

**Three-Year
Program and Expenditure Plan Requirements**

**Mental Health Services Act
Community Services and Supports**

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PART I: COUNTY/COMMUNITY PUBLIC PLANNING PROCESS AND PLAN REVIEW PROCESS

Section 1.1 Planning Process

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

Trinity County's local Mental Health Services Act (MHSA) planning process was designed to facilitate and obtain meaningful participation from a broad range of stakeholders throughout this small, rural county. The process was also designed to obtain input from stakeholders who were historically unserved in the mental health system and from under-served communities.

In early January 2005, there was an initial 'kickoff' of the planning process. In preparation for the public process, presentations that explained the Mental Health Services Act were made to entire Trinity County Behavioral Staff and to the Mental Health Board. Clinicians who attended the trainings became part of the outreach team, explaining the MHSA in groups they provided and in different venues throughout the community. Two large focus groups were held in Weaverville, the county seat, while numerous smaller focus groups met throughout the county to discuss the MHSA. Prior to the group meetings, an article was written for the local newspaper, soliciting participation in the MHSA planning process. Invitations were extended to the following groups:

- Mental Health consumers
- Mental Health clients' families
- Health & Human Services Staff – including APS and CPS
- Health and Human Services clients and families
- Students and families of elementary, middle, and high schools
- Churches
- Courts
- Local Primary Health Providers
- Far Northern Regional Center
- Native American Tribal Associations
- Veterans Affairs
- Public Utilities District
- Job/Link/TOT
- Probation
- Law enforcement, including County Sheriff and Highway Patrol
- Juvenile Hall
- Local Mental Health Care Providers
- Southern Trinity Health Services
- Human Response Network

- Mental Health Board
- Trinity County Office of Education
- Shasta College

Following are other events/venues at which the MHSA was presented/discussed

- Public/televised question and answer presentation to Trinity County Board of Supervisors
- Shoppers at TOPS Market in Weaverville
- Shoppers at Wylie's Market in Hayfork
- AmeriCorps Volunteers
- Kids First Meetings
- Golden Age Center

The purpose of the meetings was to bring individuals from the community together to learn about Proposition 63, the importance of the Proposition to small county mental health programs, and to begin eliciting support for passing the proposition, as well as ideas and information to complete a comprehensive needs assessment.

The initial public forum afforded an opportunity to provide information on the values of the MHSA, as well as the importance of the opportunity for mental health transformation. The principles of consumer and family empowerment and the recovery model were also shared. This process provided a model on how to facilitate groups. Our group discussed the importance of meaningful involvement of consumers and their families, providers, other stakeholders, and the community of Trinity County in the process of planning for mental health services even if the proposition did not pass. Trinity County has no threshold languages so interpreter services were not provided or deemed necessary. Attendance was excellent, with over 30 individuals attending each of the two initial stakeholder sessions.

Following the first two large stakeholder groups, our MHSA Coordinator, Judy Hoffman coordinated and facilitated the comprehensive planning process. Ms. Hoffman was an excellent choice to provide coordination of the entire planning process. Ms. Hoffman and other Trinity County Health Services staff conducted over multiple focus groups and community stakeholder meetings to discuss the MHSA. These smaller focus groups provided the opportunity to obtain input from consumers, family members, and diverse community members. The focus groups were held throughout the county, and included the Kids First Meetings, the Mental Health Board, an open meeting of the Trinity County Board of Supervisors (a public meeting which was also televised on local cable television), the Golden Age Center, schools around the county, juvenile hall, and local community faith-based organizations. A focus group of Transition Age Youth was also conducted to facilitate the vision of a transformed mental health system for this age group.

A list of all the focus groups and community meetings that were held along with the number of participants in each group is available (see Appendix X). We plan to

utilize the survey results of this substantial outreach effort to support many years of system improvement initiatives.

The following outreach strategies were used to gather participants for the focus groups and community meetings:

Fliers were created and placed at clinics, as well as in high-traffic venues throughout the County such as libraries, stores, and Laundromats. The flyers were also mailed to key stakeholders who have participated in mental health activities during the past several years. The fliers announced the MHSA planning process and its intent to transform the system, making it more responsive to the needs of the un/under-served and inviting individuals to attend community meetings scheduled throughout the county. For two successive weeks, information booths were set up at the county's largest supermarket during peak time. Surveys and information were distributed. Shoppers had the opportunity to speak with staff knowledgeable about the MHSA.

- Refreshments and food were provided and some participants were offered stipends for their time. Transportation was arranged for those who needed assistance.
- Community input was obtained from participants in their homes and community settings, including community events, and the Senior Center. Mental Health staff also //outreached to homebound clients. Public events and other areas where target populations congregated were targeted for MHSA related outreach.
- Individuals and organizations with a history of organizing consumers and family members and working with un/under-served populations were solicited to assist in the outreach effort (e.g. church leaders, neighborhood leaders, and leaders of cultural organizations).
- Local government and non profit organizations helped Mental Health staff organize outreach efforts to consumers and families through focus groups and distribution/collection of MHSA information, collecting surveys from the individuals they serve (e.g., Human Response Network, the Trinity County Schools, CalWORKS, and the Probation Department).

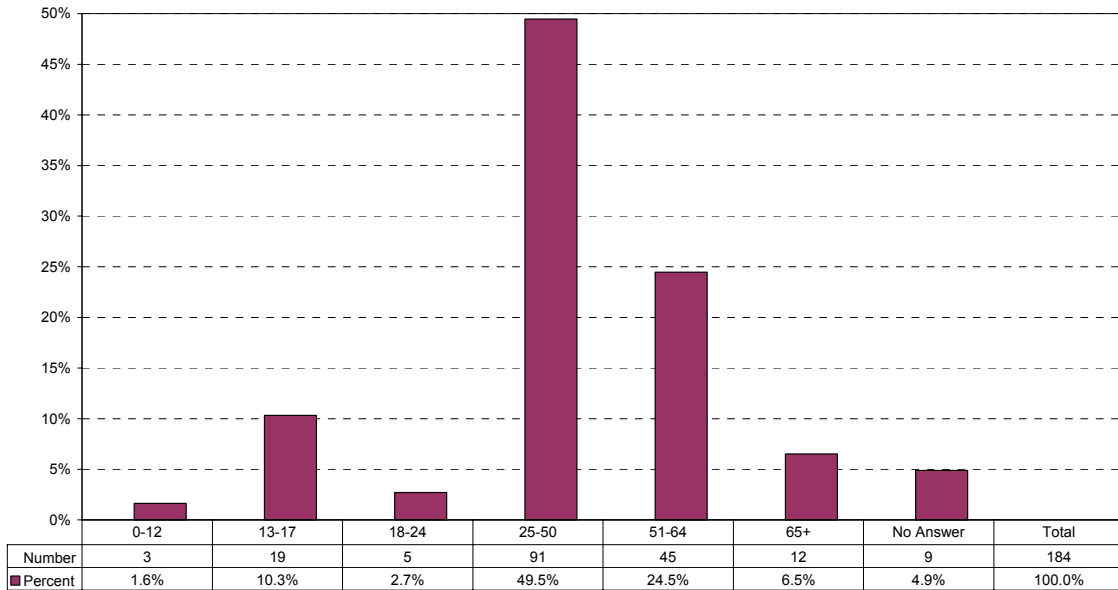
At each focus group, a brief training was conducted, explaining the core components of the MSHA, the vision and goals of the transformation, and the importance of family and consumer driven services. Following a group discussion of the service needs of the unserved and underserved, each participant was asked to complete a MHSA Survey Questionnaire. This questionnaire allowed each participant to have a unique voice in expressing his/her vision for a transformed mental health system and identify his/her own priorities for mental health services.. Individuals were also offered assistance in completing the survey.

Trinity County envisions the outreach activities for the MHSA planning process as a starting point to a sustained dialogue with neighborhood and cultural leadership. This dialogue will allow communities to be informed of the variety of mental health services available and to participate in shaping how those mental health services are delivered.

