services					X	X	X
❖ Housing, employment, and education support services				X	X	X	X
❖ Leadership and workforce development training					X	X	X
❖ Recreational and cultural activities				X	X	X	X
❖ Specialized services for TAY				X	X		

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Tri-City	Program Work Plan Name: **Supplemental Crisis Services**
Program Work Plan #: TC-04	Estimated Start Date: October 1, 2009
Description of Program *Describe how this program will help advance the goals of the MHSA*	Currently people in the three cities who have a mental health crisis after hours or on weekends, and who are not receiving mental health services, must wait for a response from Los Angeles County's Psychiatric Mobile Response Team (PMRT). Given the three cities' location at the eastern edge of the County, this can sometime take hours, leaving people at risk and often preventing police officers from returning to patrol duty. While Tri-City Mental Health System cannot replace LA County's PMRT system, we want to provide a clinician who is available after hours and on weekends. These clinicians (there will likely be several who will rotate availability) will be on-call to support police officers and family members with a person in crisis. While they will not be LPS qualified, they will be able to meet the police officers, work with the person in crisis, and likely be able to decompress the situation in ways that will prevent a 5150 from being issued in many circumstances. As part of the mental health system in the three-city area, these clinicians will also be able to help with follow-up linkages to services once the crisis is averted.
Priority Population *Describe the situational characteristics of the priority population.*	People who are unserved in the three cities who suffer a mental health crisis and their families.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Supplemental crisis services		X		X	X	X	X
❖ Crisis support for stabilization and linkage to ongoing community-based services							

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Tri-City	Program Work Plan Name: **Field-Capable Services for Older Adults**
Program Work Plan #: TC-05	Estimated Start Date: October 1, 2009
Description of Program *Describe how this program will help advance the goals of the MHSA*	Older adults are the fastest growing population in La Verne and Claremont, two of the three cities in the Tri-City area. They are also often underserved for many reasons, among them that they cannot get to services that would benefit them. Tri-City Mental Health system will hire or contract with a full-time clinician with expertise in older adult mental health issues. This clinician will spend much of his/her time engaging with seniors who have serious mental health issues in their homes, in senior centers, and other places where seniors are present. This clinician will integrate his/her work with other providers of senior services in the Tri-City area.
Priority Population *Describe the situational character-istics of the priority population.*	Older adults in the Tri-City area who have serious mental health needs but who may not qualify or cannot access (because of limited availability) full service partnerships.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Field-capable services for older adults		X	X				X
❖ Outreach and engagement							
❖ Bio-psychosocial assessments							
❖ Individual and family treatments							
❖ Case management support							
❖ Family education and support							
❖ Linkages to a range of other older adult services in the Tri-City area							

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Tri-City	Program Work Plan Name: **Administration**
Program Work Plan #: TC-06	Estimated Start Date: June 1, 2009 (or as soon as the CSS plan is approved)
Description of Program *Describe how this program will help advance the goals of the MHSA*	While it may be unusual to treat Administration as a program, the investment we are making in Administration has immense significance for the system of mental health services in the three cities. Tri-City has just emerged from bankruptcy. Prior to the bankruptcy Tri-City employed over 300 employees; it now has less than 80. The silver lining of this tragedy has been that other providers have emerged to provide services and meet needs of people in the three cities. Unfortunately, there is no real system in place to coordinate these various providers and their services; no data system to support planning, billing, and to track outcomes; no contract monitoring infrastructure to allow straightforward subcontracting of services. All of this infrastructure will have to be created, and will be through the CSS plan. It will pay enormous dividends across the system, and insure the efficient provision of effective services to Tri-City residents.
Priority Population *Describe the situational characteristics of the priority population.*	All people with mental health issues in the three cities, with an initial focus on the priority focal populations for the Full Service Partnerships for all four age groups, un-served and under-served ethnic communities, special populations, and others.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Administration	X	X	X	X	X	X	X
❖ Transformative infrastructure to support the mental health system in the three cities							

TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

EXHIBIT 5

BUDGET AND STAFFING DETAIL WORKSHEETS

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2008/09

Work Plan # TC-01 a

Work Plan Name Children Full-Service Partnerships

Months of Operation 0

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$0**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$0
Funding Requiredments for Non-recurring expenditures	$0
	$0

Prepared by: Margaret Harris Date 3/16/09

Telephone Number: (909) 623-6131

TRI-CITY MENTAL HEALTH

CHILDREN FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 a

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
It is anticipated that all service provider contracts for the provision of Children's Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year. Therefore, there is no budget presented for fiscal 2008-09 or any funding requirements.

A.5 Expenditures When Service Provider is not Known
None

A.6 Non-Recurring Costs
None

B.1 New Revenues
None

C. Total Funding Requirements--None

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-01 a

Work Plan Name Children Full-Service Partnerships

Months of Operation 7

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$1,139,383			$1,139,383
6. Non-recurring expenditures	$66,000			$66,000
7. Total Proposed Work Plan Expenditures	**$1,205,383**	**$0**	**$0**	**$1,205,383**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$346,042			$346,042
b. State General Funds	$256,071			$256,071
c. Other Revenue				$0
2. Total Revenues	$602,113	$0	$0	$602,113
C. Total Funding Requirements (Note a)	**$603,270**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$537,270
Funding Requiredments for Non-recurring expenditures	$66,000
	$603,270

Prepared by: Margaret Harris | Date 3/16/09

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TRI-CITY MENTAL HEALTH

CHILDREN FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 a

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that all service provider contracts for the provision of Children's Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year and that 91 clients will be served by the end of the year.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $1,139,383 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that children's needs are met based on a "whatever it takes" commitment. These services could include clothing, food, transportation and housing stipends.

· ***Estimated personnel expenditures*** expected to support the full-service partnerships. It is projected that approximately 34.4 full time equivalent staff will be required and that approximately 50% of the related salaries and benefits costs will commence at the beginning of December 2009, with the remaining staffing completed by early June, 2010.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

A.6 Non-Recurring Costs

It is anticipated that this program will require $66,000 in non-recurring funds for program set-up costs of the service provider. See Exhibit #2 Non-Recurring Program Work Plan.

B.1 New Revenues

New revenues of $602,113 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP of $346,042 is for six months.

· ***State General Funds*** anticipated from provision of services to Medi-Cal eligible youth that qualify under EPSDT. The projected EPSDT of $256,071 is for six months.

C. Total Funding Requirements--$603,270

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2010/2011

Work Plan # TC-01 a

Work Plan Name Children Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$3,134,140			$3,134,140
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$3,134,140**	**$0**	**$0**	**$3,134,140**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$1,408,243			$1,408,243
b. State General Funds	$1,042,100			$1,042,100
c. Other Revenue				$0
2. Total Revenues	$2,450,343	$0	$0	$2,450,343
C. Total Funding Requirements (Note a)	**$683,797**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$683,797
Funding Requiredments for Non-recurring expenditures	$0
	$683,797

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TRI-CITY MENTAL HEALTH

CHILDREN FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 a

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that 183 Children's Full-Service Partnerships will be in place and served in fiscal 2010-2011.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $3,134,140 includes:

- ***Estimated flexible funds*** to be used to provide wraparound services to ensure that children's needs are met based on a "whatever it takes" commitment. These services could include clothing, food, transportation and housing stipends.
- ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately 34.4 full time equivalent staff.
- ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $2,450,343 include:

- ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP of $1,408,243 is for twelve months.
- ***State General Funds*** anticipated from provision of services to Medi-Cal eligible youth that qualify under EPSDT. The projected EPSDT of $1,042,100 is for twelve months.

C. Total Funding Requirements--$683,797

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-01 a

Work Plan Name Children Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$3,228,166			$3,228,166
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$3,228,166**	**$0**	**$0**	**$3,228,166**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$1,449,768			$1,449,768
b. State General Funds	$1,072,828			$1,072,828
c. Other Revenue				$0
2. Total Revenues	$2,522,596	$0	$0	$2,522,596
C. Total Funding Requirements (Note a)	**$705,570**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$705,570
Funding Requiredments for Non-recurring expenditures	$0
	$705,570

Prepared by: Margaret Harris | Date 3/16/09

Telephone Number: (909) 623-6131

TRI-CITY MENTAL HEALTH

CHILDREN FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 a

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that 183 Children's Full-Service Partnerships will be in place and served in fiscal 2011-2012.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $3,228,166 includes:

- ***Estimated flexible funds*** to be used to provide wraparound services to ensure that children's needs are met based on a "whatever it takes" commitment. These services could include clothing, food, transportation and housing stipends.
- ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately 34.4 full time equivalent staff.
- ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $2,522,596 include:

- ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP of $1,449,768 is for twelve months.
- ***State General Funds*** anticipated from provision of services to Medi-Cal eligible youth that qualify under EPSDT. The projected EPSDT of $1,072,828 is for twelve months.

