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hhsa/mh_board.htm**

Mendocino County Behavioral Health Advisory Board Annual Report 2015-2016



May 9, 2016

Letter from the Chair

TO: Mendocino County Board of Supervisors
Ms. Jenine Miller, MH Director

First of all, I want to thank John Wetzler for leading the BHAB through a difficult and tumultuous time. We have emerged a stronger, more effective, advisory board with an active, compassionate full complement of members. Also, while serving as Treasurer then Vice Chair, John has tutored and mentored me so now I am only moderately panicked about taking on the responsibilities of the Chair.

Taking my cue from the County/ASO transition team, I see this time as a period of transition and stabilization; making every effort to ensure no client falls through the cracks. To be an effective advisory body, our job will be to understand the contractual obligations of the ASO and the County. Going forward we will review the status and effectiveness of service delivery and compliance with the MHSA Plan and annual updates. We will continue to advocate for quality services and address unmet needs in the Mental Health system. I am pleased to undertake this task and support the developing spirit of mutual trust, cooperation, collaboration and transparency, all to the benefit of mental health consumers, their families and friends. My hope is to build on the vibrant, dedicated BHAB that developed under the leadership of John Wetzler. By being informed, compassionate and dedicated to our state mandates and mission statement I am sure we will meet our goals and responsibilities. Many thanks to the Board of Supervisors, the Behavioral Health and Recovery Services, John Wetzler and the members of the Behavioral Health Advisory Board.

Nancy Sutherland

Chair
Behavioral Health Advisory Board

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Annual Report and Editorial from the Chair Fiscal Year 2015-2016

What a long strange trip it has been for the Mendocino County Behavioral Health Advisory Board. We opened the year with high hopes for a quick, collaborative effort among Ortner Management Group, Redwood Quality Management Corporation and the County of Mendocino Mental Health Department to implement the long delayed Laura's Law or AB 1421 program. With bad news from the State regarding seven year old audit exceptions and the preoccupations with our Administrative Service Providers disputing over administrative costs, utilization reviews, contracts, money and contract amendments, our hopes for AB 1421 were soon dashed. What did this portend? Contracts were not signed until deep into the first quarter. A new Request for Proposal and a rebid of contracts were proffered. What was happening? We as a Board were left in the dark as to county activities, and the focus of our mental health system of care seemed to be out of focus.

The midsummer progressed under the cloud of delayed contract amendments and a general feeling of dis-ease. The Mendocino County Chief Executive Officer Carmel Angelo began receiving complaints from the Public, community and the mental health stakeholders. These issues were immediately taken up with the leadership of the Health and Human Services Agency. CEO Angelo determined that HHSA's responses were plausible and satisfactory. As the summer moved further along, new complaints rose to the level of money missing and improprieties around contracts. More follow-up with HHSA did not provide satisfactory answers. The CEO came to the conclusion that she needed to dig deeper; and an outside entity who had no stake in our system was asked to weigh in. Kemper Consulting Group was called in by CEO Angelo, and an exhaustive study of our mental health services delivery system began. Some important changes occurred almost immediately, and a new course and goals were soon to be delivered. A "Patient is Always First" direction would be the new county goal driving the coming transition to implement the Kemper Report's recommendations.

What soon followed was the removal of Tom Pinizzotto as the Mental Health Director for our county. HHSA Director Stacey Cryer was appointed as Interim Mental Health Director. This occurred without the input of the Mental Health Board. This was a clear violation of the Welfare and Institutions Code 5604.2(d). An immediate search for a permanent Mental Health Director was initiated. As I delve back into my three years as an executive of the Mental Health Board, it is with the expressed intention that history is not lost, but instead informs us as to direction and planning as we all work for the Public good. The Public pays attention. What went wrong? The Kemper Report intimates that there was a lack of communication between the ASOs and county entities: HHSA, the CEO's Office, the Board of Supervisors (BOS) and Human Resources. What really went wrong was a disinterest within the majority of the Public and county government that allowed our mental health system to disintegrate following the recession of 2008, and not to revitalize it as the economy began improving. Mental Health treatment is hard and expensive, and when it is ignored, it becomes really hard and really expensive and even fatal. The Aaron Bassler case is a poignant reminder of this failure. There are no easy answers to the provision of

mental health services. Providing them has to be robustly funded and populated.

When Tom Pinizzotto came on the scene, after working for Ortnier Management Group (OMG), our system of care was at its nadir. 'Let's try privatization; that might work.' An easy solution: 'Just write a Request for Proposals (RFPs) and pick the best bidder.' So far, so good. 'Now I [Tom Pinizzotto] will be on the RFP selection committee.' Big mistake when OMG was then selected as the administrative service organization to provide adult mental health services to the county. Couldn't the Human Resources Department or the CEO's Office have recognized the obvious conflict of interest? The Grand Jury noticed, and so did the Public. The well was poisoned, and stayed poisoned until the removal of Tom Pinizzotto and the advent of the Kemper Report.

Due to the aforementioned, OMG was mistrusted from the beginning of their tenure here. Labeled as outsiders, their very presence here was in question. Did they do their job? Yes they did. Did mental health services improve? Yes they did. Was there a pent up demand for Adult Mental Health Services? Yes there was. Were mistakes made? Yes there were. The lack of crisis care after hours and on weekends proved problematic for hospital ER's and law enforcement, for example. Did OMG do such an inadequate job that they were asked to rebid their contract against other providers also from out of the area? Well, Lee Kemper did not recommend that, but three Mendocino County Supervisors did. Ortnier arrived with a defensive posture that permeated their relations with the Public and the county; and left after 2 1/2 years unable to satisfy the Public and three County Supervisors.

We are now left in crisis mode. OMG will be gone by July 1st. We must assemble an Adult Mental Health Services Program from whole cloth. There is no doubt in my mind that the team from Redwood Quality Management Corporation (RQMC) will be able to handle this heavy load. At least they won't be entering under a cloud of mistrust. They are local, connected, tested, confident and willing, all the right tools to be successful.

The county also has some heavy lifting to do. If these new services are to be successful, then funding and support to create a smooth transition must be forthcoming and collaborative. So far this has been my observation, and I also applaud the new era of transparency and inclusiveness with an in-house system of mental health care for our adult population.

The Mental Health Program must work to end the perception that outreach, post-hospitalization therapy, post-incarceration therapy and senior peer counseling are non-existent. The Program also needs to correct the perception that treatment is only through a 911 call and the following 5150 toward hospitalization. We must assure our Public that a system of care to bring treatment to our clients commences before a crisis. The county needs the vision to generate new funding streams to increase mental health revenues, whether it be grants, taxes or public initiatives. All agree that mental health programs throughout our country are the most poorly funded and the first to be cut during times of stress. It's time to turn that train around. The best place for money to be invested is into our professional work force. Our county has to start

offering a compensatory wage structure, if we are to attract the best and brightest, and then keep them on the payroll. The county could nearly eliminate the amount of turnover, training and job searches with a decent wage structure. Remember: The people who provide the mental health services are our most valuable asset.

Mental Health care is a 24/7 endeavor, no different than the Police Departments, the Sheriff's Office or our hospitals, which are all populated by highly trained workforces dedicated to their professions. A supportive working environment and a competitive wage will reduce the loss of labor to other counties. These people provide the required services expected in a modern society to benefit the well-being of our communities. We need to fill out our organizational (employee) chart, starting with a Chief Psychiatrist, a full time Forensic Psychologist, a full time Patient's Rights Advocate, a Mental Health Clinical Services Director and a team of Licensed Clinical Social Workers, Marriage and Family Therapists and a licensed Psychiatric Nurse Practitioner. Whether the county would hire all of these or some would be picked up by RQMC would be the question.

Our BHAB has come a long way during Fiscal Year 2015-2016. Emboldened by the validation of the Kemper Report that our previous work had been positively recognized, new relationships throughout the county Mental Health Program were forthcoming. Our Board and its leadership became more proactive by insinuating ourselves into the county decision making process. As changes have occurred at an accelerated rate at the county leadership level, we have been included in a more consistent manner. Special Meetings regarding the Kemper Report, active participation in the selection of our new Mental Health Director and participation in the "Transition Team Meetings" are but a few examples of the BHAB's growth in becoming a more active participant in our mental health system.

Almost a year now of a full complement of 15 BHAB members shows the strong community interest in mental health matters. Last year's ad hoc committee reports and this year's, soon to be out, will indicate that we are a consequential group of individuals seeking to be the Public's sounding board and link to the Mendocino County Board of Supervisors and the county's Mental Health System of Care.

Now BHAB's leadership has changed. The more than capable Nancy Sutherland has become our Board's Chair. Nancy's leadership will guide our Board with more proactivity and engagement than what my tenure produced, which was more reactive as we were continuously searching for information that was not always forthcoming. Our own transition looks bright and strong. I am confident and am looking forward to a new era of county transparency and

collaboration. A well informed Behavioral Health Advisory Board is an asset to our community. And lastly, I offer a heartfelt thank-you to all Board members past and present who have volunteered their time and efforts in the interest of those unable to care for themselves. Honor to you all.

Respectfully Submitted by Retired Chair,

John G. Wetzler

John G. Wetzler

Mendocino County
Mental Health Board/Behavioral Health Advisory Board
2015/2016
Annual Summary of
Actions, Observations and Activities
Timeline
May 7, 2016

Note: Events presented chronologically by month.

Composite of meeting items and other activities that occurred outside the meetings.

July Laytonville Regular Meeting

Public Comment reflected lack of county services to outlying areas, most notably after tragedies occurred in June in the Laytonville community.

RQMC and Ortner contracts possibly to be reviewed and rebid.

MOU between Rural Housing Development Corporation and Mendocino County Mental Health Program, to leverage \$1.3 million for permanent SMI housing.

Retirement of William Russell from Board, effective July 15, 2015.

Introduction of Stepping Up Program.

Bylaws and Policies and Procedures discussion initiated.

Chair Wetzler tours Howard Hospital with Margie Handley. Concludes that this facility is full of promise.

AOT put on back burner. Rollout date: January 1, 2016

August Gualala Regular Meeting

RFQ between county and RCHDC signed. Search on for sites. Leverage funding.

Tom Ortner interested in purchasing old Howard Hospital..

AOT plan being written by Bev Rae.

Senior peer counseling non-existent in south county.

Public Comment reflects concern about lack of services to outlying areas during times of crisis.

September Ukiah Regular Meeting

Chair Wetzler and Treasurer Sutherland meet with county CEO, HHSA Department Head, Assistant CEO and Dan Hamburg. Financial questions presented to committee; awaiting answers.

Chair Wetzler sits with county HR officials during Mendocino County Fair. Very enjoyable experience. Met a lot of people and had serious discussions concerning mental health services delivery in this county.

County informs Mental Health Board that County will no longer support minutization of public comments. The Board reluctantly agreed to take on this activity.

The Board acknowledged Remembrance Day 2015, in memory of all those who passed away at Talmage State Hospital.

Wellness Grant implementation program is being drafted. Site selection in progress.

Member Dina Ortiz had requested a report on the county's Cultural Competency programs. This request was made by member Ortiz and the Board regarding the obvious poor penetration rate shown by our data provided by our ASOs. This topic will be addressed in the near future, as the State has continued to change format and new plan requirements are expected. Unfortunately Dina Ortiz missed the Board meeting when this presentation took place, while she was providing services to fire victims in Lake County.

Our mobile outreach plan is up and running, overseen by Joy Kinion, Mental Health Rehabilitation Specialist, along with a Sheriff's Services Technician, visiting our outlying areas. As of 9-15-15 Ms. Kinion had made approximately 106 contacts and they are operating with a \$200,000 budget provided by intergovernmental Transfer Sustainability Reserve Funds and a small State grant. This is a 3 year program.

October Willits Regular Meeting

Job description for AOT Coordinator released by Bev Rae. Training schedule to follow.

State and Federal auditors conduct CMS unannounced audits of mental health system. Stacey Cryer becomes new Interim Mental Health Director, also retaining her HHSA Directorship.

Concerns are raised by Judge Moorman regarding backlog of prisoners not receiving competency restoration services. The Mental Health Department has a contract to perform these services. The concerns were raised over unnecessary and extended time in custody for many individuals, at great expense to the Sheriff's Department and taxpayers, to say nothing of the violation of the prisoners' civil rights.

Lois Lockart's membership brought our Board to a full complement of members.

Mendocino County's mental health system has decided to opt into the State's 1115 Bridge to Reform waiver. The pilot program is required to provide early intervention, outpatient services, residential narcotic treatment programs, withdrawal management, recovery services, case management services and physician consultation services.

Public Guardian update indicates 58 Lanterman-Petris-Short Act (LPS) Conservatorships. Approximately 22 are in Mendocino County presently. There are approximately 35 patches at a cost of \$20-250 per day.

RQMC made a presentation on using "tiny houses" as a way of providing shelter for the chronically homeless.

Recruitment is now underway with the qualifications posted for the selection of a new county Mental Health Director.