This planning process was quite comprehensive for a small county. Input was obtained from 184 individuals and involved a large number of consumers and family members. A brief summary of the findings will be discussed below.

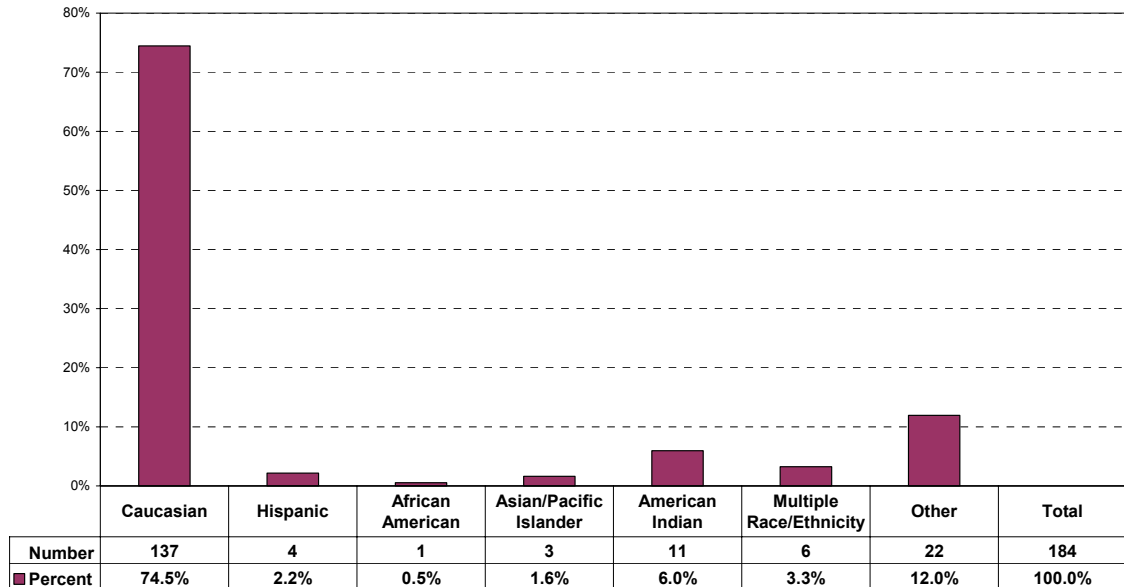
Figure 1 shows a total of 184 individuals attended our focus groups and or responded to our MHSA surveys. Twelve percent (11.9%) of these individuals were ages 0-17, 2.7% were ages 18-24, 49.5% were ages 25-50, 24.5% were 51-64 years, and 6.5% were 65 years or older. Five percent chose not to answer this question.

Figure 1
Trinity County MHSA Survey Results as of August 2005
Number and Percent of Survey Respondents by Age
N=184



The race/ethnicity of the respondents closely resembles the county population (see Figure 2). Two percent (2.2%) were Hispanic (N=4), 74.5% Caucasian, and 1.6% for Asian and 6.0% American Indian. Other Race/Ethnicity groups represented 15.3% of the respondents.

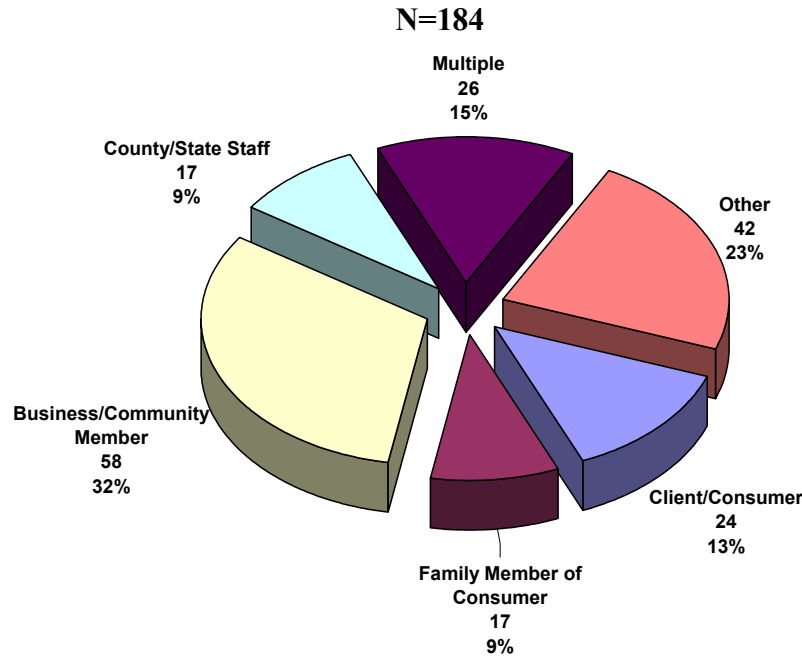
Figure 2
Trinity County MHSA Survey Results as of August 2005
Number and Percent of Survey Respondents by Race/Ethnicity
N=184



To reach family members, Ms. Hoffman actively invited individuals from across the county to participate in the planning process. There were at least 17 participants in the process who identified themselves as family members. To reach consumers, Ms. Hoffman held several smaller focus groups within mental health programs, juvenile hall, the jail, and senior centers. There were at least 24 participants in the process who identified themselves as consumers. The outreach process focused on inclusion of mental health consumers and their families and un-served populations who are not generally part of advocacy efforts.

As shown in Figure 3 below, consumers and family members had meaningful involvement in this planning process. There were 17 family members of consumers (9%) and 24 consumers (13%). These groups represent 22% of all persons who completed a survey. Consumers and family members participated and had meaningful involvement in this planning process.

Figure 3
Trinity County MHSAs Survey Results as of August 2005
Number and Percent of Survey Respondents by Self Identified Group
Affiliations



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

Figure 3 above also illustrates the comprehensiveness of the Trinity County planning process. In addition to the 41 consumers and family members, there were 58 business and community members (32%) and 17 county/state staff members (9%) who participated in the planning activities held in the county. An additional 42 individuals (23%) reported Other Affiliations, and 26 (15%) represented multiple affiliations.

Trinity’s MHSAs planning process engaged a significant number of representatives of un/under-served populations throughout the community. To reach un/under-served youth, focus groups were held at schools, and juvenile hall, and programs that provide counseling to youth. A focus group that included Transition Age Youth allowed them to give input on ‘what else they need to become independent adults’.

To reach un/under-served adults, focus groups were held and surveys distributed to persons who were homeless, living in supported housing situations, the jail

population, skilled nursing facilities, physician's offices, Public Health office, WIC, and to persons participating in substance abuse programs.

To reach un/under-served older adults a focus group was held at the Senior Center and a presentation was made to the Regional Council on Aging. In addition, homebound older adults were interviewed by staff.

Mental Health took a variety of steps to ensure the substantial involvement of both Mental Health Board and consumers and family members as leaders in the planning process. Local stakeholders were asked to send a representative from their agency to be leaders in the planning phase of the process. Consumers and family members who stated an interest in participating in the further development of the MHSA Plan were also included in the Leadership Team. Demographically, the Leadership Team is representative of our County Community and includes persons of Native American and Hispanic ethnic backgrounds, clients, family members, mental health board members and stakeholders from partner agencies, including Health and Human Services, Trinity Office of Education, Probation, Southern Trinity Health Services, and the Human Response Network.

The Leadership Team has been meeting monthly to review stakeholder input and discuss priorities. This planning culminated in a consensus on the determination of the priorities agreed on by the Leadership Team. A draft budget to fund the priorities reflecting the recommendations of the participants was structured and discussed with the Leadership Team.

Overall, our planning process closely followed the process outlined in the Trinity County Plan to Plan. The results of the planning process, including survey and focus group data, demonstrate that we were very successful in obtaining meaningful input from a representative sample of individuals, families, organizations, and other interested parties from this small, rural community.