C. Total Funding Requirements--$705.570

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2008/09

Work Plan # TC-01 b

Work Plan Name TAY Full-Service Partnerships

Months of Operation 0

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$0**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$0
Funding Requiredments for Non-recurring expenditures	$0
	$0

Prepared by: Margaret Harris | Date 3/16/09

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TRI-CITY MENTAL HEALTH

TAY FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 b

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
It is anticipated that all service provider contracts for the provision of TAY Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year. Therefore, there is no budget presented for fiscal 2008-09 or any funding requirements.

A.5 Expenditures When Service Provider is not Known
None

A.6 Non-Recurring Costs
None

B.1 New Revenues
None

C. Total Funding Requirements--None

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-01 b

Work Plan Name TAY Full-Service Partnerships

Months of Operation 7

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$245,850			$245,850
6. Non-recurring expenditures	$32,000			$32,000
7. Total Proposed Work Plan Expenditures	**$277,850**	**$0**	**$0**	**$277,850**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$61,532			$61,532
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$61,532	$0	$0	$61,532
C. Total Funding Requirements (Note a)	**$216,318**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$184,318
Funding Requiredments for Non-recurring expenditures	$32,000
	$216,318

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TRI-CITY MENTAL HEALTH

TAY FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 b

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that all service provider contracts for the provision of TAY Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year and that 27 clients will be served by the end of the year.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $245,850 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that transitional youth's needs are met based on a "whatever it takes" commitment. These services could include employment and education support, clothing, food, transportation and housing stipends or support.

· ***Estimated personnel expenditures*** expected to support the full-service partnerships. It is projected that approximately 4.5 full time equivalent staff will be required and that approximately 75% of the related salaries and benefits costs will commence at the beginning of December 2009, with the remaining staffing completed by early March, 2010.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

A.6 Non-Recurring Costs

It is anticipated that this program will require $32,000 in non-recurring funds for program set-up costs of the service provider. See Exhibit #2 Non-Recurring Program Work Plan.

B.1 New Revenues

New revenues of $61,532 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for six months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$216,318

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2010/11

Work Plan # TC-01 b

Work Plan Name TAY Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$478,078			$478,078
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$478,078**	**$0**	**$0**	**$478,078**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$143,030			$143,030
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$143,030	$0	$0	$143,030
C. Total Funding Requirements (Note a)	**$335,048**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$335,048
Funding Requiredments for Non-recurring expenditures	$0
	$335,048

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TRI-CITY MENTAL HEALTH

TAY FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 b

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $478,078 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that transitional youth's needs are met based on a "whatever it takes" commitment. These services could include employment and education support, clothing, food, transportation and housing stipends or support.

· ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately 4.5 full time equivalent staff.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $143,030 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for twelve months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$335,048

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-01 b

Work Plan Name TAY Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$492,422			$492,422
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$492,422**	**$0**	**$0**	**$492,422**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$147,249			$147,249
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$147,249	$0	$0	$147,249
C. Total Funding Requirements (Note a)	**$345,173**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$345,173
Funding Requiredments for Non-recurring expenditures	$0
	$345,173

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TRI-CITY MENTAL HEALTH

TAY FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 b

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $492,422 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that transitional youth's needs are met based on a "whatever it takes" commitment. These services could include employment and education support, clothing, food, transportation and housing stipends or support.

· ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately 4.5 full time equivalent staff.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $147,249 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for twelve months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$345,173

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2008/09

Work Plan # TC-01 c

Work Plan Name Adult Full-Service Partnerships

Months of Operation 0

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$0**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$0
Funding Requiredments for Non-recurring expenditures	$0
	$0

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TRI-CITY MENTAL HEALTH

ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 c

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
It is anticipated that all service provider contracts for the provision of Adult Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year. Therefore, there is no budget presented for fiscal 2008-09 or any funding requirements.

A.5 Expenditures When Service Provider is not Known
None

A.6 Non-Recurring Costs
None

B.1 New Revenues
None

C. Total Funding Requirements--None

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-01 c

Work Plan Name Adult Full-Service Partnerships

Months of Operation 7

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$591,166			$591,166
6. Non-recurring expenditures	$80,000			$80,000
7. Total Proposed Work Plan Expenditures	**$671,166**	**$0**	**$0**	**$671,166**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$138,971			$138,971
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$138,971	$0	$0	$138,971
C. Total Funding Requirements (Note a)	**$532,195**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$452,195
Funding Requiredments for Non-recurring expenditures	$80,000
	$532,195

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TRI-CITY MENTAL HEALTH

ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 c

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that all service provider contracts for the provision of Adult Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year and that 71 clients will be served by the end of the year.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $591,166 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that adult's needs are met based on a "whatever it takes" commitment. These services could include employment and education support, housing support, clothing, food and transportation.

· ***Estimated personnel expenditures*** expected to support the full-service partnerships. It is projected that approximately 10.3 full time equivalent staff will be required and that approximately 75% of the related salaries and benefits costs will commence at the beginning of December 2009, with the remaining staffing completed by early March, 2010.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

A.6 Non-Recurring Costs

It is anticipated that this program will require $80,000 in non-recurring funds for program set-up costs of the service provider. See Exhibit #2 Non-Recurring Program Work Plan.

B.1 New Revenues

New revenues of $138,971 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for six months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$532,195

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2010/11

Work Plan # TC-01 c

Work Plan Name Adult Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$1,160,767			$1,160,767
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$1,160,767**	**$0**	**$0**	**$1,160,767**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$322,846			$322,846
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$322,846	$0	$0	$322,846
C. Total Funding Requirements (Note a)	**$837,921**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$837,921
Funding Requiredments for Non-recurring expenditures	$0
	$837,921

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TRI-CITY MENTAL HEALTH

ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 c

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $1,160,767 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that adult's needs are met based on a "whatever it takes" commitment. These services could include employment and education support, housing support, clothing, food and transportation.

· ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately10.3 full time equivalent staff.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $322,846 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for twelve months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$837,921

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2011/12

Work Plan # TC-01 c

Work Plan Name Adult Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$1,195,590			$1,195,590
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$1,195,590**	**$0**	**$0**	**$1,195,590**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$332,375			$332,375
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$332,375	$0	$0	$332,375
C. Total Funding Requirements (Note a)	**$863,215**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$863,215
Funding Requiredments for Non-recurring expenditures	$0
	$863,215

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TRI-CITY MENTAL HEALTH

ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 c

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $1,195,590 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that adult's needs are met based on a "whatever it takes" commitment. These services could include employment and education support, housing support, clothing, food and transportation.

· ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately10.3 full time equivalent staff.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $332,375 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for twelve months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$863,215

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2008/09

Work Plan # TC-01 d

Work Plan Name Older Adult Full-Service Partnerships

Months of Operation 0

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$0**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$0
Funding Requiredments for Non-recurring expenditures	$0
	$0

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TRI-CITY MENTAL HEALTH

OLDER ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 d

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
It is anticipated that all service provider contracts for the provision of Older Adult Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year. Therefore, there is no budget presented for fiscal 2008-09 or any funding requirements.

A.5 Expenditures When Service Provider is not Known
None

A.6 Non-Recurring Costs
None

B.1 New Revenues
None

C. Total Funding Requirements--None

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-01 d

Work Plan Name Older Adult Full-Service Partnerships

Months of Operation 7

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$181,309			$181,309
6. Non-recurring expenditures	$22,000			$22,000
7. Total Proposed Work Plan Expenditures	**$203,309**	**$0**	**$0**	**$203,309**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$49,204			$49,204
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$49,204	$0	$0	$49,204
C. Total Funding Requirements (Note a)	**$154,105**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$132,105
Funding Requiredments for Non-recurring expenditures	$22,000
	$154,105

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TRI-CITY MENTAL HEALTH

OLDER ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 d

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that all service provider contracts for the provision of Older Adult Full-Service Partnerships will be awarded in the second quarter of fiscal 2009-2010 and that commencement of services will occur at the beginning of the third quarter of the fiscal year and that 23 clients will be served by the end of the year.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $181,309 includes:

- ***Estimated flexible funds*** to be used to provide wraparound services to ensure that older adult's needs are met based on a "whatever it takes" commitment. These services could include housing support, transportation, clothing, hygiene and other needed support .
- ***Estimated personnel expenditures*** expected to support the full-service partnerships. It is projected that approximately 3.25 full time equivalent staff will be required and that approximately 75% of the related salaries and benefits costs will commence at the beginning of December 2009, with the remaining staffing completed by early March, 2010.
- ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

A.6 Non-Recurring Costs

It is anticipated that this program will require $22,000 in non-recurring funds for program set-up costs of the service provider. See Exhibit #2 Non-Recurring Program Work Plan.