Review of the county mental health delivery system is in progress by Kemper Consulting Group.

November Mendocino Regular Meeting

Mendocino Hospitality Center progress report: Delivered by Anna Shaw. 25 people being served on an average day. Plans in the works for further improvements. Will keep you posted.

HHSA has agreed to fund \$130,000 to NAMI, Manzanita, Nuestra Alianza, Mendocino County Youth Project, Laytonville Healthy Start (CalFresh) and SUDT Prevention programs.

New Mental Health Director's template to be created for BHAB use.

Notification from State that an additional \$130,000 from the Realignment Growth Fund received.

Old Howard Hospital representatives have met with OMG about a possible collaboration.

MHSA Innovation Plan to target Round Valley.

SB585 funds to AOT Implementation discussed. More to come.

Chair and Treasurer interviewed by Lee Kemper and Jim Featherstone.

Public Comments: Mat O'Neil from Laytonville requesting additional support funds from the county. Submitted a plan with specific goals for more funding. Concerns expressed about privatization of mental health services.

The perception of the Mendocino County community is that we have seen the Mental Health Department go from a full cadre of 140 mental health workers, case managers and personnel to a figure in the low 40s. Housing and jobs for our mentally ill, with no feeling of support, and with mental health issues as a priority, not potholes.

December Ukiah Regular Meeting

Jay Holden progress report on competency restoration: May soon include low level felons into competency restoration program. Margie Jones is the Licensed Educational Psychologist who will head this program with funding from a collaborative pilot project announced by the Mental Health Director's department.

MHSA's \$1.3 million capital facilities funds to be determined with input from BHAB and recommendations from Behavioral Health Recovery Services (BHRS).

Election for new calendar year BHAB officers: Chair Wetzler, Vice Chair Sutherland, Treasurer Gaston, and Secretary Ortiz.

AOT meetings with court officials and BHRS staff occurred November 16th and 18th.

January 2016 Ft. Bragg Regular Meeting

January 11: Special Meeting to interview candidates for new Mental Health Director. Jenine Miller appointed by Mendocino County BOS the following week.

BHAB created a new Standing Finance Committee chaired by Jan McGourty.

Draft Bylaws discussion presented by member Sutherland.

1/20: Large crowd of Public in attendance at Old Coast Hotel for regular meeting.

ER Doctor Andrea McCollough (local speaker.) A summary of Dr. McCollough's comments is attached to this report.

Introduction of Grace Fantulin RN as new Patients' Rights Advocate.

January 19: AOT meeting, ASO integration into program. Search for AOT Coordinator continues. Susanne Yonts-Baughman acting now as referrals come into department.

February Willits Regular Meeting

Kemper Report released to Public.

Discussion to insure BHAB's participation in upcoming transition and implementation of Kemper Report's recommendations.

Sheriff's Initiative explained to BHAB and participation of BHAB Chair
Dear BHAB members,

On January 11th I was approached by Sheriff Allman and asked to participate in an organizational meeting with five other community members associated with our county's Mental Health Program. I said yes. That Thursday we met and were presented with a plan to initiate a .5 cent sales tax increase for the next five years. This tax would raise over \$20,000,000 to fund a mental health facility which would be used as a locked psychiatric unit to house individuals being conserved under a 5150 hold. Other uses for the facility were discussed also. This unit would be located in the Ukiah Valley. Lengthy alternative discussions ensued. An initiative draft was presented and a plan to commence the electoral process was shared. The efficacy of building a new structure was discussed and an alternative more inclusive use of The Old Howard Hospital as a site was broached. Seismicity concerns and other unknown problems with that site did not carry the day. I attended two meetings. As I was going to be out of town and thought that there were to be more meetings to be held I asked the Sheriff if our Vice Chair Nancy Sutherland could join our group. Sheriff Allman agreed to that idea and Nancy and I attended a third meeting. As for now no new meetings have been scheduled. A final draft of the initiative is being prepared. I wish the Sheriff well and took away from this experience a deep seated frustration with county administration and the BOS. The Sheriff is single minded, persuasive, popular and determined to affect a positive change in the way mental Health services are delivered to our seriously mentally ill and drug addicted population.

Nancy Sutherland appointed to Homeless Continuum of Care coalition.

OMG is intending to move the present Access Center to the “Old Coast Hotel’s” westerly five office spaces.

SUDT Department loses one Staff Assistant II and one Substance Abuse Counselor II

30 calls to Patients' Rights Advocate's office. Some confusion as to referrals which fall under Grace's responsibilities.

EQRO report shows great improvement. Two Performance Improvement Plans are presented this year: one for adults' needs assessments and a non-fundable (PIP) on Latino penetration rates.

ER Doctor Ace Barash presents his displeasure and concern about mental health services collaboration with the Willits Hospital ER Department. A letter with 50 signatories was presented to the Mendocino County BOS.

From Supervisor John McCowan: The goal now, given the Kemper Report, is to rewrite the contracts with both ASOs and create a dual track including the writing of an RFP for both ASOs.

February 26th Special Meeting Willits: The following Letter of Advisement to BOS was presented to the BOS during public comment.



**MENDOCINO COUNTY
BEHAVIORAL HEALTH ADVISORY BOARD**
1120 SOUTH DORA STREET
UKIAH, CA 95482
(707) 472-2355

Behavioral Health Board

John Wetzler
Chair
Dancy Sutherland
Vice Chair
Dina Ortiz
Secretary
Kate Gaston
Treasurer
John McCowen
Member of Supervisors
Dan Hamburg
Member of Supervisors
Alternate
Jan McGourty
Cathy Harpe
Debra O'Sullivan
Tammy Lowe
Emily Strachan
Bill McCaughna
Margie Handley
John Gilmore
Lois Lockhart
Roger Schwartz
Denise Gorny

February 29, 2016

To: Mendocino County Board of Supervisors

The Mendocino County Behavioral Health Advisory Board has decided to present you with a considered letter of advisement at this time of consequence and juncture. Today we heard from the Chief Executive Officer of Mendocino County, Carmel Angelo. We were presented with a course of action recommended by the Staff of the CEO's Office. We too want to participate in this process. Our concerns regarding the implementation of the Kemper Study's recommendations, along with our own input, alternatives and implications follows as agreed upon by the BHAB bullet points.

Follow-up Recommendations from the Kemper Report

1. Section III, line 5: MOUs will meet a 90 day target, as recommended in Kemper Report.
2. Section III, line 1: a) A contract manager to oversee financial claiming and service delivery outcomes. b) A program manager to work with the clinical side and directly with the behavioral health and service delivery director to assure coordination of administration and clinical oversight, and review all facilities.
3. Section IV, line 1: Meet the recommendations to hold the public forums specific to residential care and crisis residential services.
4. Section IV, line 2: Ensure the MOU and 5150 Review happens within 90 days, and develop and implement an arbitration process for psychiatrists, ASOs, hospitals and the County.
5. Section VII: An outside independent financial audit will be conducted of both ASOs contracted services
6. Section VI: Renewed spirit of openness and transparency with the Behavioral Health Advisory Board.
7. Section III, line 4: Electronic health records will be ready to implement by both ASOs with the County by July 1, 2016.

8. Formalize and finalize contracts for 18-24 year olds (TAY) services and transition with both ASOs.

9. Section III, line 6: Propose definitions for ASO administration, direct mental services, and utilization review and proposed methodology for determining payments for these activities.

10. Section VII, line 1: Present quarterly financial summary reports, all inclusive, to Behavioral Health Advisory Board.

Additional recommendations from the BHAB

1. A monthly report will be provided to the BHAB from the CEO and BOS on

the status of the Kemper recommendations, including finances/dollars.

2. We recommend the County apply for the peer respite grant due March 8, 2016. This follows in line with Kemper's suggestion that we look to increasing seeking additional funding. In consideration of residential care and crisis residential services, also address the imminent need to use the \$500,000 wellness grant that has a deadline
3. Prioritize recruiting and hiring credentialed case managers
4. Prioritize and provide necessary resources to hire a full time County psychiatrist
5. Credentialed 5150 card holder staff able to respond in all outlying areas within 25 minutes
6. Talk-therapy and persistent follow-up for those who are discharged from mental health hospitalization
7. Fully staffed Substance-Use Disorder Treatment department
8. Create and Implement Mental Health Crisis/Respite and Substance-Use Disorder Treatment Detox Centers inland and coast
9. Recommend employment of a full-time Assisted Outpatient Treatment Program Coordinator for Laura's Law pilot program
10. Board of Supervisors form the ad-hoc committee at the BOS level to track the implementation and management of the Kemper Report's recommendations, and ensure board member involvement in the process.
11. There was a lack of review, comment or inclusion of Latinos in the Kemper Report, as well as in the External Quality Review, and we recommend this be addressed.
12. Implement the recommendation to increase the penetration rate for county Latino population
13. Participation of First Nation People needs to be included in the services and actions of the department.
14. Mental health consumers' voices need to be included in developing recommendations
15. Develop in 2016 an employment outreach service for consumers and clients, and ensure continuous follow-up
16. Housing guide and a housing case manager to assist clients to move off the streets and out of couch-surfing and into regular housing, with funding to add a small subsidy over SSI and SSDI income.
17. County and both ASOs will provide a full staff list to BHAB with positions, to include individuals' credentials and licenses.
18. 90-day target to revisit prior proposals which include the MHSA plan
19. Strong recommendation is that the county's general fund be used to supplant shortfall in any funding needed to meet these recommendations and

the follow through of the Kemper report.

Please know that these points have been vetted and voted upon by the Mendocino County Behavioral Health Advisory Board, and are intended to assist you in a collaborative manner, to come to a well reasoned decision regarding the provision of services within the mental health system of care. We remain vigilant and engaged in all future processes, to come to a favorable outcome for the entire community of Mendocino County and the Mental Health and Substance-Use Treatment Departments.

Thank you for your consideration.
Sincerely,

John Wetzler
Chair, Mendocino County Behavioral Health Board

cc: CEOs office
Behavioral Health Advisory Board
Clerk of the Board of Mendocino
Behavioral Health Director

Comment from Chair: This was probably our most deliberated and least respected letter to the Mendocino County Board of Supervisors. After its presentation to the BOS, the advice in the letter was accepted by the two supervisors most conversant with our mental health system. The three supervisors who have had the least contact with the BHAB voted not to accept our advice.

Public Comment: Too destructive to change ASOs now. "Let's make what we have work."

BOS votes to write RFP to find other bidders to provide mental health services to county. OMG representatives walk out of chambers.

March Ukiah Regular Meeting

March 7th: Received phone call from CEO Angelo that Ortner Management Group will be leaving the county as of June 30, 2016.

Chair recognized Carmel Angelo, Mendocino County Chief Executive Officer, to report on the current transition plans and progress in response to the recent resignation of Ortner Management Group as of June 30, 2016.

March 1, 2016 BOS gave direction to county staff to move forward with the Kemper Report recommendations.

March 9, 2016 county received a letter from OMG formally resigning.

County goes into crisis mode, and starts making plans to have RQMC take over the delivery of adult mental health services. This all will involve MOUs, contracts and personnel decisions.

Search for an HHSA Director goes into hyperspeed. The BHAB Chair will be on the selection committee.

Kemper recommendations will still be honored.

The Mental Health Department will seek an extension from the State for accessing funds from Wellness Grant SB 82.

Supervisor McCowan suggests a joint meeting between BHAB and BOS.

MHSA yearly update to be out soon, and ready for BHAB oversight and review.

AOT needs immediate exposure, and an explanation of this program of voluntary intervention.

RQMC will be hiring additional staff to provide adult services.

Our new Standing Finance Committee is now populated, according to Chair McGourty. BHAB members of the committee: Lois Lockart, Kate Gaston, Margie Handley, John Wetzler, Jan McGourty. Non-BHAB members: Jackie Williams, Supervisor Tom Woodhouse and Donna Moschetti.

Special Meeting to be called April 8th to address BHAB oversight and participation with the BHRS transition team. The transition must be in place by July 1, 2016.

April 8th: Special Meeting in Ukiah to address participation with BHRS during the transition period.

Chair Wetzler resigns seat as Chair of the BHAB, and Vice Chair Nancy Sutherland assumes role as Chair as per Bylaws. Wetzler takes over role as interim Vice Chair.

Chair Sutherland presented the Board with an evaluation form to critique the meetings' format.

Bylaws will be on the agenda for the April 20th Regular Meeting.

Permanent change: Current events item to become discussion item only, no action.

Review of MHSA one year update must be secret, before final draft is presented to our Board.

BHAB members should be integrated into formulation of MHSA 3 Year Plan.

Goals of BHAB to be on agenda of our next regular meeting in Covelo.

April 20, Regular

Chloë Guazzone-Rugebregt, MPH. Executive Director Anderson Valley Health Center,
P.O. box 338, 13500 Airport rd. Boonville CA 95415

Approved the Bylaws with recommend changes. Forwarded to County Counsel for review and approval.