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

Judy Hoffman, MHSA Coordinator, led the planning process in Trinity County and has devoted 50% of her time to MHSA. Trinity County also hired Virginia Allin to assist in coordinating groups and collecting data. Ms. Allin has specialized experience in organizing and facilitating focus groups.

In addition, the small but energetic staff of Trinity County Behavioral Health Services also participated in organizing focus groups, helping to distribute surveys, and collect information from concerned community members. Ms. Hoffman conducted the many of the focus groups and organized the Leadership Team meetings as well. Ms. Hoffman worked closely with consumers, family members, and case managers to assure that all participants who required transportation or other specialized services to attend the meetings obtained the needed support. She also organized consumer and family member participation during Leadership Team meetings.

Ms. Hoffman arranged stipends for reimbursement for consumer/family member attendance at Leadership team meetings. She provided the oversight and coordinated efforts to assure that consumers involved in MHSA Steering Committee meetings had travel arrangements, stipends, and training registrations completed to assure their successful attendance at MHSA related trainings offered offsite.

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

Engaging consumers, family members, and other community members who historically do not participate in community planning processes is an important first step for developing family and consumer driven services. The next critical step is to provide them with the kind of support, information, and training that allows them to participate as equal partners with other work group and Leadership Team members who are versed in reviewing data and participating in planning activities. It is also important to recognize that many agency partners which collaborate with the Mental Health program or deliver services to mental health clients (e.g. probation, social services, education) may be less familiar with the specific issues related to the delivery of mental health services or the principles and values of the MHSA and its intent to transform how those services are delivered.

The purpose of the initial focus groups was to orient stakeholders to the MHSA, to begin to train stakeholders in issues related to mental health and the transformation called for in the MHSA, and to outline the various opportunities for stakeholders to become more involved in the planning process.

In addition to the initial focus groups and trainings, virtually every meeting conducted during this process blended education and training of stakeholders with priority-setting that ultimately guided the development of this plan. Training topics offered to stakeholders, Leadership Team members, Organizational Providers, and Trinity County staff included:

- Overview of the Mental Health Services Act
- Discussion and guidance to assist in the understanding of outcome measures
- Discussion and explanation of the concept of Full Service Partnerships
- Explanation of Consumer and Family involvement in treatment

Additionally

- County Mental Health Department staff were trained on the concepts of the Recovery Model, Consumer Employment, and Consumer Culture
- Consumer and peer-based services and supports
- Wellness and recovery
- Discussions of strategies for transforming the mental health service system
- Consumer-led services
- Client empowerment

- Discussion on Evidence-Based Practices and the integration of these practices into our CSS plan development
- Culturally-competent treatment approaches
- Collaboration between service systems
- Recovery and Resiliency

By attending DMH's statewide stakeholder meetings, California Mental Health Planning Council, and the California Network of Mental Health Regional MHSA Two day Training, clients and stakeholders were trained specifically in:

- Self-Advocacy
- Developing Client Driven Services
- Recovery Principles
- In addition, Trinity County Behavioral Health sponsored a large picnic inviting consumers from Trinity County to meet with and learn from the Butte County Stomp Out Stigma Organization.

Every step in the development of the Mental Health Services Act requirements was presented to County staff, the Mental Health Board, and our MHSA Leadership Team. To facilitate these discussions and trainings, data were shared on the number of clients currently served by age, race/ethnicity, and gender; the range of services currently offered; and the current collaboration between agencies.

The initial training activities have resulted in achieving two critical goals:

- a) Building a core group of stakeholders who are knowledgeable of the current mental health system, the MHSA, and the opportunity to transform how services and supports are delivered, and
- b) Creating a plan generated by those stakeholders to produce a sense of ownership and authorship. It is particularly noteworthy that two current consumers who became involved in the MHSA planning process have now moved forward to being members of the local Mental Health Board. This is a clear demonstration of how the planning process instills a sense of empowerment, advocacy, and ownership in the County Mental Health service delivery system.

This process has helped to orient stakeholders and to improve their abilities to make key recommendations and decisions. These training experiences, in turn, will result in a Community Services and Support Plan that will be implemented with enthusiasm. These training activities will continue throughout the development, implementation, and evaluation activities of the MHSA.

Section 1.2 Plan Review

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

Trinity County made multiple efforts to assure that anyone who wanted to review the draft plan was able to do so conveniently.

- The Draft plan including the Executive Summary was posted on the county website 7/19/06. A special notice to alert visitors to the main site was included. The website invited interested individuals to contact Behavioral Health reception if a printed copy of the plan was desired.
- A newspaper article describing the local plan along with the experience of other counties was published in the Trinity Journal on 8/23/06. The article contains information about how to review the plan.
- Copies of the Plan and separate copies of the Executive Summary were available to visitors to the Behavioral Health booth at the Trinity County Fair held 8/25/06 – 8/27/06.
- Copies of the Draft plan were available to visitors to the Behavioral Health offices in Weaverville and Hayfork.
- Copies of the Draft plan and Executive Summary were available to visitors to the offices of Human Response Network, the only non-governmental agency in the county.
- Copies of the plan were reviewed at the Quality Improvement Committee meeting 8/14/06, the Adult Multidisciplinary Team Meeting 7/25/06 and the Mid-Level Management Team meeting (children's issues) 8/06 as well as with the full staff meeting for Health and Human Services 8/23/06.

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

A public hearing was conducted by the Board of Behavioral Health on 8/28/06 at the Supervisors' Conference Room of the Trinity County Library, Weaverville. There was representation from most areas of the county.

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

Comments at the public hearing were supportive. A member of the CA. Client Network spoke about how the plan development process has been empowering for consumers/ family members and indicated the commitment of Behavioral Health to partner with others in this process. She also spoke about how the plan is a living document that will change over time as we continue to work more closely. Others asked for clarification of specific items in the plan and assurance that as funds allow, there will be increased efforts to provide additional services such as an additional drop-in center in more remote parts of the county.

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

Based on the comments at the Public Hearing and during the public comment period, there were no substantive changes needed for the plan to reflect the needs and interests of our communities. The Draft Plan was approved by the Trinity County Board of Supervisors for submission to the Department of Mental Health on 9/6/06. It had

previously been approved by the Trinity County Mental Health Board on 2/1/06 with additional approvals granted as revisions were made to the Plan.

PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Section 2.1 Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

Please answer each of the following questions pertaining to how community issues resulting from a lack of community services and supports were identified in the public planning process.

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

Stakeholder input identified the following issues, by age group, as well as a number of suggestions for addressing the issues. The suggestions for addressing the issues are presented in parentheses.

Judy- Please review this table and make more relevant to Trinity. Thanks!

To me the parentheses are confusing – I would do it like so but whatever you think...I would like to see these split or at least remove the PCIT from Children/Youth box since it is so specific. I suggest issues in one table and strategies in a correlating table Also combine 2&6 in Older Adult section.