B.1 New Revenues

New revenues of $49,204 include:

- ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for six months.
- ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$154,105

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2010/11

Work Plan # TC-01 d

Work Plan Name Older Adult Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$349,238			$349,238
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$349,238**	**$0**	**$0**	**$349,238**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$114,483			$114,483
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$114,483	$0	$0	$114,483
C. Total Funding Requirements (Note a)	**$234,755**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$234,755
Funding Requiredments for Non-recurring expenditures	$0
	$234,755

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TRI-CITY MENTAL HEALTH

OLDER ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 d

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $349,248 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that older adult's needs are met based on a "whatever it takes" commitment. These services could include housing support, transportation, clothing, hygiene and other needed support .

· ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately 3.25 full time equivalent staff.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $114,483 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for twelve months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$234,755

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-01 d

Work Plan Name Older Adult Full-Service Partnerships

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$359,715			$359,715
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$359,715**	**$0**	**$0**	**$359,715**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)	$117,857			$117,857
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$117,857	$0	$0	$117,857
C. Total Funding Requirements (Note a)	**$241,858**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$241,858
Funding Requiredments for Non-recurring expenditures	$0
	$241,858

Prepared by: Margaret Harris | Date 3/16/09

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TRI-CITY MENTAL HEALTH

OLDER ADULT FULL-SERVICE PARTNERSHIPS

WORKPLAN # TC-01 d

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $359,715 includes:

· ***Estimated flexible funds*** to be used to provide wraparound services to ensure that older adult's needs are met based on a "whatever it takes" commitment. These services could include housing support, transportation, clothing, hygiene and other needed support .

· ***Estimated personnel expenditures*** expected to support the full-service partnerships includes salaries and benefits for approximately 3.25 full time equivalent staff.

· ***Estimated operating expenditures*** required to support the program. These costs could include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

B.1 New Revenues

New revenues of $117,857 include:

· ***Medi-Cal revenues*** anticipated from Federal Financial Participation for approximately 75% of expected clients that will be eligible under the Medi-Cal program. The projected FFP is for twelve months.

· ***State General Funds*** are not anticipated.

C. Total Funding Requirements--$241,858

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2008/09

Work Plan # TC-02

Work Plan Name Community Navigators

Months of Operation 1

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$17,875			$17,875
4. Operating Expenditures	$1,200			$1,200
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures	$30,000			$30,000
7. Total Proposed Work Plan Expenditures	**$49,075**	**$0**	**$0**	**$49,075**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$49,075**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$19,075
Funding Requiredments for Non-recurring expenditures	$30,000
	$49,075

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TRI-CITY MENTAL HEALTH

COMMUNITY NAVIGATORS

WORKPLAN # TC-02

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
Community Navigators will be recruited and hired and ready to provide services by June 1, 2009. These navigators will include four positions, one which is targeted to be filled by a consumer. The budget presented for fiscal 2008-09 represents one month of expenses and certain non-recurring costs. It is expected that during this month at least 20 clients will be served.

A.3 Personnel Expenditures--$17,875
It is projected that approximately 4 full time equivalent staff will be required to create a service navigation support team to provide connection between the community and available mental health services. These positions are targeted to be staffed on June 1, 2009, and therefore, the costs included in the budget reflect one months of salaries and benefits.

A.4 Operating Expenditures-- $1,200
These costs are required to support the staff and include office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--$30,000
This includes employee set-up costs for furniture and equipment, as well as system software costs for community connectivity and resources.

B.1 New Revenues
None

C. Total Funding Requirements--$49,075

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-02

Work Plan Name Community Navigators

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$214,500			$214,500
4. Operating Expenditures	$10,000			$10,000
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$224,500**	**$0**	**$0**	**$224,500**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$224,500**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$224,500
Funding Requiredments for Non-recurring expenditures	$0
	$224,500

Prepared by: Margaret Harris | Date 3/16/09

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TRI-CITY MENTAL HEALTH

COMMUNITY NAVIGATORS

WORKPLAN # TC-02

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General
Community Navigators will be recruited and hired and ready to provide services by June 1, 2009. These navigators will include four positions, one which is targeted to be filled by a consumer. The budget presented for fiscal 2009-10 represents twelve months of expenses. It is expected that during the year at least 950 clients will be served.

A.3 Personnel Expenditures--$214,500
It is projected that approximately 4 full time equivalent staff will be required to create a service navigation support team to provide connection between the community and available mental health services.

A.4 Operating Expenditures-- $10,000
These costs are required to support the staff and include office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--None

B.1 New Revenues
None

C. Total Funding Requirements--$224,500

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2010/11

Work Plan # TC-02

Work Plan Name Community Navigators

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$220,935			$220,935
4. Operating Expenditures	$10,300			$10,300
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$231,235**	**$0**	**$0**	**$231,235**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$231,235**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$231,235
Funding Requiredments for Non-recurring expenditures	$0
	$231,235

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TRI-CITY MENTAL HEALTH

COMMUNITY NAVIGATORS

WORKPLAN # TC-02

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

A.3 Personnel Expenditures--$220,935

Approximately 4 full time equivalent staff will be required to create a service navigation support team to provide connection between the community and available mental health services. It is expected that 1,200 clients will be served during the fiscal year.

A.4 Operating Expenditures-- $10,300

These costs are required to support the staff and include office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--None

B.1 New Revenues

None

C. Total Funding Requirements--$231,235

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-02

Work Plan Name Community Navigators

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$227,563			$227,563
4. Operating Expenditures	$10,609			$10,609
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$238,172**	**$0**	**$0**	**$238,172**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$238,172**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$238,172
Funding Requiredments for Non-recurring expenditures	$0
	$238,172

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TRI-CITY MENTAL HEALTH

COMMUNITY NAVIGATORS

WORKPLAN # TC-02

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

A.3 Personnel Expenditures--$227,563

Approximately 4 full time equivalent staff will be required to create a service navigation support team to provide connection between the community and available mental health services. It is expected that 1,200 clients will be served during the fiscal year.

A.4 Operating Expenditures-- $10,609

These costs are required to support the staff and include office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--None

B.1 New Revenues--None

C. Total Funding Requirements--$238,172

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2008/09

Work Plan # TC-03

Work Plan Name Wellness + Recovery Center

Months of Operation 0

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$0**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$0
Funding Requiredments for Non-recurring expenditures	$0
	$0

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TRI-CITY MENTAL HEALTH

WELLNESS AND RECOVERY CENTER

WORKPLAN # TC-03

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
The CSS plan is to either purchase or build a wellness and recovery center. It is estimated that this process will commence at the beginning of fiscal 2009-2010 and take between nine to fifteen months. Therefore, there is no budget presented for fiscal 2008-09 or any funding requirements.

A. Expenditures
None

A.6 Non-Recurring Costs
None

B.1 New Revenues
None

C. Total Funding Requirements--None

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-03

Work Plan Name Wellness + Recovery Center

Months of Operation 3

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$161,200			$161,200
4. Operating Expenditures	$20,038			$20,038
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures	$4,000,000			$4,000,000
7. Total Proposed Work Plan Expenditures	**$4,181,238**	**$0**	**$0**	**$4,181,238**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$4,181,238**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$181,238
Funding Requiredments for Non-recurring expenditures	$4,000,000
	$4,181,238

Prepared by: Margaret Harris | Date 3/16/09

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TRI-CITY MENTAL HEALTH

WELLNESS AND RECOVERY CENTER

WORKPLAN # TC-03

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General
The Wellness and Recovery Center is slotted to open either the first or second quarter of fiscal 2010-2011. However, it is anticipated that costs related to the purchase or building of the center will occur during fiscal 2009-2010. In addition, it is anticipated that staff will be hired during the last quarter of the fiscal year in order to work on outreach and programming for the center.

A.3 Personnel Expenditures--$161,200
It is projected that approximately 11.5 full time equivalent staff will be required to support the Wellness and Recovery Center. These positions are targeted to be staffed at the beginning of the last quarter of fiscal 2009-2010, and therefore, the costs included in the budget reflect three months of salaries and benefits.

A.4 Operating Expenditures-- $20,038
These costs are required to support the center and include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

A.6 Non-Recurring Costs--$4,000,000
It is anticipated that this program will require $4,000,000 in non-recurring funds for the purchase or construction of the facility, including required professional fees, as well as non-recurring set-up costs. See Exhibit #2 Non-Recurring Program Work Plan.

B.1 New Revenues--None

C. Total Funding Requirements--$4,181,238

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2010/11

Work Plan # TC-03

Work Plan Name Wellness + Recovery Center

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$652,093			$652,093
4. Operating Expenditures	$106,476			$106,476
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$758,569**	**$0**	**$0**	**$758,569**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$758,569**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$758,569
Funding Requiredments for Non-recurring expenditures	$0
	$758,569

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TRI-CITY MENTAL HEALTH

WELLNESS AND RECOVERY CENTER

WORKPLAN # TC-03

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

General
The Wellness and Recovery Center is slotted to open either the first or second quarter of fiscal 2010-2011. The budget for fiscal 2010-2011 projects that the facility will be open at the beginning of the year.