John G. Wetzler, Retired Chair

January 20, 2016

ATTACHMENT

A paraphrased Transcript of comments delivered to the Mendocino County Behavioral Health Advisory Board by **Dr. Andrea McCullough, General Practitioner with 9 1/2 years experience in the E.R. at Mendocino Coast District Hospital, Ft. Bragg**

Prepared by Chairman John Wetzler

We have issues at our ER room with mental health crisis. I have been interested in mental health and had worked in a psychiatric hospital in Pennsylvania before coming here. I know and understand the remoteness of our hospital and the scarcity of services. Things are better now than 9 1/2 years ago. More patients are hospitalized and we have more follow-up now. We need improvement.

Pediatric services are excellent. We are very happy with RQMC and they do a great job communicating with their patients and with their families. We have had a lot of disagreements when it comes to the adult side of mental health care. We've recently had a patient who died, and we all felt very bad about that. We disagreed with the disposition that was made to release. After the death, the pendulum swung the other way to a more committed approach, and additional hospitalizations occurred. We have to have sitters with the patients, until a mental health worker arrives. It is a gray area with mental health adult workers; maybe they need more training. We often times disagree with the adult mental health workers who come to the ER. The local providers are good and competent: John Wieser and Rod. If there were a way to have more local providers, high quality, then patients wouldn't have to wait hours for someone to come from Ukiah after hours. They need more empathy and they don't know the patients, and ask us to do some of their paperwork and charts. Phone calls and HIPPA violations are a concern, being unprofessional with our staff when dealing with possible intoxication issues. Having sitters in the ER is a strain on our program. We understand that when a patient is on a 5150 hold, they shouldn't be allowed to run out of the hospital while they are a hold. Mental Health Adult Services tell us that if they are being treated, they are not on a hold, and this becomes extremely complicated if they are not on a hold when we are treating them, if they escape. No Sheriffs on duty after hours when a patient ran out of the ER. Had to wait til next morning to get the guy back. Sometimes police have to come several times while a patient is waiting for a bed or a trip to Ukiah.

Police are usually very helpful. Follow-up needs more providers. Poor communication with Access Center. We are doing some of their paperwork.

We had a question from the Board membership (Tammy Lowe): What is the average response time from Ukiah?

Dr McCullough thinks there is only one mental health worker after hours for adult services. If this worker is tied up, that time could be 3-4 hours. They will wait for the patient to be medically cleared before leaving Ukiah. Many different people come from

Ukiah, maybe 5 or 6 different individuals have come.

Question from the Board (Supervisor McCowen): Have things improved in the past 2 1/2 years?

Up and down. Static. OMG came out initially and met with our hospital staff. This was good with a lot of discussion, but that has dropped off recently. I would describe the delivery of services as a constant plateau, not better.

Question from the Board (Jan McGourty): What are the qualifications of personnel being sent after hours from Ukiah?

Dr McCullough indicates that she has the same question, and continues: In Pennsylvania, mental health workers were trained psychiatric workers or advanced nurse practitioners. A lack of picking up information from family, nurses and neighbors describing behaviors of patients. There was this push-back to not receive information from a mother of a patient. What are you going to base your decision on for this assessment? "A psychotic patient in crisis?" This defies logic. When it comes down to Adult Mental Health Services workers' judgment, much is missed from the Ukiah crew. "Of course they are not going to say (the patients) that they are going to kill themselves" to the mental health worker. Much is missed.

Question from the Board: Is there an off-site worker who is called during assessment?

Yes. Todd Harris makes the final decision, seems okay and asks the right questions; but could be biased by information received from the mental health worker, who is actually present with the patient.

Question from the Board: Is there a safety net?

Response: Yes. Our staff is responsible, and if there are questions regarding safety of the patient, we may call Todd Harris or Dr. Riley. Our second safety net is the Ft Bragg Police Department. We at the ER have no ability to retain patients in the ER until a 5150 has been written. We have never received credentials from Adult Service providers who write the 5150. We have not questioned that.

Ukiah people won't come out to the coast until the patient is medically cleared. Also they will not come if patient is intoxicated. Thus the ER can become a Drunk Tank.

Behavioral Health Advisory Board

Finance Standing Committee

According to the Kemper Report: “in our overall review of financial documents associated with the ASO model, we generally found an absence of easily understandable information about how the ASO system is budgeted by fund source (i.e. Med-Cal, MHSA, Realignment and County General Fund) and how this budgeting fits within the County’s larger framework for revenues and expenditures for BHRS/MH. Furthermore, we heard from a number of Key Informants that there is a lack of understanding about how the ASO model has been constructed and financed and how it is placed in the overall financing structure for mental health services in the County.”

Mr. Kemper reiterated this position at his May, 2016, update to the Board of Supervisors using the terms “opaque” and “mystifying” to describe the current process and reporting.

At the January 20, 2016 meeting, the BHAB adopted the following resolution:

Board Action: Upon motion by Member Sutherland, seconded by Member Ortiz and carried with the following YAY votes from: Chair Wetzler and Members Harpe, Ortiz, Strachan, McGourty, McCaughna, Gilmore, Gaston, Lockart, O'Sullivan, Sutherland and Lowe: IT IS ORDERED at 1:34PM that the Behavioral Health Advisory Board accept the establishment of a Standing Finance/Contracts Committee.

Jan McGourty is the Chairperson. This Committee is public and subject to the provisions of the Brown Act. At its first meeting the Committee agreed to coordinate a MH Finance Training for the BHAB, stakeholders and public. County Mental Health and the RQMC will collaborate to inform participants on all aspects of mental health financing and delivery of services. The meeting is planned for late August, 2016.

The Ad Hoc Audit Committee

This committee did not prepare a report. The establishment of the Standing Finance Committee made this committee redundant.

One major improvement in the County's position on transparency and openness is their commitment to publish all audit reports on the Behavioral Health Recovery Services website as they become available. Also, in recent months audit reports have been openly discussed at BHAB and BOS meetings.

Submitted by:

Nancy Sutherland

May 8, 2016

Behavioral Health Advisory Board
Annual Report
2015-2016

Bylaws ad hoc Committee

New bylaws were prepared and forwarded to the BOS for approval. Additions and correction were made and approved by the BHAB on April 20, 2016. As of the date of this report, the revised Bylaws are being reviewed by the County Counsel and the Board of Supervisors.

Submitted by:
Nancy Sutherland
Emily Strachan
Kate Gaston

May 8, 2016

Revised Behavioral Health Advisory Board Policies and Procedures

The delay in the approval of the Bylaws resulted in a delay in revising the BHAB Policies and Procedures. The current policies and procedures handbook is outdated and difficult to use. The new handbook will elaborate BHAB policies derived by from the Bylaws and include essential support documentation. The goal is to have a handbook that is user friendly, that can be easily revised to accurately reflect changes within the BHAB and the delivery of Mental Health Services in Mendocino County

Submitted by:

Nancy Sutherland
Emily Strachan
Kate Gaston

May 8 2016

Cultural Competency Development Committee
Report Ending May 6, 2016

Charge to Committee: Assess the Behavioral Health Department’s current cultural competency plan for services and inclusion, and make recommendations to the Behavioral Health/Mental Health Board for their annual report to the BOS.

The purpose of the plan is to have culturally sensitive and language appropriate mental (behavioral?) health services to support and encourage safe and stable families, specific to Latino and Native American populations, but also for others; in essence enable a system that will be effective and appropriate, inclusive and sensitive, and provided throughout the county to population centers that allow our diverse members to readily access culturally and comprehensible therapies, while feeling respected and valued.

The following are observations on the current plan and implementation of strategies in the plan. It is critical to remember plans by the county department and staff aimed at increasing inclusion of diverse communities in programming, are not a panacea for problems in community and leadership commitment to overcoming blind biases, where lack of diversity among overall board memberships, commissions and administrations, may or may not contribute to the very slow change in cultural inclusion.

During 2015-16, the County’s Behavioral Health Department, and the County’s service delivery systems

- **Experienced stress and disruption in leadership and overall support:** The drama involving the delivering of adult services and the contracted ASO drew attention away from what could have been a year of growth in the area of Cultural Competency. While the ASOs both reported monthly on statistics, and their efforts to hire bi-lingual and culturally engaged staff, and the County Behavioral Health staff worked towards completing the objectives in their state approved plan, energy and time was limited, and could not focus in such ways as to ensure meaningful plans to engage diverse communities in strong leadership roles, prior to pen being put to paper to create a “plan”;
- **Struggled to face the challenge of entrenched beliefs and practices** around the areas of inclusion, cultural norms and language barriers; such challenges will require focused county leadership on making changes that seem to daunt all of us. Such changes will demand this cannot be a staff directed effort, or efforts; Health and Human Services Administration must explore new modalities of community engagement, and employment enrollments, reflecting racial and ethnic make-up of our county;
- **Lacked necessary level of outreach to neighborhoods and natural and native community leaders,** which is necessary as the first step in developing the means to listen,

engage, enroll and serve members of the County who are not part of the dominant culture, and/or who experience barriers to participation;

- **Showed a surprising lack of flexible funding and mentoring to help sustain** cultural community groups who needed such support to fully participate in answering the department's already struggling challenges. Specifically, the loss of Nuestra Casa in Ukiah may have partially contributed to the department pulling back from supporting this small but necessary nonprofit during a harsh point in their funding and development. This lack of understanding took place during a period of already mentioned stress and competition among service providers, and the quiet shift to focusing on another provider in Willits is confusing. With such a high need, both programs should have been supported. Developing a nonprofit with an important mission and struggling forward through numerous challenges is a battle that goes on year after year. Letting one die because of personality conflicts, or imposed deadlines, or because communication or emails dwindled are highly regrettable. Starting over is near impossible, and for this reason losing history and foothold is deplorable. The program in Willits, Nuestra Alianza de Willits, is to be commended for developing in that community, and hopefully will be able to expand to other communities or work in conjunction with leaders in the diverse latino communities to build outreach. In addition, in Native American communities, comments were made about not receiving funding from the County. This comment was not about funding to ASOs to provide services, but that such funding did not go directly to the tribal associations and clinics;
- **We're challenged to build a community inclusive plan which is alive and not on paper:** County staff who administer the cultural competency projects in alignment with the comprehensive plan, are recognized as striving forward to meet the plan as submitted and approved by the state, and the few staff who are managing this should be complimented for what they have accomplished. An objective of the state plan was to develop a community wide and inclusive community advisory committee to both advise and help develop the next three year plan; this objective was easier to meet on paper than in real life. Membership on the committee varied based on where the quarterly meeting was held, often in conjunction with a scheduled training, and the overall committee members listed did not participate as a full group in discussion, planning and implementation;
- **Focused efforts on developing cultural competency through training programs,** which were listed in the three-year plan, and were highly ambitious when assessed against the time, money and staffing the department was able to contribute. Twenty-four (24) trainings, workshops, webinars are listed in the plan, covering multiple cultures and concerns, areas specific to suicide prevention, the LGBTQ culture, Native American, Latino, veterans, and other small subsets. The staff have continued to schedule programming around the county; whether this has increased collaboration with our diverse communities remains to be seen, or whether it provides awareness, understanding and tools for the provider communities. Final trainings for 2015-2016 take place on May 11 (Latino Cultural Competency Training), on May 16 (Asian/Pacific Island Heritage) and June 23

(Gay and Lesbian Pride). In addition, department staff have ensured their packets and awareness campaign is shared at health fairs, farmers markets, special events around the County and **sought to use every training available to meet the goal of creating inclusion and awareness across a spectrum of “cultures”**.

We recommend the County expands funding and resources for natural leaders in our diverse communities, towards building real change and inclusion in future plans and their implementation.

Respectfully Submitted, Kate C Gaston, Ad-hoc Chair Cultural Inclusion Ad Hoc Committee Report.

**Co-Occurring Disorders
Ad Hoc Committee Report
April 30, 2016**

THE UNMET NEED

Substance Use Disorder Treatment (SUDT) and Integrated Co-occurring Disorder Treatment have long been identified as serious unmet needs in Mendocino County. The Kemper Report identified “Lack of Interface with County Substance Use Disorder Treatment Services.” as one of the six areas of tension in the County Mental Health System. Kemper cited last year’s Mental Health Board report as identifying the following service gaps.” Lack of services for dual diagnosis clients and the lack of an affordable local detoxification facility that accepts insurance,” and the “Need for a robust and accessible substance abuse treatment program.”

The Kemper Report further recommended in Section IV(6):

Most other California counties have either integrated mental health and SUDT services or begun efforts to do so. Beyond this integration, many California counties are also seeking integration and/or linkage of mental health and SUDT services with the broader health care delivery system. In Mendocino County, we believe the opportunity exists to focus on greater linkage and integration within BHRS, and with community health centers (FQHC, RHC and Tribal Health Programs) for residents with SUD conditions, residents who suffer mild to moderate mental health problems, and residents that are served by the two ASOs. In particular, we believe coming opportunities for expanded SUDT under the State’s Drug Medi-Cal Waiver provide an opportunity for the County to work toward this type of linkage and system integration.