Children/Youth	TAY	Adults	Older Adults
1. *Child, peer, and family problems: Parent Child Interactive Therapy; Parenting classes	1. *Youth, peer, and family problems: (Managing behavior; Family relationship development, child welfare involvement)	1. *Housing issues: Supportive housing services; homeless services	1. *Isolation (Outreach to older adults; Mental health services to homebound older adults)
2. Need for out-of-home placement services (Mental health services for foster children and those in other placements); involvement in child welfare	2. *Need for out-of-home placement services (Services to transition youth back to the community following out-of-home placement)	2. *Ability to manage independence (Supportive employment; Benefits counseling; Supportive housing services to maintain independent living)	2. *Housing issues (Assistance to remain living independently in the community)
3. School issues include inability to be in mainstream school, school failure, and after school issues (After-school programs)	3. *Skills development to live independently (Vocational assistance; Support services to maintain independent living)	3. *Substance abuse services for dual diagnosis clients	3. *Mental health services coordinated with senior services
4. SED children in juvenile hall: Supportive mental health services for children in the juvenile justice system	4. Resolving teenage problems	4. *Wellness center for classes, services, and supports, antistigma and consumer culture activities, employment of family partners and peers	4. Transportation to services
	5. *Substance abuse services for dual diagnosis clients	Support for family and consumer networks.	5. *Substance abuse services for dual diagnosis client

	6. *Wellness Center	Supportive Services for seriously mentally ill in jail -	6. *Support services to maintain independent living
	7. SED TAY in jail or juvenile hall: Supportive services for TAY in Justice System		

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

The work groups and the Steering Committee collaborated to develop a list of criteria to apply to the ideas/issues compiled from the various focus groups and survey results. The information from the stakeholders was analyzed and utilized to prioritize the issues. Those ideas that have been selected for implementation in Trinity County met the following criteria:

- Identified as a high priority by stakeholders, as noted by the number of responses in favor of the idea, or by the number of responses citing the issue;
- Consistent with the identified unserved and underserved populations;
- Consistent with the prevalence need in Trinity County;
- Addresses the cultural needs of the community;
- Consistent with the needs of children and youth with serious emotional disturbance, and adults and older adults with serious mental illness; and
- Consistent with the focus and intent of the Mental Health Services Act.

Several issues were selected for more than one age group, including coordinated mental health and substance abuse services for dual diagnosis clients and independent living skills. Although each age group is unique, some issues are relevant to multiple populations and can be addressed through similar strategies. Each of the issues that were selected for multiple age groups met the criteria listed above and was indicated as relevant to the stakeholders.

The Steering Committee considered issues related to untreated mental illness identified by State DMH, but primarily devoted time to considering which un/under-served populations were in greatest need and which strategies could best address their needs and contribute to the transformation of the mental health system. The primary issues discussed included:

- Which un/under-served populations should be served by MHSA funding, as well as Full Service Partnerships?
- What outreach and engagement strategies should be implemented?
- What transformational structures, strategies, and supports were most important to improving the quality of life of the consumers within each age group?
- What strategies and supports were likely to meet the cultural needs of the community?

Ongoing Steering Committee meetings were comprised of consumers, family members, community leaders, County Department Heads or staff, and Mental Health Board members. Representatives from cultural communities were encouraged to

attend. The Steering Committee met monthly to review MHSA activities. This frequency provided the Committee an opportunity to comment and give feedback on the process, and provide oversight and input throughout the planning process. This planning culminated in a meeting at which Steering Committee members reviewed the priorities identified through prior input and planning and further distilled those concerns into a set of priorities reflecting the recommendations of stakeholders and planning groups.

In addition to the global criteria described above, the work groups and Steering Committee identified the following issues and factors which led to the foci of MHSA Services for this three-year plan. Overall, the stakeholder focus groups were encouraged to discuss issues and to suggest positive outcomes and strategies for addressing the issues. As a result, we will present both issues and suggested strategies in this section.

It is important to note that we have a very small community and will be receiving only a few dollars to supplement existing services. We have outlined some of the issues identified in the planning process below.

Children/Youth

1. Child, peer, and family problems were issues identified throughout the community planning process and included the need for parenting classes for parents with young children who may be involved with Child Protective Services or high-risk families. Parent Child Interactive Therapy (PCIT) was suggested as an evidence-based practice for developing parenting skills for individuals with young children. Employing this evidence-based practice would enhance existing parenting classes in the community and would offer a higher level of intensive parenting skills development focused on tailored services to families experiencing the most serious issues.
2. Out-of-home placement issues revolved around delivering mental health services for children and youth at risk of out-of-home placement, those in foster care or juvenile hall, and those returning from out-of-home placement. These issues includes the need for mental health services for families who are involved in family preservation and family reunification services. Supporting and enhancing the children's program would decrease out-of-home placement, facilitate shorter stays in out-of-home placement, and assure comprehensive, effective services through additional staff time devoted to children and families.
3. School issues including inability to be in mainstream school and school failure. This included a need for additional mental health services in the schools, along with training, screening, assessment, and various treatments in schools. There is also a need for after-school programs to involve youth and provide healthy activities to engage youth into the community. Possible evidence-based practices to be considered include Parent Child Interactive Therapy (PCIT) or related therapies?.

4. Involvement in Juvenile Justice included preventative mental health services to reduce placements in Juvenile Hall and provide services to children and youth who are already involved in the legal system.

Transition Age Youth (TAY)

1. Youth and family problems included offering programs to help youth and families manage behavior and develop family relationships. A component of this is to expand transition age services to the 21-25 population. Move the following material to the teenage problem area since it is an individual focus rather than family issue per se. At the present time, there are no services for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. There is no organized, visible therapeutic support system for youth adjusting to gay/transgender identities. A need for support focused on development of coping skills to deal with feelings of alienation, heightened levels of self consciousness, and low self esteem has been identified. I think this is a good idea and it is true but it was never identified as a need – people might see this as a small issue here.
2. Out-of-home placement and youth returning to the community after they turn 18 years were identified as an area of concern. At the present time, there is a lack of housing options for youth emancipating from care/treatment. There is concern that youth are falling through the cracks when they turn 18 years of age and dropping out of the treatment system prematurely. There is also a concern that safe housing is not available for them when they age out of their placement settings. There is a need for mental health support services to help youth develop independent living skills and help them access housing, education, and job opportunities in the community.
3. Ability to manage independence is a challenge for most transition age youth. Supportive mental health services help youth develop independent living skills and achieve goals in employment, education, stable living situation, and personal and community functioning. Assisting youth to secure benefits, when needed, was a concern identified as a priority support service to target for development. A drop-in center for youth to access support groups, peer mentors, life skills training, and other meaningful activities would promote wellness and provide a non-traditional setting for service delivery that would have a greater chance of acceptance by transition age youth compared to the traditional clinic setting. A special emphasis will be to engage Native American (*don't forget our biggest minority population*) Latino youth in participating in these services particularly since these ethnic groups are over represented in our juvenile justice system.
4. Resolving teenage problems requires involvement in multiple areas of a youth's life and includes not only counseling, but non-traditional areas of support provision in areas such as development of independent living skills, vocational skills, and social support networks. Standard modes of treatment, such as talk

therapy (although still viewed as valuable), do not deal with the comprehensive array of support services and life skills development necessary to successfully transition an individual from youth to adulthood. In order to improve our services to the Native American and Latino communities, we plan to develop a program to address issues of acculturation and assimilation. Add verbage about lesbian/gay here.

5. Substance abuse services for co-occurring disorder clients are an ongoing and growing need for Transition Age Youth with serious mental illness. Services specific to these co-occurring disorders will provide both mental health services and substance abuse services together to address the combined needs of these youth. It was identified that treatment accessibility for youth with substance abuse problems is virtually non-existent in the community. Services tailored to address both issues in an integrated service delivery package do not currently exist. Developing services which are age appropriate and culturally sensitive will be a priority.
5. Involvement in Juvenile Justice included working with Probation to reduce placements in Juvenile Hall and provide services to children and youth who are involved in the legal system.

Adults

1. Housing support included a need for safe, low-income housing with access to (*we have no public*) transportation; supportive services to help an individual remain in an independent living situation; and the need for mental health support services to aid adults who have been in residential care settings to develop independent living skills and help them access housing in the community.
2. Independent living and the development of independent living skills that help to ensure success is a challenge for many adults, and even more so for individuals with serious mental illnesses. Supportive mental health services which help adults develop independent living skills and achieve success in employment, education, stable living situations, and personal and community functioning was identified as key areas for development of new services to target. Assisting adults to secure benefits can be critical to their stability in the community. Developing a drop-in center allows a place to gather and a place for adults to develop these important life skills. It also allows adults to participate in support and life skills promoting groups, while interacting with other consumers as support persons. A drop-in or wellness center would be an important component of the adult system of care services. Creating a culturally inviting environment that fosters participation in basic life skills classes and activities would promote wellness.
3. Substance abuse services for co-occurring disorder clients are an ongoing and growing need for adults with serious mental illness. Currently, treatment availability for adults with substance abuse problems is almost non-existent and

treatment services provided in an integrated service package for individuals with diagnoses of mental illness and substance abuse are not available. Services specific to these co-occurring disorders will provide both mental health services and substance abuse services together to address the combined needs of these adults.