A.3 Personnel Expenditures--$652,093

It is projected that approximately 11.5 full time equivalent staff will be required to support the Wellness and Recovery Center. These positions are targeted to be staffed at the beginning of the last quarter of fiscal 2009-2010, and therefore, the costs included in the budget reflect twelve months of salaries and benefits.

A.4 Operating Expenditures-- $106,476

These costs are required to support the center and include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

A.6 Non-Recurring Costs--None

B.1 New Revenues--None

C. Total Funding Requirements--$758,569

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-03

Work Plan Name Wellness + Recovery Center

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$671,656			$671,656
4. Operating Expenditures	$109,670			$109,670
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures	$0			$0
7. Total Proposed Work Plan Expenditures	**$781,326**	**$0**	**$0**	**$781,326**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$781,326**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$781,326
Funding Requiredments for Non-recurring expenditures	$0
	$781,326

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TRI-CITY MENTAL HEALTH

WELLNESS AND RECOVERY CENTER

WORKPLAN # TC-03

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

A.3 Personnel Expenditures--$671,656

It is projected that approximately 11.5 full time equivalent staff will be required to support the Wellness and Recovery Center.

A.4 Operating Expenditures-- $109,670

These costs are required to support the center and include facility costs such as rent, utilities, equipment and related maintenance, as well as staff mileage, office supplies and employee training costs.

A.6 Non-Recurring Costs--None

B.1 New Revenues--None

C. Total Funding Requirements--$781,326

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2008/09

Work Plan # TC-04

Work Plan Name Supplemental Crisis Services

Months of Operation 0

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$0**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$0
Funding Requiredments for Non-recurring expenditures	$0
	$0

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TRI-CITY MENTAL HEALTH

SUPPLEMENTAL CRISIS SERVICES

WORKPLAN # TC-04

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
It is anticipated that service provider contracts for the provision of Supplemental Crises Services will be awarded by October 2009, the second quarter of fiscal 2009-2010, and that commencement of services will occur concurrently. Therefore, there is no budget presented for fiscal 2008-09 or any funding requirements.

A.5 Expenditures When Service Provider is not Known
None

A.6 Non-Recurring Costs
None

B.1 New Revenues
None

C. Total Funding Requirements--None

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-04

Work Plan Name Supplemental Crisis Services

Months of Operation 9

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$58,500			$58,500
6. Non-recurring expenditures	$2,000			$2,000
7. Total Proposed Work Plan Expenditures	**$60,500**	**$0**	**$0**	**$60,500**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$60,500**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$58,500
Funding Requiredments for Non-recurring expenditures	$2,000
	$60,500

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TRI-CITY MENTAL HEALTH

SUPPLEMENTAL CRISIS SERVICES

WORKPLAN # TC-04

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General

The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that service provider contracts for the provision of Supplemental Crises Services be awarded in October, 2009, the second quarter of fiscal 2009-2010, and that commencement of services will occur concurrently. It is estimated that 180 clients will be served by the end of the fiscal year 2009-2010.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $58,500 includes:

· ***Estimated personnel expenditures*** expected to support the supplemental crisis services program. It is projected that this program will require 1 full time equivalent staff that could be contracted out to several providers on a part-time basis in order to provide full-time coverage. It is expected that these positions will be filled by the beginning of October, 2009 and therefore, the estimated salaries and benefit costs reflect nine months of operations.

A.6 Non-Recurring Costs

It is anticipated that this program will require $2,000 in non-recurring funds for program set-up costs for communication equipment. See Exhibit #2 Non-Recurring Program Work Plan.

B.1 New Revenues--None

C. Total Funding Requirements--$60,500

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2010/11

Work Plan # TC-04

Work Plan Name Supplemental Crisis Services

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$80,340			$80,340
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$80,340**	**$0**	**$0**	**$80,340**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$80,340**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$80,340
Funding Requiredments for Non-recurring expenditures	$0
	$80,340

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TRI-CITY MENTAL HEALTH

SUPPLEMENTAL CRISIS SERVICES

WORKPLAN # TC-04

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that Supplemental Crises Services program will be operating at 100% capacity and it is estimated that 240 clients will be served during fiscal 2010-2011.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $80,340 includes:

- ***Estimated personnel expenditures*** expected to support the supplemental crisis services program. It is projected that this program will require 1 full time equivalent staff that could be contracted out to several providers on a part-time basis in order to provide full-time coverage.

A.6 Non-Recurring Costs--None

B.1 New Revenues--None

C. Total Funding Requirements--$80,340

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-04

Work Plan Name Supplemental Crisis Services

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$82,750			$82,750
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$82,750**	**$0**	**$0**	**$82,750**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$82,750**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$82,750
Funding Requiredments for Non-recurring expenditures	$0
	$82,750

Prepared by: Margaret Harris | Date 3/16/09

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TRI-CITY MENTAL HEALTH

SUPPLEMENTAL CRISIS SERVICES

WORKPLAN # TC-04

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $82,750 includes:

· ***Estimated personnel expenditures*** expected to support the supplemental crisis services program. It is projected that this program will require 1 full time equivalent staff that could be contracted out to several providers on a part-time basis in order to provide full-time coverage.

A.6 Non-Recurring Costs--None

B.1 New Revenues--None

C. Total Funding Requirements--$82,750

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2008/09

Work Plan # TC-05

Work Plan Name Field Capable Services for Older Adults

Months of Operation 0

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$0**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$0
Funding Requiredments for Non-recurring expenditures	$0
	$0

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TRI-CITY MENTAL HEALTH

FIELD CAPABLE SERVICES TO OLDER ADULTS

WORKPLAN # TC-05

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General
It is anticipated that service provider contracts for the provision of Field Capable Services to Older Adults will be awarded by October 2009, the second quarter of fiscal 2009-2010, and that commencement of services will occur concurrently. Therefore, there is no budget presented for fiscal 2008-09 or any funding requirements.

A.5 Expenditures When Service Provider is not Known
None

A.6 Non-Recurring Costs
None

B.1 New Revenues
None

C. Total Funding Requirements--None

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2009/10

Work Plan # TC-05

Work Plan Name Field Capable Services for Older Adults

Months of Operation 9

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$58,500			$58,500
6. Non-recurring expenditures	$2,000			$2,000
7. Total Proposed Work Plan Expenditures	**$60,500**	**$0**	**$0**	**$60,500**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$60,500**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$58,500
Funding Requiredments for Non-recurring expenditures	$2,000
	$60,500

Prepared by: Margaret Harris Date 3/16/09

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TRI-CITY MENTAL HEALTH

FIELD CAPABLE SERVICES TO OLDER ADULTS

WORKPLAN # TC-05

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that service provider contracts for the provision of Field Capable Services for OA will be awarded in October, 2009, the second quarter of fiscal 2009-2010, and that commencement of services will occur concurrently. It is estimated that 125 clients will be served by the end of the fiscal year 2009-2010.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $58,500 includes:

· Estimated personnel expenditures expected to support the field capable services to older adults program. It is projected that this program will require 1 full time equivalent staff that could be contracted out to one or two providers on a part-time basis in order to provide full-time coverage. It is expected that these positions will be filled by the beginning of October, 2009 and therefore, the estimated salaries and benefit costs reflect nine months of operations.

A.6 Non-Recurring Costs

It is anticipated that this program will require $2,000 in non-recurring funds for program set-up costs for communication equipment. See Exhibit #2 Non-Recurring Program Work Plan.

B.1 New Revenues--None

C. Total Funding Requirements--$60,500

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health Fiscal Year: 2010/11

Work Plan # TC-05

Work Plan Name Field Capable Services for Older Adults

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$80,340			$80,340
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$80,340**	**$0**	**$0**	**$80,340**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$80,340**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$80,340
Funding Requiredments for Non-recurring expenditures	$0
	$80,340

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TRI-CITY MENTAL HEALTH

FIELD CAPABLE SERVICES TO OLDER ADULTS

WORKPLAN # TC-05

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

General
The estimated expenditures below are anticipated costs of service providers who are not yet known. It is anticipated that the Field Capable Services for OA program will be operating at 100% capacity and it is estimated that 180 clients will be served during fiscal 2010-2011.

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $80,340 includes:

· Estimated personnel expenditures expected to support field capable services to older adults program. It is projected that this program will require 1 full time equivalent staff that could be contracted out to one or two providers on a part-time basis in order to provide full-time coverage.