RECOMMENDED ACTION

We recommend the County Executive direct BHRS to take the following actions:

Develop and execute an MOU between the between the Mental Health and SUDT Branches and the ASOs that defines and describes service linkages and responsibilities between SUDT services and mental health services.

First Five Mendocino prepared and published a White Paper response to the Mendocino County Grand Jury Report of May 19, 2015, entitled “Children at Risk.” The First 5 report included the following:

Provide Adequate Substance Abuse Treatment Services. Over the past five years, alcohol and other drug treatment services in Mendocino County HHS have diminished substantially. There is currently just one drug and alcohol counselor serving the entire coast. In addition to the same recruitment, hiring and retention difficulties explained

previously, some positions have been left unfilled, resulting in waiting lists rather than treatment for citizens who are actively seeking support to become drug and alcohol free.

WHAT NEEDS TO BE DONE

Addressing the unmet need for co-occurring treatment for those diagnosed with a mental health and substance use disorder requires three significant changes or enhancements to the current services:

1. MOUs, formal policies and procedures addressing bi-directional referral and mutually accepted client releases of information (ROIs), collaboration and case management.
2. Taking advantage of all available funding sources; Medi-Cal, Drug-Medi-Cal, MHSA and grant funding options.
3. Strengthening and enhancing current local SUDT prevention and outpatient treatment services, while expanding access to residential treatment. This includes County support of the 1115 Med-Cal waiver, discussed below.

CURRENT SERVICES

The County Behavioral Health Recovery Services (BHRS) is the primary provider of both substance use disorder and mental health services. In response to the Kemper Recommendation, BHRS and RQMC are working on developing referral policies and MOUs with various service providers and agencies. BHRS/SUDT's provides Outpatient Treatment Program substance use disorder treatment for adults and adolescents primarily through individual and group counseling. Counselors are State registered or certified. Services are available only in Ukiah and Fort Bragg. Services are on a sliding fee scale based on income. County Medical Services Program (CMSP) and Medi-Cal pay the cost of treatment for people with that coverage.

- All programs offer chemical testing for participants.
- All programs offer resource and referral services.

Outpatient Treatment Programs - Ukiah served 93 outpatient clients this year. They are currently serving 54 outpatient clients. The Fort Bragg site has served 35 clients this year. For several years Fort Bragg had just one treatment counselor. A new counselor is scheduled to start on May 23, 2016. Both programs have waitlists. The waitlist is prioritized from female/pregnant IV user to self-referrals.

WINDO - Women's Perinatal Treatment Program (7 participants/2 openings) provides treatment services to women with substance use problems who have children (including those in foster or out of home care) and to those who are pregnant. Participants in the WINDO program receive parenting classes and the group and individual services described above. While in the program, women may be a part of the cooperative child care program and get transportation or help with transportation. These services are in Ukiah, and are free to participants.

OPTIONS Adult Drug Court (15 participants/2 openings) provides treatment to individuals who are referred by the court system, usually those who have a drug-related felony charge and who are on Probation. OPTIONS is a collaboration between SUDT, Mendocino County Superior Courts, the Mendocino County Probation Department, and other treatment providers. The program is geared to provide treatment for 18 or more months. A licensed therapist is available to all Options Clients. Treatment for this program is free. The program is offered in Ukiah.

Family Dependency Drug Court (FDDC) (19 participants/no openings) The program is a collaboration of the Mendocino County Superior Court's Juvenile Division, HHS's Child Welfare Services and SUDT. It provides treatment for parents who are referred by Child Welfare. Residential treatment detox is available for some FDDC parents. Transitional housing is available at Ford Street for some FDDC parents. FDDC has a licensed therapist that they utilize for their clients. Program services are free to participants. The program is offered in Ukiah.

AB 109/Probation
SUDT provides treatment for Probation referred Local Probation/Parole clients. AB109 clients may be referred to a designated County-employed therapist.

Administrative Service Organization (ASO) Sub-Contracted Service Providers

The three major ASO-subcontracted service providers all reported a high need among their client population for enhanced SUD and co-occurring disorder treatment options. Although there are no plans to privatize SUDT, both the County and RQMC may be contracting out some SUD services as we move into the 1115 Waiver, discussed below.

Redwood Services

Redwood Services is Drug-Medical Certified to provide outpatient SUD treatment. These services are generally provided to transitional age youth (TAY). The Arbor hosts Narcotics Anonymous and Alcoholic Anonymous meetings for support. The plan to hire a substance abuse counselor who will be able to bill Drug-Medi-Cal (DMC.) As part of the current transition of adult services from OMG, RQMC is currently negotiating a subcontract with Ford St. Project/Unity Center for the provision of some services.

Manzanita Services

Executive Director Wynd Novotny reported currently serving approximately 99 clients with a SUD diagnosis. Manzanita does not bill Drug Medical and has one certified substance abuse counselor case manager. Rather than SUD treatment they are able to provide case management and peer support. Manzanita currently offers weekly Wellness Education Groups, including a dual diagnosis group. The Dual Diagnosis Care Manager is a certified SUD counselor. Bi-directional referrals are a relatively small percentage of the total SUD-diagnosed clients.

The Executive Director identified housing as a primary barrier to client stability. She also recognized the need to educate the community and service providers about the stigma experienced by people with co-occurring disorders.

Hospitality Center

According to Executive Director Anna Shaw, Hospitality Center provides wellness services in Fort Bragg. They have a small federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant (\$45,000) that has a \$15,000 allocation for dual diagnosis services. Last year a total of 33 clients were case managed through this grant. Hospitality Center is not able to bill Drug-Medi-Cal for services but provides peer-based, supportive services and case management. There is no certified substance abuse counselor. Hospitality Center provides a group called “Off the Hook” which is primarily an education peer-support group focused on substance abuse and recovery.

Bi-directional referrals are not effective on the Coast due to the almost total lack of SUD services. There is no drug court. No family dependency drug court. No AB109 services. No ability to serve the felony population on the Coast. No detox. No rehab. The County employs one AODP counselor with no receptionist. The disparity between the funding and provision of coastal and inland drug and alcohol treatment services is one of the most critical issues in our county. Consistent with prior years, the Coast remains a high need population with woefully few services for the addicted with co-occurring mental health disorders. Community education to mitigate stigma issues would benefit the coastal communities.

Mendocino County Aids/Viral Hepatitis Network (MCAVHN)

Executive Director, Libby Guthrie, EdD, MFTi, reported MCAVHN serves approximately 65 clients with a SUD-diagnosis. The MCAVHN case managers are all trained in harm reduction counseling and intervention. Several are trained as substance abuse counselors and have done internships, and one case manager is certified as a Registered Addiction Specialist. The executive director has a doctorate in Counseling Psychology, supervises AOD and Human Services interns. She also teaches Co-occurring Disorders at the college. Their Recovery-Oriented Systems of Care case management program is meant to specifically address the issues and needs of those with co-occurring disorders, and aggressively seek treatment options (for both SUD and MH) that are either sensitive to co-occurring disorders, or are appropriately integrated to concurrently meet the treatment needs of SUD and mental health diagnoses. All case management care plans reflect a holistic recovery paradigm, addressing a full spectrum of needs. Co-morbidities, trauma, mental illnesses and substance use disorders are addressed within all case management programs.

MCAVN does not bill Drug Medi-Cal. To improve substance use disorder and co-occurring disorder treatment MCAVHN suggests a much wider dissemination of information regarding comorbid conditions be offered to the general public, mental health, and SUD providers; with the eventual outcome of thoroughly understanding the concepts and need, and developing appropriately integrated services that will be available to all. Also, funding streams should be sought for integrated service provision. According to Dr. Guthrie “Mendocino County must work

more aggressively towards having services that are available with a REAL collaboration of interdisciplinary team members who understand the need to treat concurrently.”

Other community based agencies providing limited services include,

Mendocino Community Health Clinic (MCHC) FQMC

Behavioral Health Director, Sam Fernandez, stated that MCHC does not provide direct Drug-Medi-Cal billable services. They provide medical-based services such as Suboxone and Behavioral Health services that support recovery and may address abuse and addiction issues. They employ clinicians with substance use treatment background.

Ukiah Recovery Center (formerly Ford St. Project)

Unity Recovery Center is the only local SUD residential treatment service provider in Mendocino County. Ukiah Recovery Center is a co-ed facility. It contracts with County Probation, Family Dependency Drug Court and until recently State Parole. They also accept private pay. Ford St. Project is currently in negotiation with RQMC to provided co-occurring disorder treatment options.

Yuki Trails, Covelo

Yuki Trails Behavioral Health Services include substance abuse and mental health counseling to the people of the Round Valley community. Counseling services include: Outpatient substance abuse counseling for adolescents and adults, Outpatient mental health counseling for children, adolescents and adults, Facilitated group counseling for substance abuse recovery, anger management, and grief and loss.

Consolidated Tribal Health

As part of Consolidated’s behavioral health programs the following supportive services are provided: Substance abuse counseling. Assessments, referrals, clinical screening and assessment, substance abuse counseling, support group counseling, cognitive behavioral therapy, chronic pain management through stress reduction, hypnotherapy, stress management through self relation techniques and meditation. Group support: Red Road to Wellness, Traditional Healer Program.

THE FUTURE

The 1115 Waiver

On August 13, 2015, the Federal Centers for Medicare and Medicaid Services (CMS) approved California's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver amendment

for a five-year demonstration period. This amendment is part of the 1115 waiver. California was the first state to receive CMS approval of a waiver of this type.

The (DMC-ODS) 1115 demonstration waiver provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment services and is expected to demonstrate how organized Substance Use Disorder (SUD) care increases the success of DMC beneficiaries while decreasing other system health care costs.

The DMC-ODS Waiver makes improvements to the Drug-Medi-Cal service delivery system including improved coordination of case management services, implementation of evidenced based practices in substance abuse treatment and coordination of care with other systems including mental health and physical health. It also allows for the extension of Drug Medi-Cal Residential Treatment Service as an integral aspect of the continuum of care. It eliminates the Institutions for Mental Diseases (IMD) exclusion of 16 beds or less and allows operation of residential facilities with no bed limit.

Participating counties with approval from the state may develop regional delivery systems. Opt-in Counties are required to submit a county implementation plan with details on their proposed oversight, monitoring and evaluation plan. Additionally, Board of Supervisors of each county must enter into an interagency agreement with the State.

The requirements for implementing this delivery system are difficult for a small rural county due to limited resources. Mendocino County has been participating along with seven other counties (Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta and Lassen) in discussions on forming a northern region collaborative that could potentially opt-in as a region.

Overall, the Waiver bypasses Medicare provisions that may have a negative impact on the delivery of substance use disorder treatment. It supports the movement toward parity in all segments of health care. The 1115 Waiver has the potential to transform the system through a partnership of the state and federal governments, providing equity and safeguarding the “whole person.”

In January 2015, the CEO’s Office reported, “Substance Abuse is prevalent in Mendocino County and this would bring needed services to the region and to our beneficiaries. We will continue to keep the Board of Supervisors updated with new information as it develops. HHSA recommends the DMC item be assigned to the HHSA standing committee for further discussion.” We support this position.

CONCLUSION

Untreated mental illness and substance use disorders have severe negative consequences for the afflicted, their families and friends, law enforcement, health and human service resources and community well-being. The Committee recognizes the current inadequacy of both SUD and

integrated co-occurring disorder treatment services and strongly recommends the BHRS and Board of Supervisors prioritize financial and other resources by supporting the following:

- an integrative “no wrong door” referral and treatment system with a focus on co-occurring disorder treatment options
- maximizing and leveraging the use of all available funding sources, including the 1115 Waiver and hiring a permanent grant writer
- locating and staffing Substance Use Treatment Disorder Treatment options county-wide
- the reactivation of a AOD Advisory Board. We recommend quarterly AOD/BHRS meetings
- providing transportation support for those remote locations
- implementing SUD and co-occurring disorder treatment services addressing the needs of the critically under-served community populations, including seniors, Hispanic (including bilingual service providers,) Native American and others

Submitted By: The Behavioral Health Advisory Board Co-Occurring Disorders ad hoc Committee.

Maureen O’Sullivan
Jill McCaughna
Nancy Sutherland

Housing
Ad Hoc Committee Report
April 30, 2016

Chronic homelessness is a continuing problem in Mendocino County. The January 2015, Point-in-Time Count found there were 71 Seriously Mentally Ill adults in emergency shelters and safe havens. 141 adults with serious mental illness were unsheltered. The statistics for adults with substance abuse use disorder were equally alarming; 40 sheltered, 198 unsheltered. As citizens we validate this data through our daily experience. The 2016 Point-in-Time results have not been released. The individuals doing the counting report a higher penetration rate, and greater individual participation. A more inclusive count, the closing of the homeless shelter, together with no significant improvement in the transitional or permanent housing options suggests no likely improvement to 2015 numbers.