4. Drop-in Center or Wellness Center provides a supportive environment with a wellness focus which is offered in an alternative setting to the traditional clinic for adults. The concepts of recovery and resilience will provide the foundation to develop independent living skills and achieve goals in employment, education, stable living situations, and personal and community functioning. Providing support advocacy and assistance for adults who are having difficulty securing benefits, when needed, is an important component. Such a center would be peer run client driven programs. Participation in basic skills classes and activities would promote wellness. Offering these supportive services in a drop-in-center environment promotes engagement and empowers clients to exercise choices to participate and select services in a manner not encumbered with the traditional structure of hourly appointments in the office.

Older Adults

1. Isolation and the fear of loss of independence is an ongoing issue for older adults with mental illness. Many older adults are homebound and not able or motivated to initiate access to care. There are also issues of loneliness, isolation, and depression that have developed due to factors such as losing a spouse or a change of lifestyle brought about by physical or financial limitations. There is a need to develop integrated, multi-modal services for individuals with co-occurring serious physical illness and mental illnesses. Partnering with physical health care providers and other accepted Older Adult service providers (Senior Centers and local senior services programs), and co-locating mental health services with these already existing recognized and accepted providers is a way to outreach to this population. In our community, some of these providers are also the primary providers for the predominant ethnic minority population here. Many Latino individuals and families utilize these providers and often are identified as appropriate to receive mental health services.
2. Housing issues frequently arise for older adults with serious mental illness. Supportive mental health services which help older adults maintain independent living skills help individuals to continue living at their current level of functioning. Assisting adults to secure needed benefits, and simply helping them to complete forms, is an important component to living independently.
3. Mental Health Services in collaboration with Senior Services would help to reduce the stigma of mental health services for those individuals who are not ready to accept that they could benefit from receiving mental health services. By offering services as a component of other Center activities, individuals are more likely to

initiate discussion of issues that may be affecting their lives. Promoting easier access by offering mental health services in an environment already utilized by this population would promote utilization of mental health services in a non-threatening manner that could help these individuals maintain or improve current levels of functioning. Collaboration with existing senior services will provide the opportunity to conduct Outreach and Engagement activities to Older Adults.

4. Transportation to services is a critical issue for seniors who live in this county which covers a geographically large area. With very limited public transportation, seniors have substantial problems in getting access to care and services.
 5. Substance abuse services for co-occurring disorder clients are an ongoing and growing concern for older adults with serious mental illness. . Currently treatment for older adults with co-occurring disorders is almost non-existent and participation is further impacted by lack of a peer group and transportation issues. Older adults may also be at risk for the abuse of prescription medications and alcohol. Prescription medication abuse and unhealthy levels of alcohol use are sometimes the treatment of choice for individuals suffering from social isolation, depression, and poor adjustments to deteriorating physical health. Services specific to these co-occurring disorders will combine both mental health services and substance abuse services together to address the multiple needs of these older adults.
 6. Support services to maintain independent living are critical for helping older adults maintain their ability to prepare meals; shop; budget and pay bills; and manage their medications.
- 3) *Please describe the specific racial, ethnic, and gender disparities within the selected community issues for each age group, such as access disparities, disproportionate representation in the homeless population and in county juvenile or criminal justice systems, foster care disparities, access disparities on American Indian rancherias or reservations, school achievement drop-out rates, and other significant issues.*

Our analysis of disparities in Trinity County begins with the State DMH website data regarding prevalence projections as factored by 200% of poverty. However, as acknowledged in the DMH Letter No: 05-02, 200% of poverty is not an adequate predictor of need in counties. Two hundred percent of poverty prevalence does not adequately reflect the need for mental health services or the amount of services required by different individuals. In addition to the prevalence data, we also provide comparisons between the percent of the population projected and population served. This helps to estimate the number of unserved persons in the county.

The information provided by the State DMH prevalence projections has some limitations for analyzing prevalence rates with the MHSA Transition Age Youth (TAY) age groups. The prevalence data defines TAY as 18-25 years, while the

MHSA TAY ages range from 16-25. A similar discrepancy occurs with Older Adults. The prevalence data uses 65+, while MHSA uses 60+.

The DMH data also does not provide the prevalence estimates by age and ethnicity; it only provides it separately. However, this data provides a beginning point for assessing service disparities.

Following a discussion of the prevalence data in comparison to utilization data, a narrative analysis of data from other sources will be used to describe other factors which reveal disparities in populations in the county (throughout this narrative, data sources are identified).

Figure 4 shows the State DMH prevalence data, which predicts the number of persons in Trinity County who are below 200% of poverty (2004) and who have a need for mental health services (Column A). This data is shown by gender, age, race/ethnicity, and language. Column C shows the percent of the Trinity County Mental Health clients (2004/05). This data is also shown by gender, age, and race/ethnicity. Column D shows a comparison of the prevalence estimates to the number of clients served.

As shown in Figure 4, in Trinity County, it is estimated that 473 persons have an income below the poverty level and have a need for mental health services. In Fiscal Year 2004/05, we served 403 persons. This is 85.2% of the estimated number of individuals needing services.

This prevalence data helps to examine the possible unserved populations in the county. For gender, we are serving 97.4% of the expected number of males and 76.9% of the females. For children we are serving 114.7% of the estimated number predicted. The prevalence data for transition age youth shows that we are serving twice as many youth as predicted. In FY 2004/05, we served 89 transition age youth (in comparison to the predicted 41 TAY). This represents 217.1% of expected number of clients.

For adults, we are serving fewer adults than expected. In FY 2004/05, we served 237 adults. The prevalence data shows 298 expected clients. This shows that we served 79.5% of the expected.

Many older adults are underserved, with only 39.1% of the estimated number of older adults receiving mental health services. Eighteen older adults were served, compared to the estimated 46 expected.

The prevalence data shows differences in service utilization and expected rates the different race/ethnicity groups. There are three main race/ethnicity groups in Trinity County. Caucasians were 'under-served' with 80.5% of the expected number receiving mental health services. Latinos were 'appropriately' served, with 105.0%

of the expected number receiving mental health services. American Indians were 'under served' with 80.8% of the expected number served.

The other race/ethnicity groups have extremely small numbers of individuals, both in the prevalence data and in the numbers served. For Asian/Pacific Islanders, 2 were expected to be served and 3 received services (150%). For other groups, 23 were expected to be served and 32 received services (139.1%).

In summary, adults, older adults, American Indians, and Caucasians were underserved based on this prevalence data.

Figure 4
Prevalence Rates

		A		B	C	D
		Prevalence Estimates <200% poverty 2004		Mental Health Consumers	Percent of Total Mental Health Consumers	Percent of Mental Health Consumers served compared to the prevalence estimates FY 2004/05
Total		473	100.0%	403		85.2%
Gender Distributions						
Male		195	41.2%	190	47.1%	97.4%
Female		277	58.6%	213	52.9%	76.9%
Age Distributions						
Children	00-17	129	27.3%	148	36.7%	114.7%
Transition Age Youth	18-25	41	8.7%			
Transition Age Youth	16-25			89	22.1%	217.1%
Adults	18-64	298	63.0%			
Adults	18-59			237	58.8%	79.5%
Older Adults	65+	46	9.7%		0.0%	
Older Adults	60+			18	4.5%	39.1%
Race/Ethnicity Distributions						
White		399	84.4%	321	79.7%	80.5%
African American		1	0.2%	5	1.2%	500.0%
Asian/Pacific Islander		2	0.4%	3	0.7%	150.0%
Hispanic		20	4.2%	21	5.2%	105.0%
American Indian		26	5.5%	21	5.2%	80.8%
Other		23	4.9%	32	7.9%	139.1%
Language Distributions <i>(not available for prevalence subpopulation analysis)</i>						
		Total Population >5 years old		Mental Health Consumers		
English Only		11,983		376		
Non -English		511		3		
	<i>Spanish</i>	<i>227</i>		<i>5</i>		
	<i>Other</i>	<i>284</i>		<i>19</i>		
Total Population >5 years old		12,494				

In addition to using the prevalence data, we examined data regarding homeless status, disability status, seasonal and migrant farm workers, school drop out rates, probation, and child welfare data, when available. A brief discussion of this data follows.