A.6 Non-Recurring Costs--None

B.1 New Revenues--None

C. Total Funding Requirements--$80,340

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-05

Work Plan Name Field Capable Services for Older Adults

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Total Expenditures when service provider is not known	$82,750			$82,750
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$82,750**	**$0**	**$0**	**$82,750**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$82,750**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$82,750
Funding Requiredments for Non-recurring expenditures	$0
	$82,750

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TRI-CITY MENTAL HEALTH

FIELD CAPABLE SERVICES TO OLDER ADULTS

WORKPLAN # TC-05

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

A.5 Expenditures When Service Provider is not Known

The total estimated expenditure of $82,750 includes:

· Estimated personnel expenditures expected to support field capable services to older adults program. It is projected that this program will require 1 full time equivalent staff that could be contracted out to one or two providers on a part-time basis in order to provide full-time coverage.

A.6 Non-Recurring Costs--None

B.1 New Revenues--None

C. Total Funding Requirements--$82,750

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2008/09

Work Plan # TC-06

Work Plan Name Administration

Months of Operation 1.5

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$47,499			$47,499
4. Operating Expenditures	$4,170			$4,170
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures	$60,900			$60,900
7. Total Proposed Work Plan Expenditures	**$112,569**	**$0**	**$0**	**$112,569**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$112,569**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$51,669
Funding Requiredments for Non-recurring expenditures	$60,900
	$112,569

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TRI-CITY MENTAL HEALTH

ADMINISTRATION

WORKPLAN # TC-06

BUDGET NARRATIVE—FISCAL YEAR 2008-2009

General

While it may be unusual to treat Administration as a program, the investment being made in Administration has immense significance for the system of mental health services in the three cities. The following budget reflects the initial costs expected to be incurred in 2008-09 to develop an infrastructure to support the system of care and coordination of the various providers and their services.

A.3 Personnel Expenditures--$47,499

These costs include adding 3 full time staff that will be solely dedicated to the Mental Health Services Act and CSS plans. In addition, approximately one FTE of executive team time will also be required to oversee the administrative process and coordinate an efficient system of care. These costs represent approximately one to two months of operations in fiscal 2008-09.

A.4 Operating Expenditures-- $4,170

These costs are required to support the staff and include office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--$60,900

This includes employee set-up costs for furniture and equipment, system software costs for billing and data collection and costs for developing RFPs for Full-Service Partnerships.

B.1 New Revenues

None

C. Total Funding Requirements--$112,569

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2009/10

Work Plan # TC-06

Work Plan Name Administration

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$474,630			$474,630
4. Operating Expenditures	$83,540			$83,540
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures	$299,500			$299,500
7. Total Proposed Work Plan Expenditures	**$857,670**	**$0**	**$0**	**$857,670**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$857,670**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$558,170
Funding Requiredments for Non-recurring expenditures	$299,500
	$857,670

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TRI-CITY MENTAL HEALTH

ADMINISTRATION

WORKPLAN # TC-06

BUDGET NARRATIVE—FISCAL YEAR 2009-2010

General

The following administration costs reflect the estimated investment to be made in Administration over the fiscal year 2009-10. This has immense significance for the system of mental health services in the three cities as it will be required to institue the contracting and quality control processes with service providers in the community. The following budget reflects the infrasturcture development and operational costs expected to be incurred in 2009-10 to support the system of care and coordination of the various providers and their services. The estimated on-going administrative costs will be approximately 15% of the total CSS budget.

A.3 Personnel Expenditures--$474,630

These costs include the 3 full time staff added in fiscal 2008-09 plus an additional 2 full time staff in fiscal 2009-10. These individuals will be solely dedicated to the Community Service Plans and will be required for management, outreach, data collection for outcome reporting, billing and accounting, In addition, approximately one FTE of executive team time will also be allocated to oversee the administrative process and coordinate an efficient system of care.

A.4 Operating Expenditures-- $83,540

These costs are required to support the staff and include facility costs such as rent and utilities, office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--$299,500

In addition to employee set-up costs for furniture and equipment, as well as system software costs for billing and data collection, these costs include professional fees expected to be incurred for the awarding of and implementation of service provider contracts.

B.1 New Revenues

None

C. Total Funding Requirements--$857,670

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2010/11

Work Plan # TC-06

Work Plan Name Administration

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$488,869			$488,869
4. Operating Expenditures	$86,046			$86,046
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$574,915**	**$0**	**$0**	**$574,915**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$574,915**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$574,915
Funding Requiredments for Non-recurring expenditures	$0
	$574,915

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TRI-CITY MENTAL HEALTH

ADMINISTRATION

WORKPLAN # TC-06

BUDGET NARRATIVE—FISCAL YEAR 2010-2011

General
The following administration costs reflect the estimated on-going costs required to manage and oversee the community providers and their services. The estimated on-going administrative costs will be approximately 15% of the total CSS budget.

A.3 Personnel Expenditures--$488,689
These costs include the 5 full time staff solely dedicated to the Community Service Plans and will be required for management, outreach, data collection for outcome reporting, billing and accounting, In addition, approximately one FTE of executive team time will also be allocated to oversee the administrative process and coordinate an efficient system of care.

A.4 Operating Expenditures-- $86,046
These costs are required to support the staff and include facility costs such as rent and utilities, office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--None

B.1 New Revenues
None

C. Total Funding Requirements--$574,916

FY 2009/10 Mental Health Services Act
Community Services and Supports Projected Revenues and Expenditures for New Work Plans

County: Tri-City Mental Health | Fiscal Year: 2011/12

Work Plan # TC-06

Work Plan Name Administration

Months of Operation 12

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures	$503,535			$503,535
4. Operating Expenditures	$88,628			$88,628
5. Estimated Total Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Total Proposed Work Plan Expenditures	**$592,163**	**$0**	**$0**	**$592,163**
B. Revenues				
1. New Revenues				
a. Medi-Cal (FFP only)				$0
b. State General Funds				$0
c. Other Revenue				$0
2. Total Revenues	$0	$0	$0	$0
C. Total Funding Requirements (Note a)	**$592,163**	**$0**	**$0**	

Note a:

Funding Requiredments for on-going expenditures	$592,163
Funding Requiredments for Non-recurring expenditures	$0
	$592,163

Prepared by: Margaret Harris | Date 3/16/09

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TRI-CITY MENTAL HEALTH

ADMINISTRATION

WORKPLAN # TC-06

BUDGET NARRATIVE—FISCAL YEAR 2011-2012

General
The following administration costs reflect the estimated on-going costs required to manage and oversee the community providers and their services. The estimated on-going administrative costs will be approximately 15% of the total CSS budget.

A.3 Personnel Expenditures--$503,535
These costs include the 5 full time staff solely dedicated to the Community Service Plans and will be required for management, outreach, data collection for outcome reporting, billing and accounting, In addition, approximately one FTE of executive team time will also be allocated to oversee the administrative process and coordinate an efficient system of care.

A.4 Operating Expenditures-- $88,628
These costs are required to support the staff and include facility costs such as rent and utilities, office supplies staff mileage, and employee training costs.

A.6 Non-Recurring Costs--None

B.1 New Revenues
None

C. Total Funding Requirements--$592,163

TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

EXHIBIT 6

QUARTERLY PROGRESS REPORTS

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

Estimated/Actual Population Served

County:	Tri-City Mental Health System
Program Work Plan #'s:	TC-01; TC-02
Program Work Plan Name:	Full Service Partnerships (FSPs); Community Navigators (CNs)
Fiscal Year: *(please complete one per fiscal year)*	FY 2008-09

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
All age groups FSP total: 0	**Children and youth (0-15)** who have serious emotional disorders and their families (including Special Education pupils) who are unserved or underserved, including: • Children and their families who are uninsured, under-insured and/or youth who are not eligible for Medi-Cal because they are detained in the juvenile justice system; • Children and youth who are homeless, or at risk of homelessness; • Children and youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements; and/or • Children and youth who are at risk of out-of-home placement.							0		0	

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	Description of Initial Populations	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
	TAY (16-25) who are currently unserved or underserved who have severe emotional disorders, including youth: • With a co-occurring substance abuse disorder and/or health condition; • Who are homeless or at risk of being homeless; • Aging out of the mental health, child welfare and/or juvenile justice systems; • Involved in the criminal justice system; • At risk of involuntary hospitalization or institutionalization; and/or • Who have experienced a first episode of major mental illness.							0		0	
	Adults (26-59) with serious mental illness who are unserved or underserved, specifically including adults: • With a co-occurring substance abuse disorder and/or health condition; • Who are homeless or at risk of homelessness; • Involved in the criminal justice system (including CPS), or at risk of criminal justice involvement; • Who are frequent users of hospital and emergency room services; and/or • At risk of institutionalization.							0		0	

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	Older adults (60 years and older) with serious mental illness who are unserved or seriously underserved, and who have a reduction in personal or community functioning, specifically including older adults who are: • Homeless, or at risk of homelessness; and/or • At risk of institutionalization, nursing home care, hospitalization and emergency room services.							0		0	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total #'s to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
SD total: 20	TC-02: Community Navigators							20		20	