This report does not focus on the quantity and quality of services provided to seriously mentally ill consumers through current mental health programs. By July, 2015 Adult Mental Health Services will have transitioned from Ortner Management Group to Redwood Quality Management Services. The impact on housing services is unknown at this time. Currently Mendocino County AIDS/Viral Hepatitis Network (MCAVHN), Hospitality House and Manzanita Services provide some housing services and case management. The above statistics clearly indicate a need for expansion of current services .

On a more positive note, a group of dedicated service providers and concerned citizens in Ukiah formed an action group to establish a winter shelter. With financial assistance from the Board of Supervisors a winter emergency shelter serving up to 47 people a night opened in Ukiah. Unfortunately those seeking shelter often exceeded capacity. Also the shelter had to close before the end of the cold/rainy season. The Coast also provided emergency winter shelter services based on the severity of weather conditions.

Report from the Coast

There are two beds at the Hospitality House homeless shelter that are currently used by ICMS to place homeless people with mental health needs. These are not respite beds. These are not crisis beds. Up to 24 people can be accommodated at one time at the Hospitality House homeless shelter. Up to 15 people can be housed in Transitional Housing on Harrison Street at one time. Both facilities are currently full.

Beginning in the summer 2016, up to 10 people will be able to be housed in Transitional Housing at the Hospitality Center on Franklin Street in Fort Bragg.

The Coast has been an attractive destination for the homeless. The fairly mild climate, available camping (legal and other) and access to food programs help support outdoor living. The closing of the homeless shelter in Ukiah also may have added to the homeless population on the Coast.

An issue that has come up on the Coast and presented to the BHAB is the denial of housing services to those who use medical marijuana. A support group has formed to support and advocate for individuals facing this issue.

MHSA Housing Project The major housing project affecting supportive housing for the mentally ill is the Mental Health Services Act (MHSA) funded housing project currently under development. In March 2015 the County's Health and Human Agency published a Request for Qualifications for "Mental Health Services Act Housing with Supportive Services Development." On January 25, 2016 the County announced it would be collaborating with Rural Community Housing Development Corporation (RCDHS) on the MHSA-funded housing Project. \$1,332,379 MHSA funds are currently available. \$439,685 of these funds are allocated to operating expenses for the life of the project. RCDHS and the MHSA staff held community forums and surveyed the general public, stakeholders and mental health consumers regarding their preferences for the project. County staff and RCDHS provided information and regular updates to the BHAB. As of the date of this report, several issues need to be resolved before the project can move forward. The major issues are:

1. A decision from HHS and the Board of Supervisors on whether to use the available funds for one 30-40 unit project, or one or more smaller projects (total 8-12 units). The large project option will entail leveraging the available funds.
2. Will the project be single or mixed use.
3. Site availability and affordability.
4. Timing

Currently RCHDS, in collaboration with the County's Behavioral Health & Services, plans to present development options to Fort Bragg, Willits and Ukiah City Councils during the first half of May 2016. The BHRS and the County Executive Office will submit their recommendation to the BOS on June 21, 2016. With direction from the BOS, RCHDS will begin efforts to obtain a suitable site(s).

Recommendation: The BHAB discuss the project options and provide an advisory letter to the Board of Supervisors prior to June 21, 2016.

The Tiny Houses Project received unanimous support from the Board of Supervisors. The BOS approved two separate requests for Community Development Block Grant Funding (CBDG) for a total of \$1,014,700 to Redwood Community Services, Inc. State approval of the project is pending. The Tiny House Project will be located in Ukiah. It is a "Housing First" model designed to fill a critical unmet need by providing a bridge from chronic homelessness to transitional or permanent housing. RQMC recently hired someone to coordinate the development and implementation of the Tiny Houses Project.

Recommendation: As the Tiny Houses Project progresses, the BHAB consider advocating for onsite mental health outreach and outpatient services.

Housing Mendocino County's homeless is critical unmet need. The impact on human suffering, human service resources, law enforcement, health services, and the environment far out ways the needed investment in housing and supportive services. The local agencies and service providers have the ability and passion to mitigate these negative impacts for the general well-being of the community; however, real change requires community and financial support.

Resources and documentation used to create this report:

- The 2015 Homeless Point-in-Time Count available for the HHSA Homeless Continuum of Care Committee Page 10 of 14, attached
- The Mendocino County Housing Element 2014 -2019 Update. This General Plan update addresses all of the County's housing issues. Especially relevant to this report is: Action 4.3k *“Provide planning assistance to the Mental Health Branch of the Health and Human Services Agency if the division is working with a mental health service provider to develop new supportive care housing facilities in unincorporated Mendocino County.”*
- Request of Qualification (RFQ) Mental Health Service Act Housing with Supportive Services Development, dated March 17, 2015.
- Undated letter “The Village (a Tiny House Project) attached.
- BHAB member Nancy Sutherland became an Advisory member of the Homeless Continuum of Care Committee. www.co.mendocino.ca.us/HHSA
- Reports and BHAB presentations of Mike Pallesen, Director of Development RCHDC
- Information from MHSA Forums and presentations to the BHAB

Submitted by the Mendocino County Behavioral Health Advisory Board, Ad Hoc Housing Committee

Tammy Lowe
Denise Gorney
Lois Lockhart
Nancy Sutherland

Fiscal Year 2015-2016
CRISIS CARE
ADHOC COMMITTEE FINAL REPORT

Resources

Crisis Care Ad-Hoc Committee Members

Tammy Lowe, Dina Ortiz, Emily Strachan, John Gilmore

Information Sources

Documented and verbal status reports from the following agencies:

- Redwood Quality Management Company (RQMC) and their subcontractors Redwood Community Services (RCS) and Redwood Children’s Crisis Center (RC3)
- Ortner Management Services (OMG) and their subcontractors Integrated Crisis Management Solutions (iCMS and Manzanita)
- Mendocino County Behavioral Health and Recovery Services (BHRS)
- Mendocino Coast Hospitality Center (MCHC)
- Kemper Report: *Review of Mendocino’s County’s Administrative Service Organization Model for Mental Health Services*
- Dr. Andrea McCullough, outgoing ER doctor at Mendocino Coast Hospital
- The names and affiliations of the individuals spoken to are listed at the end of this report

Background

The topics of this crisis ad hoc committee goals were to:

- Track the implementation of consolidation of services at the MCHC
- Report on the topics identified as gaps in last year’s crisis committee report:
 - Delay of AB 1421 Implementation
 - Local Crisis Residential Treatment Center
 - A Robust and Accessible Substance Abuse Treatment Program
 - A Fully Operational, State of the Art Electronic Medical Records Program
 - Consistently applied Crisis Services, 5150 Rescission Procedures, and Follow Through at all service locations.

Report

This report is guided by the recommendation of last year's Crisis Committee to to more completely identify the specific challenges as well as best options and resolutions to issues noted in this [2015] report.”

MCHC/coastal crisis beds

Renovations of potential office space at MCHC should be completed this summer, though the Center has no plans or capability to provide crisis services and beds.

There are two beds at Hospitality House Shelter that are currently used by iCMS to place stabilized homeless people with mental health needs. These are not respite bed and these are not crisis beds. There are no crisis beds or shelter on the coast in Mendocino County at this time.

Up to 24 people can be accommodated at one time at the Hospitality House Shelter, per the Use Permit. These beds are currently full. Up to 15 people can be housed in Transitional Housing on Harrison Street at one time, per the Use Permit & HUD standards. This facility is also full.

From the summer of 2016, once the construction of kitchens is finished, up to 10 people will be able to be housed in Transitional Housing on Franklin Street in Fort Bragg at the MCHC (formerly known as the Old Coast Hotel), per HUD standards. Construction is on schedule.

The Attachments to this report begin with observations of Committee Member Tammy Lowe based on recent interviews with homeless and/or mentally ill individuals in Fort Bragg.

Delay of AB 1421 Implementation

The AOT program was implemented January 1, 2016, as a one-year pilot. It can serve up to four clients at a time.

Suzanne Yonts Baughman is interim AOT Coordinator and is able to accept and triage referrals. Interviews for a permanent AOT Coordinator occurred the week of April 18. They produced a request to hire which is awaiting response at the time of this report.

The program has received four referrals to date. One did not qualify and was referred to community resources. Two appear to meet the criteria based on information presented by the referring individual, and the AOT coordinator is outreaching with these clients to start the engagement process and make sure that all criteria are met. The last is a new referral with criteria assessment in process.

Local Crisis Residential Treatment Center

SB 82

An extension until June 30, 2017, was requested for an SB 82 Wellness Grant for Crisis Residential Treatment because a proposed building didn't work out. An extension was awarded, county is awaiting confirmation of the new deadline date.

Ballot proposal

Supporters have begun collecting signatures to place the "Mental Health Facility Development Ordinance of 2016" also apparently called the "Initiative to Revive Mental Health Services" on the November ballot. The ordinance was developed by Sheriff Tom Allman and a 12-member planning team which he assembled.

The ordinance would levy a 1/2 cent county sales tax limited to five years and expected to raise \$22 million to create a locked psychiatric facility in the county. Membership is specified for a "politically independent oversight committee" to track all spending of the proposition funding.

Staffing and ongoing operational costs are specifically excluded on the basis that they would be met by savings from current payments to out-of-county facilities and by improved management of existing county funds.

The initiative also includes development of a training facility for mental health and public safety professionals, along with citizens.

As of this report, the MHAB has no position on this proposal.

A Robust and Accessible Substance Abuse Treatment Program

The committee did not investigate this topic in sufficient detail to report.

A Fully Operational, State of the Art Electronic Medical Records Program

The Kemper report recommended that both ASO's fully develop either interfaces or systems that support the Electronic Medical Records Program by July 1st. OMG did not operate an EMRP and was scheduled to be converted to the county's AVATAR system, RQMC operated their own EXIOM system.

Since the departure of OMG, RQMC and the county have committed to meeting the July 1st deadline for medical records for all SMI patients. RQMC will take the responsibility of transferring OMG's client base to RQMC's EXIOM system. RQMC has allocated dollars to modify EXIOM to support the subcontractors and subcontractor training. RQMC is proceeding to create interface files to feed the county's AVATAR System.

Consistently applied crisis services, 5150 rescission procedures, and follow through at all service locations:

The following observations pertain to the coast, which was the committee's focus.

Lengthy response times remain common evenings and weekends.

Dr. McCullough reported that relations with crisis caseworkers coming to the Mendocino Coast Hospital have much improved since her report to the MHAB in January. They have been more responsive, courteous, and communicative, and circumspect about placing patients on 5150 holds. Having a doctor or PNP at least on call to advise on medications would be extremely helpful. Crisis workers often have no knowledge of medications.

Staff at the iCMS (to be RCS) and RC3 access centers reported that the police have unquestionably become much more skillful at identifying mental health issues and dealing with crises.

Staff at both centers expressed concern that ready follow-through and communication about medication regimens and compliance will be disrupted when the county assumes med and psychiatric services July 1 and psychiatrist Dr. Garratt and PNP Tim Jackinsky move from the iCMS center to a county mental health office.

The iCMS center has recently experienced staff reductions likely to impact timely intake of clients. John Wizner moved to RC3 and has not been replaced, leaving only Rob Henderson to respond to crisis calls. An LMFT skilled with intake transferred to the Youth Project, also without replacement.

Staff anticipate that continuity of crisis care will be greatly enhanced by both initial crisis response and up to two months of stabilizing care being handled by a single agency (RCS or RC3) contracted by RQMC.

Summary:

The Mendocino County BOS is to be commended on their effort to identify and correct the deficiencies associated with outsourcing mental health services. The engagement of the Kemper Consulting group and the implementation of their recommendations are keys to a functioning mental health service.

However, the capacity to properly handle mental health crises has been and is continuing to be impaired by ever and rapidly changing players and plans. The transfer of adult services to RQMC from OMG, early stage of developing services at the MCHC, migration of psychiatric and prescription services to the county, and changes in personnel at the county level all contribute to a chaotic environment.

Supplemental Information

1. Interviews with homeless and mentally ill homeless people by Tammy Lowe
2. Most recent (March 2016) monthly crisis data from iCMS
3. Most recent (March 2016) monthly crisis data from RQMC

Interviews

Crisis Care Committee members spoke with the following individuals:

1. Tim Shraeder, Chandra Gonsales — RQMC
2. Rob Henderson, John Wizner — iCMS Access Center, Fort Bragg.
3. John Wizner, Melissa Cornell — RC3, Fort Bragg
4. Andrea McCullough, M.D. — emergency room, Mendocino Coast District Hospital
5. Anna Shaw — Mendocino Coast Hospitality Center
6. Doug Gherkin — Mendocino County Mental Health Officer

Attachments

Interviews with the Homeless/Mentally Ill Homeless Population

by Tammy Lowe, April 2016

Having once again gone to the streets to speak with the homeless/mentally ill homeless population: They come to the coast because their is access to food (local churches and the Hospitality Center) And the climate is mostly mild as for camping in the woods or sleeping in the parks or under bridges. I spoke to people whom have come from as far away as New York and as close as Ukiah the man from New York traveled here because a friend told him the climate was mild for living outside and that the churches and Hospitality Center provided meals. the person from Ukiah relocated here when the shelter in Ukiah CA closed.