- At any point in time in 2005 there were 39 homeless individuals in Trinity County (Data Source: Dos Rios Trinity County survey). The Federal Task Force on Homelessness and Severe Mental Illness estimates that 33% of those that are homeless have a serious mental illness (SMI), and of these, 40-60% have a co-occurring substance abuse (SA) disorder. In Trinity County, this would result in almost 13 homeless individuals per year that require mental health services.
- There are approximately 1,374 individuals in Trinity County with a sensory, physical, mental or self-care disability (Data Source: Trinity County 2000 Census Data). The breakdown by age group is listed below and prevalence assumptions from the U.S. Surgeon General’s Report (9-13% of children have a serious emotional disturbance and 5.4% of adults and older adults have a SMI) are applied to calculate the number who are projected to need mental health services.

Age	Population with a disability	Prevalence Estimate	Individuals to be Served
5-20	154	@ 13%=	20
21-64	784	@ 5.4%=	42
65+	436	@ 5.4%=	24

- Trinity County has a limited number of seasonal and migrant farm workers. According to the *Migrant and Seasonal Farmworker, Enumeration Profiles Study of California (2000)*, the estimated number of migrant farm workers and their dependents in Trinity County was 30. The estimated number of seasonal farm workers and their dependents was 35. These figures put the estimated total county population of migrant and seasonal farm workers at 65. Again using the Surgeon General’s prevalence numbers, we might expect to have served 4 of these individuals. In FY 2003/04, our mental health clinic served a total of 21 individuals identified as Latino. Unfortunately, we do not know how many of the 21 Latinos who received services are farm workers. The MHSA will develop Outreach and Engagement strategies to potentially improve access to this underserved population.
- It is estimated that there are 13 youth in grades K-12 who have a primary language of Spanish (Data Source: California Department of Education). This represents less than 1% of all youth enrolled in K-12. The MHSA Outreach and Engagement activities will also strive to engage this group of students.

Children and Youth

There are racial and ethnic disparities that cut across the issues of peer and family problems, out-of-home placement, school drop-out rates, and involvement in the child welfare and juvenile justice systems.

The population of Trinity County is 83.6% Caucasian, 5.2% Latino, 1.0% Asian, 5.4% American Indian, and 4.8% other ethnic groups. For children ages 0-17, the proportion is higher, with 8.8% of all children identified as Latino. The California Data Book indicates that 21.2% of Trinity County children live below the federal poverty level. Children from low income families who are not eligible for Medi-Cal are more likely to be uninsured and, therefore, their medical and mental health needs are more likely to be untreated. Some disparities for children and youth are outlined below.

- According to the California Department of Finance, there were 2,659 youth ages 0-17 residing in Trinity County in 2004.
- In Trinity County, at any point in time, there are 16.9% or 449 children/youth who are uninsured (Data Source: California Data Book). Using the Surgeon General's prevalence forecasts, this data suggests that at least 60 children/youth in Trinity County are uninsured but require mental health services.
- By grade 12, 9.3% of Trinity County Caucasian youth have dropped out of school. Only Caucasian youth dropped out of school. Youth from all other ethnic groups remained in school through the 12th grade (Data Source: California Department of Education).

Transition Age Youth (TAY)

There is a disproportionate representation of Latino Transition Age Youth (TAY) in county juvenile criminal justice systems, approximately three times the percentage of the Latino population. Latino Transition Age Youth are at an increased risk of foster care placement and other out-of-home placements.

- According to the California Department of Finance, there were 1,827 youth ages 16-25 residing in Trinity County in 2004.
- By grade 12, 9.3% of Trinity County Caucasian youth have dropped out of school. Only Caucasian youth dropped out of school. Youth from all other ethnic groups remained in school through the 12th grade (Data Source: California Department of Education).

Probation Department Data:

- Based on the Average Monthly Census in 2003, one percent of the youth placed in Trinity County Juvenile Hall were receiving mental health services. Of these youth, 14% of the youth were receiving psychotropic medications while in Juvenile Hall (Data Source: California Department of Mental Health). Statewide, 41% of youth placed in Juvenile Hall received mental health services and 16% were receiving psychotropic medications while in Juvenile Hall. This illustrates a discrepancy in the number of youth in juvenile hall who receive mental health services in Trinity County compared to statewide data.

*I don't understand this since we provide a mental health assessment and twice weekly groups for all youth in j.h.

- In Trinity County, from 1996-2001, one youth aged 0-24 committed suicide. (Data Source: Trinity County).
- In FY 2004/05, there were 40 youth that were in out-of-home placement through Trinity County Child Welfare Services. This is in the TAY section but I suspect that it refers to minors of all ages. Can you clarify?
- There is increasing gang activity in Trinity County. (there is? – we haven't heard of this) It is difficult to estimate the number of gang members who need services and those individuals receiving services who are involved in gangs. Development of strategies for serving youth involved in gangs was one of the community recommendations.

Lesbian, Gay, Bisexual, Transgender, Questioning:

- At the present time, Trinity County does not have any services to meet the needs of individuals who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ). There is a need to assist these individuals in helping them form their cultural identities. (Our school counselor states she encounters about one student per year with this issue – but there could be a hidden need.) Additionally, which school is referenced? There are three regular high schools in the county and fifteen other educational facilities not counting adult ed. and court school.

Adults

According to the prevalence data, access for different race/ethnicity groups is equal to or higher than predicted. Only Native Americans (80.8% of expected) and Caucasians (80.55%) were lower than expected. This data shows the disparities of person served in a year compared to the number expected to be served.

- According to the California Department of Finance, there were 7,343 adults (ages 18-59) residing in Trinity County in 2004.
- At any point in time in 2000, 167 adults were in the Trinity County jail system (Data Source: U.S. Census 2000). The U.S. Department of Justice estimates

that 16% of jail inmates have serious mental illness (N=27). Of these individuals, 40-60% of these individuals also have a co-occurring substance abuse disorder. The local Sheriff's department has identified that a substantial number of the individuals in the criminal justice system have substance abuse problems and exhibit signs of mental illness. I question this since the jail only holds about 50 people total. Does this include all the folks in state prison or adult on probation/parole? I agree that this is a needy population and think we should be clear about whom we are speaking.

- In Trinity County, at any point in time, there are 14.5% or 1,195 adults (ages 18-64 years) who are uninsured (Data Source: California Health Interview Survey 2003). Using the Surgeon General's prevalence forecasts, this calculation suggests that at least 65 adults in Trinity County are uninsured and require mental health services.
- According to the California Health Interview Survey, 2001, 19.2% of Trinity County respondents (ages 18-64 years) needed help for an emotional/mental health problem, and only 9.2% of the respondents visited a health professional regarding an emotional/mental health problem.

Older Adults

The only older adults receiving mental health services were Caucasian. This shows disparities for persons who are Latino and American Indian, as well as the other race/ethnicity groups. As with the other age groups, there is a need for culturally appropriate, bilingual service providers to meet the needs of the Latino and American Indian older adult community. Cultural barriers may limit access due to culture-bound behaviors and preferences that require bilingual/bicultural service providers to address these issues, particularly in the context of behaviors related to mental illness. Concerns about stigma and non-acceptance of the concept of mental illness are issues that impede access to treatment for any culture, but especially for older adults. This becomes even more of a barrier when an individual is confronted with treatment options that are not culturally acceptable.