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

Estimated/Actual Population Served

County:	Tri-City Mental Health System
Program Work Plan #'s:	TC-01; TC-02; TC-04; TC-05
Program Work Plan Name:	FSPs; CNs; Supplemental Crisis Services (SCS); Field Capable Services for Older Adults (FCSOA)
Fiscal Year: *(please complete one per fiscal year)*	FY 2009-10

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
All age groups FSP total: 212 Total is an unduplicated count. The #'s for each quarter are *cumulative*.	**Children (0-15):** See description for FY 2008-09					91		91		91	
	TAY (16-25): See description for FY 2008-09					20		27		27	
	Adults (26-59): See description for FY 2008-09					53		71		71	
	Older adults (60+): See description for FY 2008-09					17		23		23	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total #'s to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
SD total: 1255 Total is unduplicated count. The #'s for each quarter are *additive*.	TC-02: CNs	200		250		250		250		950	
	TC-04: SCS	0		60		60		60		180	
	TC-05: FCSOA	0		35		45		45		125	

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

Estimated/Actual Population Served

County:	Tri-City Mental Health System
Program Work Plan #'s:	TC-01; TC-02; TC-03; TC-04; TC-05
Program Work Plan Name:	FSPs; CNs; Wellness and Recovery Center (WRC); SCS; FCSOA
Fiscal Year: *(please complete one per fiscal year)*	FY 2010-11

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
All age groups FSP total: 304 Total is unduplicated count. The #'s for each quarter are *cumulative*.	**Children (0-15):** See description for FY 2008-09	183		183		183		183		183	
	TAY (16-25): See description for FY 2008-09	27		27		27		27		27	
	Adults (26-59): See description for FY 2008-09	71		71		71		71		71	
	Older adults (60+): See description for FY 2008-09	23		23		23		23		23	

System Development		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Total #'s to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
SD total: 2035 Total is unduplicated count. The #'s for each quarter are *additive*.	TC-02: CNs	300		300		300		300		1200	
	TC-03: WRC	75		90		125		125		415	
	TC-04: SCS	60		60		60		60		240	
	TC-05: FCSOA	45		45		45		45		180	

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

Estimated/Actual Population Served

County:	Tri-City Mental Health System
Program Work Plan #'s:	TC-01; TC-02; TC-03; TC-04; TC-05
Program Work Plan Name:	FSPs; CNs; WRC; SCS; FCSOA
Fiscal Year: *(please complete one per fiscal year)*	FY 2011-12

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
All age groups FSP total: 304 Total is unduplicated count. The #'s for each quarter are *cumulative*.	**Children (0-15):** See description for FY 2008-09	183		183		183		183		183	
	TAY (16-25): See description for FY 2008-09	27		27		27		27		27	
	Adults (26-59): See description for FY 2008-09	71		71		71		71		71	
	Older adults (60+): See description for FY 2008-09	23		23		23		23		23	
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total #'s to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
SD total: 2120 Total is unduplicated count. The #'s for each quarter are *additive*.	TC-02: CNs	300		300		300		300		1200	
	TC-03: WRC	125		125		125		125		500	
	TC-04: SCS	60		60		60		60		240	
	TC-05: FCSOA	45		45		45		45		180	

TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

PART IV
ADDITIONAL DOCUMENTS

Health services group to meet

Staff report

CLAREMONT — The first meeting of delegates in the Mental Health Services Act planning process for the Tri-City Mental Health system has been scheduled for Monday.

The nearly 50 delegates — who represent the various Tri-City stakeholders in the cities of Pomona, Claremont and La Verne — were approved by the Tri-City board of directors to develop a draft plan to improve services for the most severely mentally ill residents of the three cities.

Once the delegates develop this draft "Community Supports and Services" plan, the Tri-City Mental Health Commission will sponsor a public hearing on the plan before the Tri-City board reviews and submits the plan to the state Department of Mental Health.

Monday's public meeting will begin at 5:30 p.m., in the Oak Room at the Joslyn Senior Center, 660 N. Mountain Ave.

Stakeholders participating as delegates in the process range from people who have received or are receiving services to Tri-City staff, representatives of law enforcement, health services and schools, representatives of the Tri-City Governing Board and others.

"This entire process really involves the community in a comprehensive assessment of needs, and helps us determine as an agency what the residents of our service area expect from us," said Jess Duff, Tri-City's chief executive officer.

Tri-City is eligible for a range of state funds under the Mental Health Services Act, approved by the voters in 2004 as Proposition 63. Under the provisions of the measure, 1 percent of state income tax for taxpayers earning more than $1 million is designated for mental health services.

To receive these funds, estimated at more than $2 million a year, Tri-City must submit and have approved five different plans. The Community Supports and Services plan is the first of these five plans.

The December meeting will serve as an organizational meeting to prepare the delegates for the intensive planning process to come, Duff said. Preparation for this first planning process has been under way since July.

Information: www.tricitymhs.org or (909) 623-6131.

Gradients of Agreement

Endorse	**Endorse** with minor point of contention	**Agree** with reservations	**Abstain**	**Stand aside**	**Disagree** but will support the majority	**Disagree** and want out from implemen-tation	**Can't go forward**
I like it	*Basically I like it*	*I can live with it*	*I have no opinion*	*I don't like this, but I won't hold up the group*	*I want my disagreement recorded, but I'll support the decision.*	*I won't stop anyone else, but I don't want to make this happen.*	*We have to continue the conversation.*

TRI-CITY MENTAL HEALTH CENTER
APRIL 16, 2009 PUBLIC HEARING ON THE COMMUNITY SERVICES AND SUPPORTS PLAN

TABLE DISCUSSIONS AND LARGE GROUP COMMENTS SUMMARY

1. **How many people at our table:**
   36 Are hearing about the MHSA and the Community Services and Supports plan for the first time
   32 Have gone to a few meetings about the CSS plan
   41 Have been substantially involved in the planning process for the CSS plan

2. **What we like most about this plan includes:**
   - How many people have participated in the process to develop the plan
   - The focus on people who are most in need
   - The commitment to recovery
   - The commitment to outcomes
   - The commitment to address disparities in access to services
   - The commitment to deliver services in culturally appropriate ways
   - The community navigators
   - The full service partnerships
   - The wellness and recovery center
   - The supplemental crisis services
   - The field-capable services for older adults
   - Increased hope
   - Develops relationships
   - No time limit. Can have help for as long as possible.
   - Actively seeking support from the community.
   - Outreach to people in need

3. **The parts of the plan that we have more questions about include:**
   - The focus on people who are most in need
   - The commitment to recovery
   - The commitment to outcomes
   - The commitment to address disparities in access to services
   - The commitment to deliver services in culturally appropriate ways
   - The full service partnerships
   - The wellness and recovery center
   - The field-capable services for older adults

4. **Other comments we want to share (both written and shared in large group dialogue)**
   - Need to take whole person approach (body, mind, and spirit)
   - Need to involve clergy, primary, secondary, and higher education leaders.
   - 24/7 clinical person will be good
   - My daughter is bi-polar and a wellness center would help her.

- We like the flexibility and the attitude of "whatever it takes" in Full Service Partnerships
- My aunt is ill. After hearing about the plan, I want her to move here to get help.
- Services for TAY will help. They often fall through the cracks.
- I have a concern about the growing problem of transiency and poverty.
- The Pomona Courts are the biggest provider of mental health services and there is no follow through or follow-up.
- Mental health providers should organize themselves to provide care for both people who qualify for Medi-Cal and those who can only use private services.
- Need to make sure we stick to providing services for all of the age groups.
- This hearing and whole process has had a rare level of participation. Complaints more common.
- John's explanation is thorough and meaningful to first-time listeners and well as to pros.
- Less repeat cycles of institutionalization (5150s) would be a good thing.
- Wellness Center will hopefully help people stick to medication courses and plans.
- No broad strokes. The individual is important.
- More fulfilling to the health care professionals.
- Single room occupancy helps recovery. Should be at the top of the list.
- You can't have a life without housing. Really need to address this need to get services. Need to get SSI for 2 years so can get Medicare for drugs.
- Village model is good.
- Good that older people will have services brought to them.
- I like the commitment to culturally appropriate services. Need to be delivered in partnership with community leaders.
- Really need a strong transportation system.
- Need a seamless system of services.
- Concern that La Verne and Claremont get their fair share of services.
- Need to work with TAY before things get out of hand.
- Really like Full Service Partnerships for TAY
- The special focus on TAY in the Wellness and Recovery Center is really good.
- Community navigators are great!
- Community navigators need to be aware of language barriers and need to be culturally knowledgeable
- Staff need to reach out to all in the community
- This is seed money. Need to get communities, managed health care, school districts, faith communities, and other to strengthen it further.
- Community navigators may need to be supplemented to reach out to all in the community.
- Really like focus on helping young people who are severely mentally ill. The Center where young people can come and "hang out" is a really good idea.
- A huge undertaking. Good luck!
- Need to educate the community about services. What about using the schools?
- Housing is important. Please make sure some money is used for housing.
- Should reach out to people who need services and let people who have recovered help people in need.