I encountered one man whom said he does not use the Hospitality Center because they will not help him because of his Medical marijuana use he has his medical card but he refuses to give up his marijuana use because it is his only form of medical treatment as he does not want to use western medicine to treat a on going life long condition in which he suffers. He was very

disappointed in that he can not access housing services thru the program here on the coast. He asked me did I know if there would ever be a change to the housing programs that would allow medical marijuana use. I told him I would include this detail in my report.



Outpatient Treatment	30 Days	FYTD
Admissions	98	857
Discharges	55	463
Response Time (Average Days from Initial Request to Billable Service)	4.06	5.2 days
Census (Total Number of Unduplicated Outpatients)	970	1397

Psychiatric Hospitalization	30 Days	FYTD
Admissions	7	89
Discharges	6	77
Average Days from Discharge to Post-Discharge Interview	1	1.5 days
Readmissions within 30 Days	1	6
Readmissions within 60 Days (excludes 30 day readmissions)	0	3
Total Inpatient Hospital Days	47	506
Average Length of Stay	7.8 days	8.96 days

5150	30 Days	FYTD
Total 5150	14	105
Upheld	7	85
Rescinded	7	21
Average response time to assessment	22.04 min	19.47 min

Crisis Services	30 Days	FYTD
Total Crisis Contacts	130	887
Emergency Mental Health Assessments	49	357
RC3 Scheduled Psychiatric Appointments	3	64

Note: Medication Support Services are provided through local FQHC's or client preference for psychiatrist. RQMC contracts with Mendocino Community Health Clinic for the services of Dr. Rebecca Timme, and each crisis client is guaranteed a follow-up psychiatric appointment within 48 hours of hospital discharge. Every crisis case is reviewed with Dr. Timme weekly, with 24/7 consult available. RC3 tracks all psychiatric appointments made, however this usually occurs prior to an intake for outpatient mental health services, thus many of these appointments do not fall on the Access Log per the County's reporting instructions.

Payer Source for New Admissions	30 Days	FYTD
Medi-Cal	87	658
Indigent	7	23
Other	4	78



Access / Crisis Response
March 2016

Total	Crisis	Access	
760 (total calls)	87	65	Number of crisis / access calls & walk-in
5			Number of clients served in Spanish
705			Number of clients served in English

Total	Crisis	Access	
81	59	22	Billable clinical assessments: CIC / BPSA
	0:48	13 days	Average response time (time from referral to face to face)
	04:39	67 days	High response time (from referral to face to face)
	0:00	0 days	Low response time (from referral to face to face)

Total	Within goal	Over goal	Goal Met Percentage	Crisis – Crisis Intervention Contact Response Time
59	51	8	86%	Total Response
39	35	4	90%	Regular clinic hours, between hours of 0900-1700 Goal = within 1 hour
20	16	4	80%	After hours, between 1700-0900; Goal = within 2 hours.

Total	Within goal	Over goal	Goal Met Percentage	Access (BPSA) Response Time
22	18	4	82%	Goal: Monitor timeliness of appointments. Reduce appointment timeline from 23 days to 14 days. A minimum of 75% will meet the timeline.

Total	Within goal	Over goal	Goal Met Percentage	Psychiatry Response Time
16	4	12	25%	Goal: Monitor timeliness of routine (initial) medication appointments. The goal is to provide the initial medical appointment within 30 calendar days from first request. A minimum of 75% will meet this timeline.

Data source: Access / Crisis Log

Crisis:
 CIC: 4 presented, 1
 Factors not met: 21
 Upheld / criteria based: 32
 Unable to assess: 7

CIC #1 (avg): 16
 CIC Willow: 6
 CIC Ukiah: 31

CIC high response time:
 14/31 not medically cleared

Access high response time:
 67 days

Psychiatry high response time:
 ...

March 5, 2016

To: John Wetzler
Chair, Mendocino County Behavioral Health
Advisory Board

RE: Jail Squad Ad Hoc Committee Update

Dear John:

On Friday March 4th, Jan, Margie, Maureen, and myself were given a tour of the Mendocino County Jail facility by Sgt. Stephen Bohner. I think I can speak for the group and say we were pleasantly surprised with the cleanliness and orderliness of the facility. The tour was comprehensive in explaining the different classes of inmate's, the reasons for their classifications, and their treatment for theirs and the jail staff's protection. We found their approach sensible and straightforward.

Clearly the pressures put upon the facility by realignment and the County's heightened mental health issues have been challenging, though adjustments made to serve each inmates needs were impressive.

The 5150 inmates are generally in lock down and are often taken to the hospital for medical clearance. Depending upon the particular mental health challenges for an inmate, there is a dorm in the wing that serves those that don't pose a threat to themselves or others – offering a more social environment which we know is so important. We also found out that there are program rooms for visitation from legal counsel, a pastor, and NA and AA counsellors are available for inmates on a limited based for those that want them. There are also medical and dental support services available.

The facility does do a limited amount of rehab even under its crowded conditions. These include work programs off-site, and an impressive on-site gardening program. There are also different opportunities for inmates to gain more freedoms based upon good behavior.

We are still trying to collect a survey provided to Lt. Pearce last year, and want to make an appointment with inmate services, which are only available during the day.

We were glad for this opportunity to learn a bit more about the services the jail provides inmates, and look forward to exploring more ways to serve those within our concern.

Sincerely,

Cathy Harpe, and members of the Jail Squad Ad Hoc Committee

The following survey was presented to the Mendocino County Jail Staff as part of the 2014-2015 Annual Report. Following several requests for response the following survey was provided on May 13, 2016. Lack of staffing was given as the primary reason for the delayed and dated data.

MENDOCINO COUNTY MENTAL HEALTH 2015 JAIL SURVEY
 County of Mendocino Sheriff's Office Jail, 951 Low Gap Road, Ukiah, CA 95482

Director of Program: Taylor Fithian MD
 Phone _____ email _____

GENERAL JAIL DEMOGRAPHICS

COMPLETED BY:
 Name Adam Teske
 Position _____

Average range of daily census for the past year: _____ to _____

Total number of bed spaces: Men: _____ Women: _____ Safety Cells: _____ Solitary: _____

Number of unduplicated clients seen by the jail mental health program in 2013: _____ 2014: _____

Estimated/Cost of Mental Health Services for Jail in FY 2013: _____ FY 2014: _____

Average monthly incarceration Total intake: _____ Male: _____ Female: _____

Total released: _____ Male: _____ Female: _____

Total retained: _____ Male: _____ Female: _____

2013 Incarceration demographics: Native Am. _____ % Hispanic _____ % African Am. _____ %
 White _____ % Asian _____ % Other _____ %

2014 Incarceration demographics: Native Am. _____ % Hispanic _____ % African Am. _____ %
 White _____ % Asian _____ % Other _____ %

JAIL MENTAL HEALTH DEMOGRAPHICS

Estimated Incarcerated with mental health issues: FY 2013 652 FY 2014 600

Number of individuals diagnosed while in custody: FY 2013 _____ FY 2014 _____

Number of individuals with MH referral: FY 2013 _____ FY 2014 _____

Inmates with severe mental illness by gender FY 2013: Male _____ Female _____

Inmates with severe mental illness by gender FY 2014: Male _____ Female _____

Estimated time:

To be seen by MH staff: 24HR To be evaluated: 24HR To be seen by psychiatrist: 7DAYS

JAIL MENTAL HEALTH TREATMENT ISSUES:

COMPLETED BY:
Name CLAIRE TESKE
Position Program Manager

Is your treatment program licensed, accredited, or LPS certified? Y N By whom? _____

What percentages of inmates receive ongoing mental health services? Men ___% Women ___% Total ___%

What percentage by demographics? Native Am. ___% Hispanic ___% African Am. ___%
White ___% Asian ___% Other ___%

Other than crisis intervention, which individuals do you provide ongoing health services to?

- Severe Mental Illness
- Substance Abuse
- Development Disorders
- Adjustment Disorders

COMMENTS: _____

Is there dedicated housing in the jail for individuals with mental disorders? YES NO

Please describe how mental health clients are housed: MOST ARE HOUSED IN
Single cells due to their need for protection

Are privileges different for individuals with mental disorders? YES NO

If Yes, please explain: _____

Do you have mental health treatment services that address co-occurring disorders? YES NO
(e.g. mentally ill, substance abuse, HIV, etc.)

If Yes, please explain: _____

Do you routinely initiate anti-depressant medication for inmates who have not been prescribed anti-depressants prior to incarceration?
 Frequently Sometimes Rarely Never

Do you have a formulary? YES NO

Do you routinely prescribe SSRI anti-depressants? Frequently Sometimes Rarely Never

Do you routinely prescribe atypical anti-psychotic medications?

Frequently Sometimes Rarely Never

Do you have strategies to control the cost of atypical anti-psychotic and SSRI medications? YES NO

If Yes, please explain: Formulary Exception Request
Approval from MH Director

Are psychiatric medications involuntarily administered in the jail? YES NO

If No, please describe how inmates with an acute psychiatric disorder receive treatment:

Do you have a unit in the jail where you treat and house inmates on a 5150? YES NO

If No, please describe how inmates with an acute psychiatric disorder receive treatment:
Placed in safety cell

Are inmates under 1372PC housed in specialized housing? YES NO

If YES, please describe the specialized housing:

Do inmates under 1372PC receive involuntary medication while in your jail? YES NO

Do inmates under 1372PC decompensate because they are not medication compliant within your jail?

Frequently Sometimes Rarely Never

If an inmate is under 1372PC, how is competency restored?
Sent to state hospital; or receive training
from local Training Program @ jail

Please describe where the conservatorship process is initiated for your inmates:

- In an acute facility
- In the correctional facility
- Other: Court / Atty

Does your jail policy provide for specialized housing for inmates at risk of suicide? YES NO

If YES, please describe the specialized housing: Safety Cell

How many suicides in your jail in the past five years? _____ Year to date? _____

How many suicides were attempted in your jail in the past five years? _____ Year to date? _____

How many of those people who committed suicides were evaluated by mental health? _____

Are at risk inmates housed with others whenever possible? YES NO

If NO, please explain: _____

Are at risk inmates observed more frequently by custody staff? YES NO

Do you use any suicide resistant garments for at risk inmates? YES NO

Do you routinely evaluate 187PC inmates for suicide risk? YES NO

Does the custody staff receive annual suicide prevention training? YES NO

How do male inmates in your jail shave?

- Razors are checked out by custody staff
- Inmates keep razors unless on suicide prevention
- Inmates on suicide prevention shave while observed
- Electric razor
- Other: _____

Do you have a formal review after a suicide? YES NO

Do you have a formal review after a suicide attempt? YES NO

Do these reviews include staff from: Mental Health Medical Custody Other: QA committee

Do you have a critical incident stress de-briefing after a suicide or serious attempt for inmates? YES NO

Do you have a critical incident stress de-briefing after a suicide or serious attempt for staff? YES NO

Do you have a quality improvement program? YES NO

What clinical information is routinely provided on an inter-facility transfer to CDCR when a client is leaving for prison?

- None
- Medications
- Diagnosis
- Treatment Course
- None
- Other: _____

COMMUNITY DIVERSION AND CONNECTIONS:

COMPLETED BY:

Name _____

Position _____

- Do you have actively link jail clients with community-based mental health programs? YES NO
- Do you have the capacity to transport special needs inmates to community programs? YES NO
- Is community resource information provided to inmates/clients upon release? YES NO
- Do you have a have a mental health diversion/alternative program? YES NO
- Do your forensic mental health staff provide followup with clients after placement in a community setting? YES NO

If YES, please explain: _____

Do you have available data relating to recidivism and linkages to case managers? YES NO
If YES, please attach a copy of your most recent data.