- According to the California Department of Finance, there were 3,543 older adults (ages 60 and older) residing in Trinity County in 2004.
- There may be a few older adults in the Trinity unserved homeless population and are among the disabled population that is unserved. This statement is confusing. Is a word misplaced?
- Few older adults access public mental health services, especially persons who are uninsured. Strategies for improving access to the older adult population is a high priority.

4) *If you selected any community issues that are not identified in the "Direction" section above, please describe why these issues are more significant for your*

county/community and how the issues are consistent with the purpose and intent of the MHSA.

Not applicable.

Section 2.2 Analyzing Mental Health Needs in the Community

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

To understand the racial, ethnic, and gender disparities regarding mental health services, we analyzed historic service utilization data to better understand patterns of service use across different populations. Data was examined to determine who is served and who is underserved. This data provided an overview of service utilization in comparison to the general population and the Medi-Cal eligible population to help understand existing service patterns and access to services. Service utilization data by age, race/ethnicity groups, and gender was reviewed to help understand race/ethnicity and gender disparities.

Below is a summary for each age-group which outlines the community issues selected for implementation, and how these issues relate to stakeholder concerns regarding the un/under-served populations. The county mental health program's goal is to provide accessible services to all race/ethnicities.

Approximately 5.2% of the Trinity County population is Latino. Similarly, 5.2% of the mental health client population is Latino. The Medi-Cal beneficiary population in Trinity County is 1.6% Latino.

Approximately 5.4% of the Trinity County population is American Indian. Similarly, five percent of the mental health client population is American Indian. The Medi-Cal beneficiary population in Trinity County is 2.4% American Indian.

Overall, the prevalence data shows that many of the race/ethnicity groups are served at rates equal to or greater than the expected (African American, Asian, Hispanic, and other). For Caucasians and American Indians, 80% of expected rates received services at Trinity County Behavioral Health.

This data shows the unduplicated count of clients served but does not address the total number of services clients receive. The next section of this plan will address the estimated need of mental health clients and how many are fully served.

**Interesting how these population stats vary. According to APS, (the EQRO contract org.) 90% of the TC pop is cauc., 5% Native American, 3.7 Latino. MediCal Pop is 96.5 cauc; 1.6 Native America, 1.1 Latino etc. This is said to be based on 1/2002 MediCal County Data Book. I'm a little concerned about establishing goals we can't reach – but, oh, well.*

2) Using the format provided in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/ inappropriately served, by age group, race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity. (Transition Age Youth may be shown in a separate category or as part of Children and Youth or Adults.)

A discussion of the county population by demographic indicators, follows Chart A showing the underserved/inappropriately served and fully served populations. Several factors impact the number of persons needing MHSA mental health services. We have examined a number of different variables which help to determine the unserved, underserved, and fully served populations in our county. Where is Chart A???? All I see are charts/tables with figures attached.

Trinity County’s updated County population assessment data is shown below. Figure 5 shows the number and percent of persons in Trinity County by race/ethnicity. This data is obtained from the California Department of Finance and shows that 83.6% is Caucasian, 5.2% of the County is Latino, 0.5% is African American, 1.0% is Asian, 5.4% is American Indian, and Other ethnic groups comprise 4.8% of the population.

**Figure 5 Trinity County Residents by Race/Ethnicity
FY 2004
N = 13,498**
(Source: California Department of Finance - 2004)

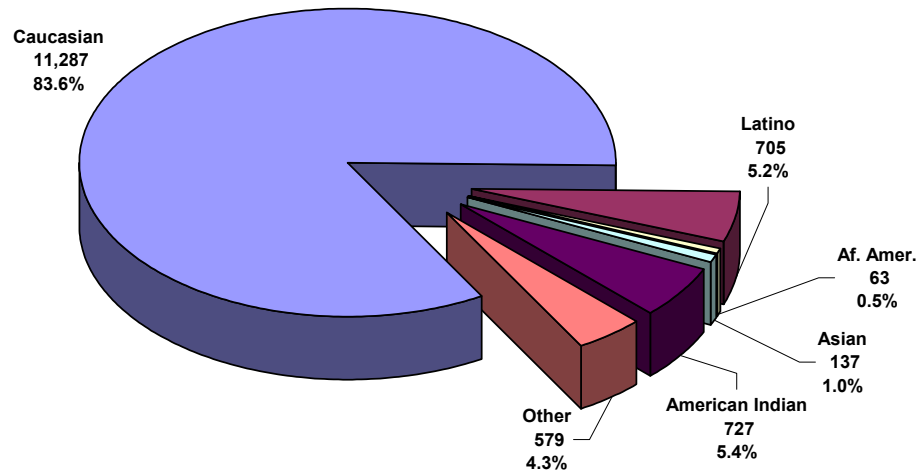
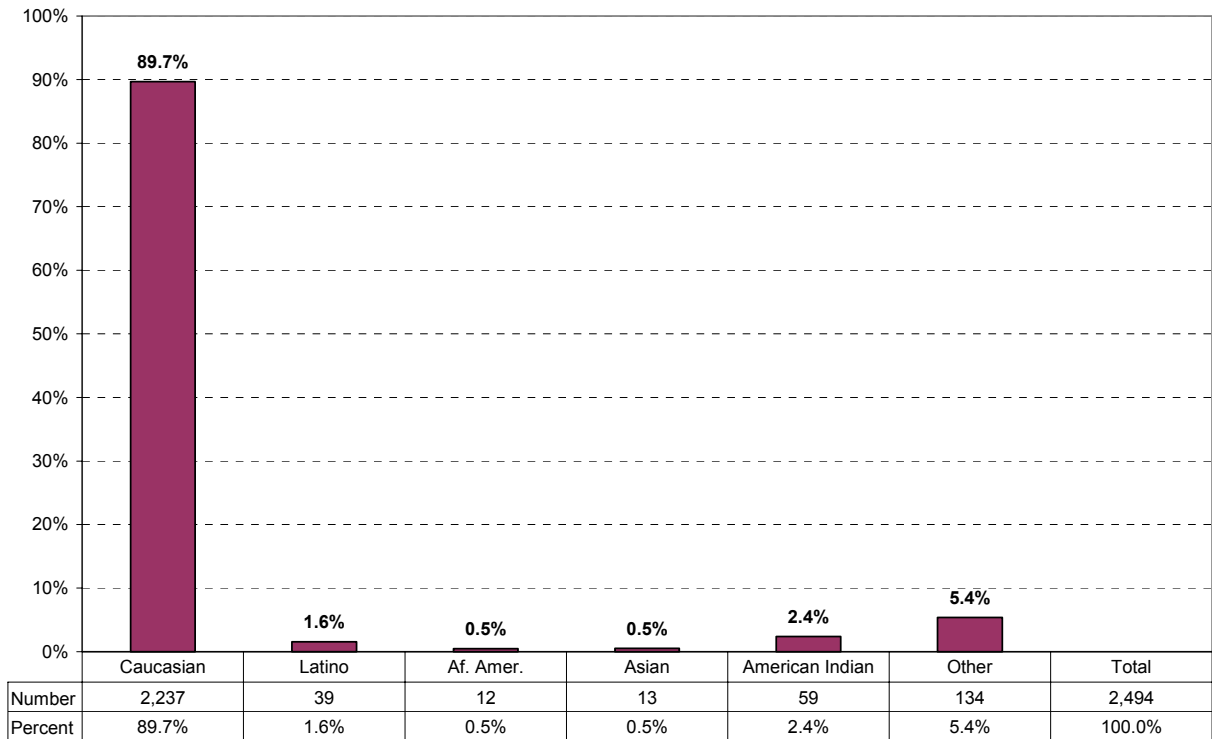


Figure XX shows the number and percent of Medi-Cal beneficiaries in Trinity County by race/ethnicity for FY 2002/03. This data is obtained from the California Department of Mental Health and shows that 89.7% is Caucasian, 1.6% of the beneficiary population is Latino, American Indians make 2.4% of the beneficiary population, and Other ethnic groups comprise 5.4% of the Medi-Cal beneficiary population.