- Need educational outreach to people in diverse cultures.
- Need more programs for young children and young adults, including social activities and support.
- Allow universal acceptance of insurance.
- To help people realize they need help, need to get someone they can trust within their community to reach out to them
- How to recognize the symptoms? Where to start? What is the difference between slow and mentally ill? Can drug abuse cause mental illness?
- Open up process to medical field. Engage them up front.
- Not enough money.
- Want to make sure the plan addresses issues of sustainability.
- Who will really qualify for services?
- How do we decrease response times for 5150s?
- The focus on crisis services
- Want to make sure people on Full Service Partnerships can transition to less intensive services over time
- Excellent plan

TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

A Proposal to the California Department of Mental Health
in Accordance with the Mental Health Services Act

ADDENDUM

April 2009

TRI-CITY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

ADDENDUM

INTRODUCTION

On April 16. 2009, the Governing Board of Tri-City Mental Health Center acted to formally recommend the Community Services and Supports Plan (CSS Plan) to the California Department of Mental Health (CA DMH) for approval. This action by the Governing Board followed an extensive community outreach and engagement process, a comprehensive stakeholder process, a thirty-day public comment period, and a public hearing following the public comment period.

Subsequent to the Board's action to formally recommend the CSS Plan for CA DMH approval, Tri-City Mental Health Center (Tri-City MHC) staff and consultants received informal feedback from CA DMH staff requesting clarifying information to several aspects of the CSS plan. This addendum seeks to address the questions raised by CA DMH staff in this informal feedback session.

QUESTION: REPRESENTATIVENESS OF PLANNING PROCESS

CA DMH staff asked Tri-City MHC to provide additional details about the representativeness of the planning process and the outreach and engagement efforts that supported it. Pages 5-12 and pages 15-17 of the plan provide an initial response to this question. In addition to the information contained in those pages, we offer the following information:

1. The delegates who participated in the planning process were a diverse group. As noted on page 11 of the plan:
   - At least 17% had received mental health services, and at least 21% were family members;
   - 19% were African American, 6% were Asian and/or Pacific Islander, 21% were Latino, 1 delegate was Native American, and 46% were White;
   - 6 delegates were fluent in Spanish, 2 in Tagalog, and 1 in Chinese Mandarin and Taiwanese;
   - 35% were men and 65% were women;
   - 52% lived in Pomona, 23% in Claremont, 19% in La Verne, and 6% lived outside the three cities; and
   - 4 were children's advocates, 4 were TAY advocates, and 3 were older adult advocates.

2. As diverse as this group was, we understand that the delegates did not precisely match the demographic characteristics of the three cities. On page 25 of the plan, we document the following demographic characteristics of the three cities:

TOTAL POPULATION BY ETHNICITY					
City: / Ethnicity:	La Verne	Claremont	Pomona	Tri-City area	% by ethnicity
African American	1,155	1,774	11,735	14,664	6.39%
Asian Pacific Islander	2,474	4,479	10,634	17,587	7.66%
Latino	8,790	6,338	110,330	125,458	54.67%
Native American	156	94	634	884	0.39%
White	22,243	22,886	21,822	66,951	29.18%
Other	46	93	149	288	0.13%
Two or more races	750	897	1,994	3,641	1.58%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley					

3. The ethnic population most under-represented on the delegates' roster was the Latino population (54.67% of general population, 21% of delegates).

4. Aware of this under-representation, we made extraordinary efforts to focus on the Latino population in our outreach and engagement efforts, as well as other traditionally unserved and underserved groups. As noted on pages 5-8 and 15-17 of the plan, between November 2008 and March 2009, we made presentations to well over 1,100 persons. Between March 16, 2009 (the date we first posted the draft CSS plan), and April 16, 2009 (the date of our public hearing), we made presentations to and engaged in conversations with more than 1,200 people. Of these over 2,300 people, over one thousand were Latino (1,034).

5. We made special efforts to engage members of the Costanoan/Ohlone tribe in meaningful ways. In addition to the involvement from a senior leader of this tribe as a delegate, 6-7 tribal members regularly attended the delegates meetings as observers and participated in many of the discussions about community needs. An anecdotal testament to the high level of trust that resulted from our engagement was an invitation that was extended to all delegates to attend a local Pow Wow being sponsored by the Costanoan/Ohlone tribe. Finally, we held extended conversations with two groups of tribal members (totaling 24 people) during the outreach and engagement process.

6. We also made special efforts to engage members of the Lesbian, Gay, Bi-sexual, Transgender, and Queer (GLBTQ) communities. At least one delegate was a member of this community. Unfortunately, there are no established advocacy groups for the GLBTQ population within the three cities. We therefore began our outreach efforts by focusing on the GLBTQ groups affiliated with the area universities. For example, we engaged members of the Cal Poly Gay and Lesbian center in an extended conversation about the needs of this community, and the scope of the CSS plan.

7. In addition to unserved and underserved ethnic and other demographic groups, we also worked hard to engage law enforcement and juvenile justice representatives. We had active participation from the three city police departments, as well as from the Los Angeles County Probation Department. The delegate from the Probation Department works closely with the juvenile halls and camps that are in Service Area 3 (the Service Area that includes Claremont, La Verne, and Pomona). She has also helped facilitate our access to multiple County Departments for data requests and other support.

8. We reached out to other County Departments as well, including the Department of Child and Family Services (DCFS) and Department of Social Services (DPSS). Representatives from these departments worked to assist us in our data collection and issue identification efforts, though, as noted in the plan, the data sets these and other departments have are focused on the county or service area level, and not specifically targeted for the three cities. We will continue working to strengthen these relationships in the coming months as we begin implementation of the CSS plan and our next MHSA planning efforts.

QUESTION: IDENTIFICATION OF PRIORITY ISSUES; ETHNIC DIFFERENCES AMONG THESE PRIORITY ISSUES

CA DMH staff asked Tri-City MHC to provide additional details about how priority issues were identified, and about any differences in impact of these issues on ethnic or other unserved or underserved groups.

Pages 18-21 of the plan discuss the following priority issues:

- A significant decline in intensive services, leading to the threat of increased homelessness, frequent hospitalizations, frequent emergency care, and increased involuntary care, institutionalization, and incarceration.
- A lack of community resources to promote independence, wellness, recovery, and resiliency, and increased employment and education;
- A lack of support for TAY struggling with mental health issues, leading to increased isolation, risk of homelessness, and risk of institutionalization;
- A lack of field capable services for older adults, leading to increased isolation, diminished capacity, and risk of institutionalization; and
- A lack of appropriate housing options for people with mental health issues in various stages of recovery.

Delegates prioritized these issues in a series of conversations in January, reflecting on data gathered by Tri-City MHC staff, experiences of the delegates themselves, and feedback they received from their constituencies. While we did not ask delegates to conduct formal focus groups on these issues, the consistently positive feedback we received from our outreach and engagement presentations to the plan and the way it addressed the priority issues provided indirect evidence of the accuracy of the delegates' analysis and the support from the community. A small example: during the public hearing, 10 members of the Vietnamese community came with printed placards

expressing support for the Tri-City and the CSS plan, and enthusiastically participated in the small group and large group exchanges.

Pages 22-24 of the plan summarize our analysis of the specific racial ethnic and gender disparities within the selected community issues for each age group. The bottom line: we do not have data to document any significant racial or ethnic disparities among these issues. The anecdotal data that we do have—from delegates, from the outreach and engagement sessions, and from the public hearing—also do not indicate any significant racial or ethnic disparities among these issues. Put differently, we believe the issues we have identified significantly impact people across all racial and ethnic communities within the three cities.

As we continue to strengthen the system of care across the three cities, we fully expect to refine our analysis of issues and needs. The positive feedback we have received, especially from unserved and underserved populations, suggests that we are on the right track.

QUESTION: RECRUITMENT OF PEOPLE FOR FULL SERVICE PARTNERSHIPS

CA DMH staff asked Tri-City MHC to provide additional details about how people will be recruited for Full Services Partnerships. Exhibit 3 on page 77 of the plan documents the ethnic and monolingual targets we have established for Full Service Partnerships.