Do you have a mental health court? YES NO

If YES, how many clients have been successfully served? _____

ADDITIONAL COMMENTS:

ADMINISTRATION AND FISCAL:

COMPLETED BY:

Name _____

Position _____

Does your program provide training to the custody staff? YES NO

If YES, please describe the subjects covered and the frequency of training: _____

Annual Training:

Is correctional staff given formal training on recognizing Mental Illness or co-occurring disorders? YES NO

Do you have a chemical dependency program in your jail? YES NO

The Forensic Mental Health system is part of:

- Sheriff's Department
- Health Department
- Mental Health Department
- Contract Agency
- Other: _____

Is there any routine screening by corrections staff of inmates who remain in custody over 30 days? YES NO

If YES, please describe: _____

ADDITIONAL COMMENTS:

MONTHLY WORKLOAD STATISTICS 2014

CATEGORY	MENDOCINO ADULT FACILITIES												YTD TOTALS
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
1. MEDICATION ADMINISTERED	11870	11,234	11,890	8,714	13456	9,780	8,956	12,709	8279	8,686	7963	9041	121578
2. OTC MEDICATION ADMINISTERED	51	56	76	118	76	507	145	123	123	78	87	70	1110
3. SICK CALL	233	185	164	221	222	216	273	181	147	264	194	263	2673
4. PHYSICIAN SICK CALL	49	47	59	63	69	64	48	56	52	44	37	62	630
5. DENTAL VISIT/ON-SITE	27	25	7	30	16	22	15	29	21	18	21	29	260
6. DENTAL VISIT/ON-CALL SURGERY OFF-SITE	0	0	1	0	0	1	0	0	0	1	0	0	3
7. EMERGENCY ROOM VISITS	9	10	6	9	4	8	9	5	8	11	3	12	92
8. HOSPITAL DAYS	6	3	0	3	8	0	3	0	0	1	2	1	27
9. HEALTH INVENTORY	140	121	117	53	73	107	136	112	110	124	57	90	1250
10. MENTAL HEALTH WORKER	163	181	145	83	172	159	202	167	166	164	154	141	1887
11. PSYCHIATRIC CONTACTS	41	49	44	41	49	63	66	42	54	44	56	52	601
12. TB SCREENINGS	140	121	112	53	70	105	130	110	110	120	65	90	1226
13. ON-SITE X-RAYS	4	6	6	6	6	4	4	4	7	3	3	7	58
14. OFF-SITE X-RAYS	0	1	0	0	2	0	3	3	2	0	0	0	12
15. REFERRAL DAYS	0	0	0	0	0	0	0	0	0	0	0	0	0
16. 6 MONTH PHYSICALS	8	8	6	5	8	5	5	5	6	5	5	8	75
17. SPECIALTY SERVICES													
A. ORIGIN OFF-SITE	2	3	4	3	3	1	3	3	5	3	3	2	36
B. ORTHOPEDIC	0	0	0	1	0	1	0	0	1	1	3	3	10
C. CARBOLOGY	0	0	0	0	0	0	0	0	0	0	0	0	1
D. OUTPATIENT SURGERY	1	0	0	0	0	1	1	1	0	0	2	1	7
E. SCANS (CT/MRI/TUMORS)	2	0	1	4	1	1	1	1	0	0	0	0	13
F. ENT	0	0	0	0	0	0	0	0	0	1	0	1	3
G. OPHTHALMOLOGY	0	0	0	0	0	0	0	0	0	1	0	0	1
H. OTHER	0	0	1	6	4	0	0	5	0	4	4	2	26
18. CONFERRED COMMUNICABLE DISEASES													
A. TB	0	0	0	0	0	0	0	0	0	0	0	0	0
B. HIV	0	0	0	0	0	0	0	0	0	0	0	0	0
C. HEPATITIS A	0	0	0	0	0	0	0	0	0	0	0	0	0
D. HEPATITIS B	0	0	0	0	0	0	0	0	0	0	0	0	0
E. MENINGITIS	0	0	0	0	0	0	0	0	0	0	0	0	0
F. STD	0	1	0	2	1	1	1	1	2	0	0	0	9
G. ECTOPARASITES	1	0	0	0	0	0	1	0	0	0	0	0	4
H. OTHER	0	0	0	0	0	0	0	0	0	0	0	0	0
19. ACCIDENTS													
A. INMATE DEATHS	0	0	0	0	0	1	0	0	0	0	0	0	1
B. INMATE GRIEVANCES	10	6	5	5	5	4	5	3	6	6	5	5	65
C. SUCIDE ATTEMPTS	0	2	2	1	0	0	0	1	0	0	0	0	6
AVERAGE DAILY INMATE POPULATION	272	293	294	280	293	295	300	294	290	301	299	296	292.92

MONTHLY WORKLOAD STATISTICS 2013

CATEGORY	MENDOCINO ADULT FACILITIES												YTD TOTALS
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
1. MEDICATION ADMINISTERED	8600	11,993	10,545	11,949	10,345	11,399	10,970	10,670	12,407	12,538	11,997	9093	133,048
2. QTC MEDICATION ADMINISTERED	150	75	96	38	56	126	80	126	178	89	123	78	1,146
3. SICK CALL	207	180	171	231	279	194	140	184	146	254	140	164	2,396
4. PHYSICIAN SICK CALL	62	48	40	51	60	57	56	60	28	52	30	43	592
5. GENITAL VISIT ROOM SITE	15	22	16	17	19	22	23	22	17	17	11	11	212
6. GENITAL VISIT ORAL SURGERY OFF-SITE	0	0	0	0	0	0	0	0	0	0	1	0	1
7. EMERGENCY ROOM VISITS	4	3	4	2	6	4	5	2	4	6	2	7	48
8. HOSPITAL DAYS	1	0	0	2	1	2	2	0	0	0	0	0	11
9. HEALTH MONITORY	117	91	118	80	102	84	119	101	72	121	81	81	1,137
10. MENTAL HEALTH WORKER	182	167	187	199	205	137	132	194	141	170	150	102	1,838
11. PSYCHIATRIC CONTRACTS	98	46	61	73	84	63	97	30	48	49	48	65	652
12. TB SCREENINGS	115	88	116	78	98	80	110	88	140	121	2	2	1,048
13. ON-SITE X-RAYS	7	3	2	7	6	9	8	6	6	5	4	4	64
14. OFF-SITE X-RAYS	1	0	1	0	0	0	2	1	0	0	0	1	6
15. INPATIENT DAYS	1	0	0	0	0	0	0	0	0	0	0	0	0
16. 6 MONTH PHYSICALS	4	6	4	6	7	5	4	6	6	6	4	4	61
17. SPECIALTY SERVICES	0	1	0	0	0	1	0	4	2	8	8	10	36
A. OBSTETRY	0	0	0	0	0	1	0	0	0	0	0	0	1
B. ORTHOPEDIC	0	0	0	0	0	1	0	0	0	0	0	0	1
C. CARDIOLOGY	0	0	0	0	0	0	0	0	0	0	0	0	0
D. OUTPATIENT SURGERY	0	0	0	0	0	0	0	0	0	0	0	0	0
E. SCANS (CT/MRI/ULTRASOUND)	1	0	0	1	0	1	0	1	0	0	0	0	4
F. ENT	0	0	0	0	0	0	0	0	0	0	0	0	0
G. OPHTHALMOLOGY	1	0	1	0	0	0	0	0	0	0	0	0	2
H. OTHER	1	0	2	1	2	1	2	0	0	0	2	1	21
18. COMPREHENSIVE COMMUNICABLE DISEASES	0	0	0	0	0	0	0	0	0	0	0	0	0
A. TB	0	0	0	0	0	0	0	0	0	0	0	0	0
B. HIV	0	0	0	0	0	0	0	0	0	0	0	0	0
C. HEPATITIS A	0	0	0	0	0	0	0	0	0	0	0	0	0
D. HEPATITIS B	0	0	0	0	0	0	0	0	0	0	0	0	0
E. MENINGITIS	0	0	0	0	0	0	0	0	0	0	0	0	0
F. STD	1	0	0	1	0	0	0	0	1	2	0	1	6
G. SICKLECELL	1	0	0	2	1	0	2	2	1	4	0	2	12
H. OTHER	0	0	0	0	0	0	0	0	0	0	0	0	0
19. INCIDENTS	0	0	0	0	0	0	0	0	1	1	0	0	2
A. INMATE DEATHS	4	4	4	5	6	4	8	6	2	2	3	4	54
B. INMATE SUICIDES	1	0	0	0	0	0	1	0	0	0	0	0	2
C. SUICIDE ATTEMPTS	1	0	0	0	0	0	1	0	0	0	0	0	2
AVERAGE DAILY INMATE POPULATION	271	281	275	282	278	283	288	285	293	293	285	286	285.83

Mental Health Service Act for the year of 2015-2016

On October 21, 2016, the Mental Health Director was moved to another position in the county. The Health and Human Service Director then became the interim director, along with all the other responsibilities of this position. In March, the Deputy Director of Mental Health was selected to be the director. During this time of transition, a private provider, Kemper, was contracted to audit the service delivery of Redwood Management and Ortner, the ASOs. The Kemper report recommended keeping the ASOs and developing contracts that addressed many issues that were not addressed in the original contracts. The County Board of Supervisors, voted to not to follow the Kemper report recommendation of keeping Ortner, the adult contractors, but to transfer the adult services; but instead to open the bid up for other contractors. Several days later Ortner resigned as the provider of adult services. The adult contract was then transferred to Redwood Management, the children service contractor.

In the meantime, the Sheriff has been advocating for a Psychiatric Health Facility for the County supported by a one half sales tax. The Sheriff is diligently working on putting the half cent sales tax on the ballot.

The mental health board recommendations for last year were

1. Increasing Psychiatric Services. Psychiatry options were reviewed as requested and both the Child & Youth and Adult and Older Adult.

There are 3 medical providers, 2 physician Assistants and 1 psychiatrist for adult services. There is one psychiatrist for children's services. No expansion from last year.

2. Increasing Life Skills. The Wellness Centers all provide a variety of Life Skills programs. Full Service Partnerships continue to focus on development and improvement of vocational and life skills.

The Wellness & Resource Centers activities are one of the areas that Mental Health Plan Providers are able to be the most responsive.

3. Utilizing Benchmarks & Outcome measures. All County services measure improvement through use of ANSA (Adult Needs & Strengths Assessment) & CANS (Child & Adolescent Needs and Strength) assessments, and other outcome measurement tools implemented every six months. Full Service Partnerships track improvements through the reporting documents. Prevention & Early intervention programs use a screening tool.

The Mental Health board has asked for these outcome measures, but has never received them. Recommendation of using a Dashboard or even a spread sheet which would include the amount of crisis contacts, hospitalizations, arrests, incarcerations, homelessness, age, ethnicity, gender, employment and diagnosis would be easy to read and could disclose the information.

4. Incorporating Assisted Outpatient Treatment. (In particular law enforcement and family member referred) Full Service Partnership model of integrated care management, and outreach and engagement is offered to the four age populations.

Outreach meaning “go to where the person is”. If the person is under the bridge, at the library, at the community kitchen, in the jail, etc. The outreach worker would go there. The outreach worker would be an advocate, a source for referrals, transportation, help with obtaining and keeping housed, helping with employment, maybe acting as a job coach if needed. “ Whatever it takes”

5. Improving Peer to Peer involvement. All Wellness Centers utilize Peer Care managers and staff. Additionally the TAY program has Peer Mentors, 11 o'clock Calendar and the FSP's also use peer providers.

A Peer support grant has been applied for by the county, this was recommended by the Mental Health Board. (Update: The County was not granted this grant, but encouraged to reapply.)

6. Meeting Care Management Ratio Standards.

The current ratio is at or below industry standard.

7. Establish Crisis Stabilization Unit/Psychiatric Hospital Facility. Mendocino County is not able to pursue an inpatient unit at this time. The county has increased the number of Access (Crisis) centers with the change in Outpatient service delivery. In FY 14/15 implementation of Mobile Prevention Services was initiated through integrated care coordination services. Crisis response includes offering 60 days post crisis follow up for safety and stabilization. The response in the Access centers has increased to include urgent services, respite, and expanded after crisis care services. There is intent to further expand these services in the 3-year plan. In FY 15/16 we will be applying for a Wellness Grant that if awarded may be implemented into a crisis residential treatment program.

The Wellness Grant was awarded, but there has been no movement to develop a Crisis Stabilization Unit and if the money is not used soon, it will be returned to the State.

(Update: This award has been extended for one year.)

8. Improve Vocational Rehabilitation Services. (Also Vocational Programs such as programs through Mendocino Community College) Rehabilitation services are offered through the Wellness Centers (see above description of life skills). Youth Wellness Centers include a contract with the Department of Rehabilitation to provide employment support as well as other Employment Support Programs. Additionally there is intent for a greater focus of vocational skills in the Full Service Partnership in the next 3 years. In FY 14/15 the Workforce Education & Training workgroup has been discussing programs and certification processes through Mendocino Community College.

The Mental Health Board needs numbers, how many people are in training, how many have been employed and for how long. How many are in college.

9. Incorporate De-Stigmatization programs. In the past year Mendocino County and our MHSA service providers have offered de-stigmatization education & training in the schools, and through outreach programs. We have developed and implemented Outreach Fairs to distribute information and resources for Behavioral Health. In FY 14/15 we increased the number of Outreach Events we participated in, including a special Awareness event in May. We have participated in the CalMHSA Know the Signs, Each Mind Matters & North Bay Suicide Prevention campaigns and have increased advertising of signs/symptoms, resources, and comfort level with discussing suicide. We have implemented an annual week long Suicide Awareness activities. We have implemented regular community trainings related to increasing awareness of and addressing signs and symptoms of suicide (QPR, ASIST, safeTALK, BASCIA Network Training). The Arbor (Youth Resource Center) has been a part of several de-stigmatization workshops and trainings with Mendocino County Office of Education (MCOE). There are plans for CIT trainings in the rural communities as well as other increased awareness and de-stigmatization events that are planned for the next 3-Year cycle. Additionally in FY 14/15, implementation of a Mobile Outreach and Prevention Services program was initiated through Specialty Mental Health Integrated Care Coordination Model to respond to the early needs of those in outlying areas to connect them with services and reduce the need for emergency intervention.

Stigmatization continues to be a very large barrier to mental health services. I strongly recommend that radio and TV be used to educate the communities about mental illness and the services that are provided. This can be done in English and Spanish; these media sources reach more individuals in our community.

The following is a copy of a proposal submitted in 2015 by Nuestra Casa. They did not received funding and have since closed their doors.

Nuestra Casa is located in Ukiah, the seat of government for Mendocino County. Mendocino County consists of 3,510 miles that makes it the 15th largest county out of the 58 counties in California. Mendocino County's population, 89,669, comprises less than ¼ of 1% of the state's population. This population is made up of 5th generation ranchers, fisher people, loggers employed and unemployed, transplanted urban professionals, people who are seeking a simpler life style, farm workers, service workers, and laborers.

The City of Ukiah population is approximately 16,000. The greater Ukiah, City of Ukiah and the surrounding area, population is approximately 31,800. Ethnically, the population of the greater Ukiah area is 70% white, 22% Latino, 3% Native Americans, 2% Asians, 1% African Americans, and 2% bi/multiracial and/or other. The Latino population is approximately 14% foreign born, and of this 14%, 85% were born in Mexico.¹ There is no accurate data on the "undocumented" population in Mendocino County. (PEW Research Center has estimated that 24%, 2,500,000 persons, of the Nations undocumented population reside in California.)² Although, Nuestra Casa does not require information about residency, it is estimated that 80% of the clients are not eligible to vote for numerous reasons.

Of Ukiah's population, 78% who are 25 and older have a high school diploma compared to 80% national wide, 18% have a bachelor compared to 24% national wide. In 2000, the median age was 35.2, which is comparable to the national's median age of 35.3. In 2000 36% of the total numbers of families had children less than 18 years of age.³

In Ukiah, many families are impoverished, 38% of families have incomes 200% or less of the Federal Poverty level; the average income for Ukiah families in 2000 was \$36,322 (nationally the average income was \$41,994). Approximately 32% of Ukiah's Latino residents have income that are far below the Federal Poverty level compared to 12.2% of Ukiah's white/non-Hispanic residents.⁴

Mendocino County rates 46th out of the 58 counties in California for the percentage of families with children in low-income households. Approximately 22% of all children live below the

¹ United States Census 2000

² Passel JS (2005) Unauthorized migrants numbers and characteristics background briefing prepared for the Task Force on Immigration and America's Future Pew Hispanic Center, Washington D.C.

³ United States Census 2000

⁴ United States Census 200

Federal poverty line, while 40% non-white children under 5 live in poverty. 74% of Ukiah's elementary students participate in the schools' Free and Reduced Price Meal Program.⁵

In March of 2008, unemployed rate for Ukiah was 7.6%, 7.4% for the county, 6.2% for the state, and 5.1% nationally. These figures do not include the 4,750 migrant and seasonal farm workers who are unemployed 4 to 5 months each year.

The National Low Income Housing Coalition "Out of Reach Mendocino County" 2006 reported that a person working minimum wage, \$8.00 an hour at 40 hours a week, could not afford a \$416 a month apartment based on the equation, 30% of your income for housing. A minimum wage earner would have to work 1.8 fulltime jobs to afford a fair market one-bedroom apartment in Mendocino County.⁶

According to the Ukiah Unified School District, 6,400 students are enrolled for academes services. The Latino population makes up 40% of the student population. 23% of the population is English learners. There are 413 teachers in this district, 44 are bilingual.

The Ukiah Unified School District in 2007 was designated a Federal Program Improvement District for it do not met the federal criteria for Adequate Yearly Progress for 2 consecutive years. The required percent proficiency for English is 23% and for Math 23.7%. Latino students scored 21.1% for English and 23.6% for Math. English learners scored 17.8% for English and 22.9% for Math. In 2006 81% of the 10th graders passed the Ca. High School Exit Exam. 65% of the Latino students passed. In 2007, 27% of Ukiah High School graduates met the California University entrance requirements, compared to 40% stated wide.⁷

In Mendocino County documented Child abuse occurs nearly 3 times more that the statewide rate, 128 persons for 1000 vs 56 persons for every 1000. The county's foster care rates 8 out of the 58 counties in California. The ethnic breakdown in foster care last year was 4.8% African American and Native American was 17.3%. The ethnic break down for youth in the juvenile hall was 3% African American, 19 Native American, and 40% were Latinos.⁹

In 2005 survey of 200 Ukiah High School students 43% stated their parents did not disapprove of their drinking, 20% reported that their parents supplied them with alcohol.

The rate of school alcohol and other drug incidents rank Mendocino County 54th highest of the 58 counties in the State. Juvenile arrest rate for alcohol and drugs is 53 highest in the state.¹⁰ The National Institute of Drug Abuse in the publication Monitoring the Future National Survey

⁵ Children Now, California County Data Book 2007

⁶ National Low Income Housing Coalition (2006) Out Reach Mendocino County, www.nihc.org.

⁷ California Department of Education, 2007

⁹ California Department of Social Services July 2007

¹⁰ Community Indicators of Alcohol and Drug Abuse Risk: Mendocino County (2004)

Results of Drug use, 1975-2001, indicates that Latino youth are at a high risk to drink and to drink at an early age compared to African American and white/non-Hispanic. (Mendocino County ranked 47th highest in capita number of retail liquor outlets; 403.9 outlets every 100,000 persons which is 100% more than the statewide rate¹¹).

Mendocino County juvenile arrests are higher than the states. There is a daily average of 240 youth on probation. In 2007, 40% were Latinos and 28% were involved with gang activities. In the 3 years between 2002 and 2005, gang related investigations have quadrupled for 16 felony charges in 2002 to 78 in 2005.¹¹

Mendocino County Health and Human Service Agency Mental Health Branch reported in 2005, 2658 clients were provided services. This breaks down to 3 out of every 4 persons who were eligible and in need of mental health services. In comparison 4% of Latino, 67% of Native American and 73% of white/non-Hispanic received mental health services from this branch. (This disparity is reflexed by the allocation of the Mental Health Service Act funding. “..hundred of dollars were allocated to agencies that provide services to the Latino population, while thousands of dollars went to agencies with no special qualifications to serve the underserved”.)¹²¹²

Needs

In reviewing the above information, the Latino population in Mendocino County suffers from poverty, unemployment, lack of housing, the educational system, and the involvement of drugs and alcohol among the youth along with the involvement of the criminal justice system and foster care. The above challenges in conjunction with stressors of acculturation and language barriers can and do attribute to clinical depression within the Latino population. It is noteworthy to draw attention to the suicide rates of Latinos. A combination of research and data offers some insight into the scope of the problem among Latinos. When compared to other groups, Kann et al. (1998) found that Latinos were more likely to have attempted suicide (10.7%) when compared to their African American (7.3%) and non-Hispanic White (6.3%) counterparts. Latinos were also found to be more likely to consider suicide (23.1%, vs. 15.4% and 19.5%) and make a specific plan (19.6%, vs. 12.5% and 14.3%) when compared to African Americans and non-Latino Whites, respectively. Data from the Centers for Disease Control show that suicide was found to be the seventh-leading cause of potential life years lost before age 75 years and the third-leading cause of death among young Latinos 10-24 years old (CDC, MMWR, 2004). Moreover, approximately 50% of all suicides occurred among Latinos 10-34 years old.¹³

¹¹ California Alcoholic Beverage Control 2004

¹¹ Mendocino County Juvenile Probation Department

¹² Mendocino Latinos Para La Comunidad, Inc., Nuestra Casa, May 21, 2008 (1F. Community Challenges and Needs) S.H. Cowell Foundation

¹³ Critical Disparities in Latino Mental Health: Transforming Research into Action, White Pages 2005

Several years ago focus groups pertaining to the improvement of mental health services with Latinos at Nuestra Casa which included 6 participants, two males and four females; the two males participated freely and enthusiastically throughout the group; one of the females needed prodding to offer comments, while the other females did communicate freely their ideas. The outcome was based on their actual experience and lack of knowledge of mental health services; hence, recommendations to improve services were limited.

Both internal (individual) and external (systemic) factors in access to care were discussed. The internal factors included the immense stigma and lack of knowledge. According to participants, many Latinos do not know the symptoms and types of mental illnesses, what to do if some one has a mental illness, and where to seek diagnosis and treatment.

The enabling factors were related both a lack of knowledge about mental health services and alienating experiences with public health services in general. Access to services is difficult because there is no knowledge about the services and what agencies have to offer. When they did access the services, cultural and linguistic barriers often prevented clients from getting help.

Recommendations focused on access, information about mental health and about mental health services. This also included the need for bilingual/bicultural professional staff. The need for information about mental health and mental health services in Spanish in written and verbally and available to Spanish speaking people. Mental health care providers need to take more time to provide information and participants would like to feel welcomed.

Information needs to be distributed throughout the community, and that healthy activity for families needs to be available and promoted.

This focus group did provide insight about the poor penetration rate for Latinos in Mendocino County's mental health outpatient clinic. Improving services that would increase the penetration rate would include hiring bicultural/bilingual professional staff, providing mass information in Spanish about mental health and treatments. The clinic would have an atmosphere that is culturally sensitive to the clients' needs. Education about services, diagnosis and treatment would be provided to the community.

This could be done by doing ads on the Spanish speaking local radio stations, by placing ads in the local Spanish newspapers, and by doing "street theater".

STRATEGIC PLAN

Vision Statement

To provide culturally sensitive mental health services to the Latino population in the Greater Ukiah Area.

Mission

The mission and purpose of the plan is to have culturally sensitive and language appropriate mental health services to support and encourage safe and stable Latino families. Values and principles that enforce this mission are to empower and support family in their efforts to provide health an nurturing environments for their children; to reduce the toll of alcohol and other drug problems in the Latino community; to prevent child abuse and neglect by providing supportive education opportunities for Latino families; counseling, after school tutoring; to develop Latino leadership through adult and youth empowerment groups and activities; and to assist individuals and families by serving as an intermediary between local agencies, health and welfare providers, schools, and the community at large.

Criteria Issues

1. Poverty-32% of Ukiah's Latino residents live on incomes that fall below the federal poverty level.
2. Unemployment rate- Ukiah has a higher rate of unemployment than the county, the state and nationally. This does not include the estimated 4,750 migrant and seasonal farm workers who are unemployed 4 to 6 months a year.
3. Housing- Families living below the federal poverty level cannot afford a one bedroom fair market apartment. 32% of Latinos in Ukiah fall below the federal poverty level.
4. Latino students enrolled at Ukiah Unified School District make up appropriately 40% of the student body. 23% of the students at UUSD are English Learners, yet out of 413 teachers employed by the district on 44 at bilingual, 9%.
5. Latino students enrolled at UUSD were below the Federal Required Percent Proficiently and only 65% of the Latinos 10th graders passed the High School Exit Exam.
6. Mendocino county Juvenile Hall population is 40% Latinos
7. The contractors of the Mendocino County Mental Health Branch provides very little services to the Latino population
8. Latino youth as documented over and over in the literature are especially high risk and even more so when residing in Mendocino County which has a high rate of juveniles abusing alcohol and street drugs.
9. According to the 2008 NYGS, half 50% of all gang members are Hispanic/latino, 32% are African American/black and 11% Caucasian.
10. Future gang member perform poorly in elementary school and generally have a low degree of commitment to and involvement in school Hill et al. 1999.

Proposed Solution

Nuestra Casa proposes to address the issue of “lack of information “ by aggressively providing information and referral services in Spanish, by providing literature in Spanish, Spanish radio ads, posters in Spanish and outreach into the Latino community. We would also use theatre as a medium to disclose information about mental illness and mental health services.

Goal is to increase the penetration rate of Latino population at the Mental Health Branch. This increase would be 25% increase within the next three years.

To provide mental health services in Spanish at Nuestra Casa. We are requesting funds to hire 2-bilingual/bicultural therapists to work with groups, families and individuals.

Goal- This would address the language and the cultural deficiencies that clients experience at county mental health.

Provide a case manager in the juvenile hall. This worker be bilingual and bicultural and would work with families and individuals.

The goal would be to decrease the Latino population incarcerated in the county juvenile hall by 5% annually

To provide a bilingual/bicultural clinician at the local high school to work with families, groups and individuals and to provide cultural diversity training to the high school staff.

The goal would be to decrease juvenile delinquency behavior and increase college entrance by Latino students. (This staff person would also be involved in graffiti clean up with community service youth after school and summers)

Two tutors to work in the after school-tutoring program.

Goal-This would increase the number of Latinos who pass the high school exit exam.

Submitted by:

Dina Ortiz

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