Consistent with these targets, we will pursue aggressive outreach and engagement efforts to identify potential candidates for our Full Service Partnerships. For example, this will be one of the first areas of focus for the Community Navigators. In addition, in the next several weeks we will begin contacting providers in Service Area 3 who have contracts with LA DMH to provide Full Service Partnerships under LA County's CSS plan. Based on our outreach efforts, we believe these providers will likely have substantial waiting lists for Full Service Partnerships, and that at least some of the people on these waiting lists may reside in the tri-city area. If this hypothesis proves true, we may be able to significantly decrease the time needed to recruit FSP participants.

QUESTION: LINKAGES TO HOUSING, EMPLOYMENT, AND OTHER SERVICES AND SUPPORTS FOR ALL CSS PLAN COMPONENTS

CA DMH staff asked Tri-City MHC to provide additional details about how the Full Service Partnerships will include housing and employment support services, and to discuss linkages to these and other services through all components of the plan.

Tri-City Mental Health Center's directly operated clinic provided services under the AB 2034 Program for approximately seven years. In that time, the clinic established an extensive network of resources and daily living support services in the three cities. Although AB 2034 funding was discontinued, Tri-City clinic staff members continue to access this network of resources to benefit clients, as do other providers in the area.

We expect this network of resources to provide a strong foundation of support for the Full Service Partnerships and other components of the CSS plan.

This network of resources includes housing and rental assistance, employment and educational support services, substance abuse treatment services, benefits establishment services, transportation services, health and dental care services, food services, and clothing and furniture support.

- *Housing and rental assistance programs* include private and public partnerships. Tri-City clinic staff members regularly work with the Pomona and Los Angeles County Housing Authorities Shelter Plus Care and Beyond Shelter programs. They also frequently link clients to both private and non-profit housing programs, including programs run by Catholic Charities, The House of Ruth, Wings Domestic Violence Shelter, Services Center for Independent Living, Our House, Mark Warren Realty, the Sober Living Network, local board-and-care homes, the Sunset Motel, American Inn and Suites, the Travel Lodge, Serenity Villa, Park Plaza Apartments, and Emerson Village.

  While most of our housing partners provide living options for clients of all ages, genders, and family situations, some of the programs limit their support to particular groups: Services Center for Independent Living—single males only; Serenity Villa—older adults only, of either gender; Park Plaza Apartments---older adults only, of either gender; Sober Living Homes Network—singles and couples only, either gender; board-and-care homes—individuals only, either gender; House of Ruth and Wings: women and children only.

- Similar to the housing and rental assistance programs, *employment and education resources* in the three cities include public, non-profit and private agencies. These services are designed for TAY, adults and older adults. Agencies include: the Worksource Center; Pomona Unified School District's Adult Education Program, Regional Occupation Program, and Skills Centers, the California State Department of Rehabilitation local office, the local Employment Development Department, the Los Angeles County Fair, Wal-Mart, Tender Care Staffing, Paradise Building Services, Diverse Staffing Solutions, Olympic Staffing Solutions, Dedicated Staffing Services, Kelly Staffing Services, and Thomas Staffing Agencies. In addition, TCMH employs an Employment Outreach Coordinator who assists clients in the area of job preparation skills as well as employment and educational linkage.

- Co-occurring disorders, particular substance abuse disorders, will of course be a major focus of Full Service Partnerships, and *substance abuse services* will be integrated into every aspect of the plan. Current partners in the tri-city area who provide substance abuse services include: the American Recovery Center (inpatient and outpatient treatment); the River Community; Prototypes; and the Acton Recovery Center (inpatient treatment).

- Both the local DPSS office in Pomona and the Veteran's Administration work in close collaboration with clinic staff members and staff members from other providers to insure that mental health clients apply for and receive whatever *benefits* for which they qualify.

- The tri-city area has extensive *transportation services* to help clients access resources to support their recovery. Pomona Valley Transit manages the Get-About program, providing door-to-door transportation for disabled clients at nominal cost. Similarly, Los Angeles County Access Services provides transportation to and from scheduled appointments for physically and mentally disabled residents. International Institute Los Angeles provides Tri-City MHC with monthly bus tokens to distribute to the most needy clients. Local taxi companies also provide monthly taxi vouchers to assist Tri-City MHC clients. We expect all of these resources will support Full Service Partnership clients, participants in the Wellness Center, and other recipients of services under the CSS plan.

- Low- or no-cost *health and dental care* is a much needed but scarce resource. Tri-City clinic staff have worked with the following partners to support clients with these needs: Lenscrafters for optical care; the Buddhist Clinic, and private practitioner Dr. Alejandro Pena, DDS for no- or low-cost dental care; and the Pomona Health Center and the Buddhist Clinic for no- or low-cost medical care.

- There are a number of food banks and low cost food resources in the three cities. Those that are most consistently stocked and available for clients, however, are the Beta Center Food Bank, the Salvation Army, St. John's Church in Pomona, and the Seventh-Day Adventist Church in Pomona.

- St. Vincent de Paul, the Salvation Army, Goodwill Industries and Quality Thrift, all located within the tri-city area, provide no- or low-cost support to clients who need *clothing and/or housing supplies* (furniture and appliances).

Again, we expect that the Community Navigators, staff of the Wellness Center, FSP subcontractors, and others providing services under the CSS plan will access these and other resources to benefit the people they serve. There are also several local collaboratives—e.g., the Pomona Continuum of Care Coalition and the Claremont Mental Health Consortium—that support an on-going exploration of opportunities to leverage and expand community resources for people with mental health issues. Members of these collaboratives have actively participated in the CSS planning process and will actively support the implementation of the plan.

QUESTION: INSURING THE CULTURAL COMPETENCY AND GENDER APPROPRIATENESS OF SERVICES

CA DMH staff asked Tri-City MHC to provide additional details about how we will insure the cultural competency and gender appropriateness of the services. We will pursue four different strategies to this end: hiring, training, feedback, and research.

- *Hiring:* Pages 35-36 of the plan compare the ethnicities of, and languages spoken by, Tri-City MHC staff to those of the general population and the poverty population in the three cities. Tri-City MHC has made an active and on-going effort to insure that its staff reflects the demographics of the three cities, and this commitment will expand through the implementation of the CSS plan. In particular, Tri-City MHC will seek to hire new staff, and to insure that its subcontractors have or hire staff, to reflect the demographics of the three cities. More important than the simple demographics of staff, however, is the ability of staff members to understand and build trusting relationships with unserved and underserved populations, including men and women of these populations and the GLBTQ population. This will be a major focus of the recruitment and hiring process for the CSS plan.

- *Training*: We will regularly provide training for staff of Tri-City clinic, and staff members of Tri-City MHC subcontractors, to help them understand some of the subtle dynamics and nuances of the various cultures among the populations in the tri-city area. This will also be a major focus of our Workforce Education and Training plan.

- *Feedback*: A major focus of the work of the Community Navigators and staff of the Wellness and Recovery Center will be to build relationships with community leaders of unserved and underserved populations. We will regularly solicit feedback from these leaders, as well as from people who receive services through the CSS plan and their families, about the cultural and gender appropriateness and effectiveness of the various CSS plan components.

- *Research:* We will work with local university faculty, community leaders, and others to conduct formal and action research related to effective engagement of different ethnic and racial groups and effective services for men, women, and GLBTQ populations within those different groups.

QUESTION: TRAINING PROVIDED TO STAFF AND PARTNERS

We will regularly provide training for the staff and subcontractors who provide services under the CSS plan. This training will focus on the principles and practices of recovery, resiliency, and wellness, community-based research and evidence-based practices related to culturally appropriate services, training related to the successful integration of people who receive services into the workplace, and other issues relevant to the implementation of the CSS plan.

A few examples of *potential* training we will provide include:

- Training by Mark Ragins on the "four-stages of recovery" model, and how to integrate medications collaboration, substance abuse treatment, and employment strategies into this model;
- Training by Michele Lewis on effective job retention services;
- Training by Bruce Anderson on Rituals of Resiliency: How Organizations Create and Sustain Positive, Hopeful Work Cultures;
- Training on evidence-based and culturally appropriate treatments of trauma; and
- Myriad other modules.

QUESTION: WHY FOUR FISCAL YEARS

Given that we are proposing services for only one month in FY 2008-09, we projected services out an additional three full fiscal years, through FY 2011-12. We of course cannot know what our CSS allocation will be for FY 2010-11 or for FY 2011-12. We only have an approved allocation figure for FY 2009-10. Understanding the economic realities confronting the State, we have built our budget using our lower FY 2008-09 allocation figure rather than the higher FY 2009-10 figure, and have projected the remaining FY 2009-10 allocation as non-recurring funds. We will submit a separate plan for these funds later in the summer of this year.

QUESTION: PERCENTAGE OF THE PLAN DEDICATED TO ADMINISTRATION

Once our plan is fully implemented in FY 2010-11, Administration will be 15% of the total CSS budget. In FY 2008-09 and FY 2009-10, however, Administration is a higher percentage of the budget because the start-up time for the other components of the plan will be longer than the start-up time for Administration.