**Figure 6 Trinity County Medi-Cal Beneficiaries by Race/Ethnicity
FY 2002/03**

(Source: California Department of Mental Health)



These two figures show that 5.2% of the Trinity County population is Latino and 1.6% of the Medi-Cal beneficiary population is Latino. American Indians in the population represent 5.4% and are 2.4% of the Medi-Cal population. Asians are 1.0% of the population and 0.5% of the Medi-Cal population. African Americans represent 0.5% of the population and 0.5% of the Medi-Cal population.

Population by Primary Language

As shown in Figure XX, 95.9% of County residents ages 5 and older speak only English at home. Two percent of Trinity County residents speak Spanish at home, while 2% speak other languages.

Figure 7
Trinity County Residents by Language Spoken at Home
Ages 5 years and Older
N = 12,494
(Source: Census 2000 Summary File 3 (SF 3) Sample Data)

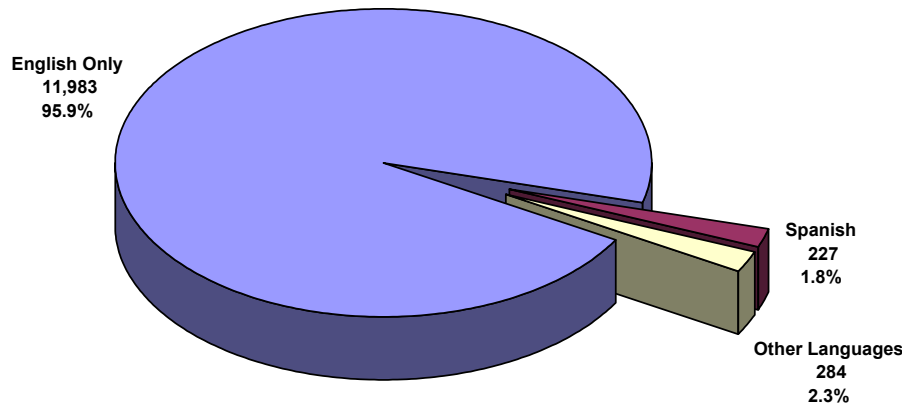
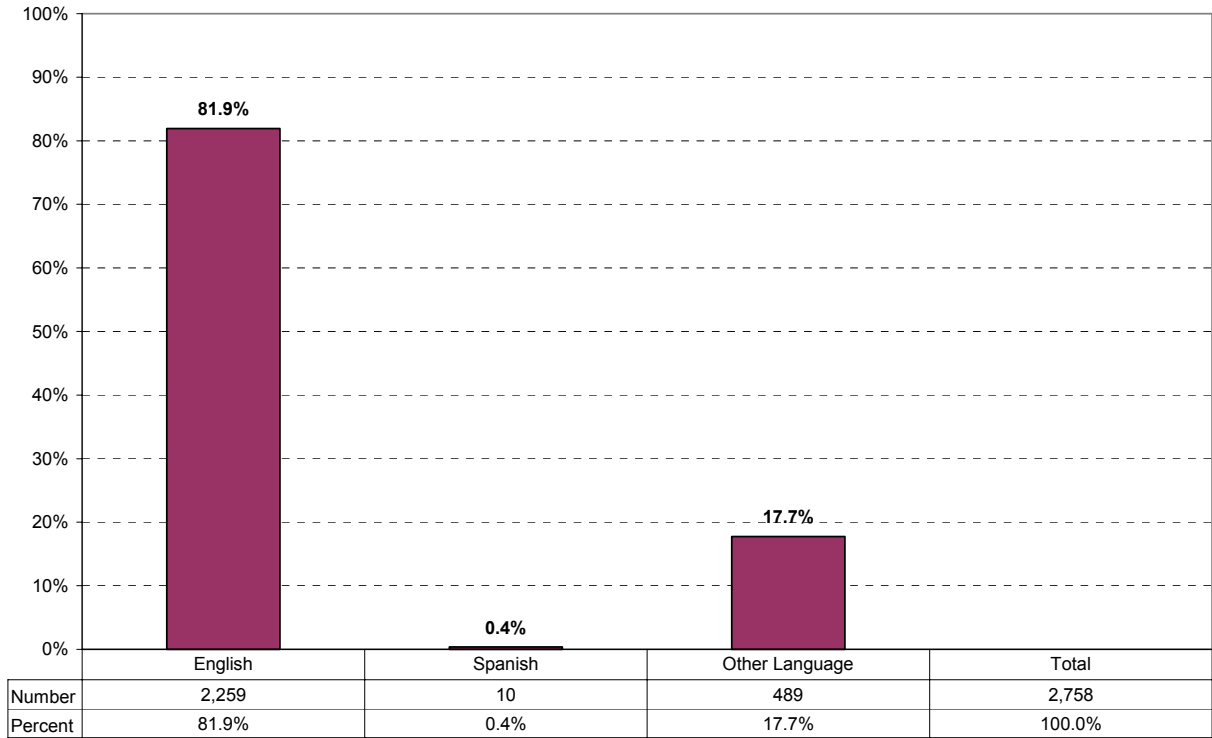


Figure 6 shows the primary language for Trinity County Medi-Cal beneficiaries in October 2002. Almost eighty-two percent (81.9%) of beneficiaries have a primary language of English, 0.4% have a primary language of Spanish, and 17.7% were Other or unspecified languages.

**Figure 8 Trinity County Medi-Cal Beneficiaries by Primary Language
October 2002**

(Source: California Department of Mental Health *Medi-Cal Beneficiaries by Primary Language Report*)



Note: I wonder how Health and Human Services, who is equally as “white” as our agency manages with this number of non-English speaking clients. I’m also very curious about the number of “other language” clients we apparently have. N

Population by Age

Figure 9 shows the breakdown of Trinity County residents by age. This data is obtained from the California Department of Finance and shows that 18.8% of the County population are youth (ages 0-17), 61.2% are Adults (ages 18-64), and 20.0% are Older Adults (ages 65+).

Figure 9 Trinity County Residents by Age

FY 2004

N = 13,498

(Source: California Department of Finance - 2004)

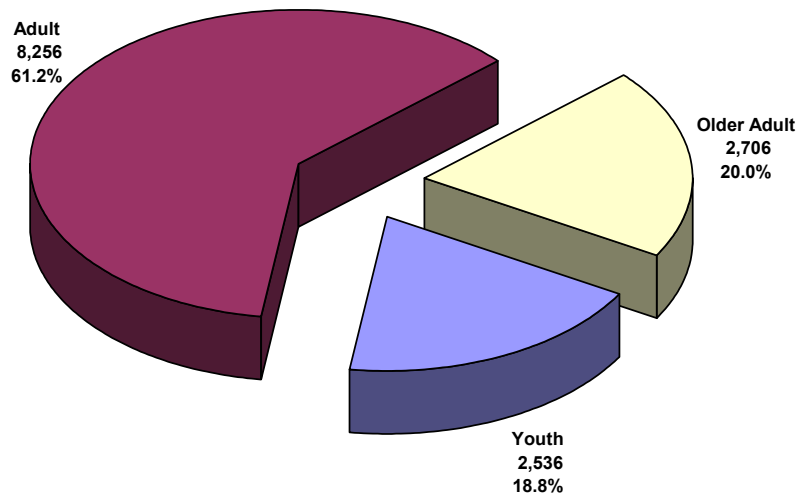
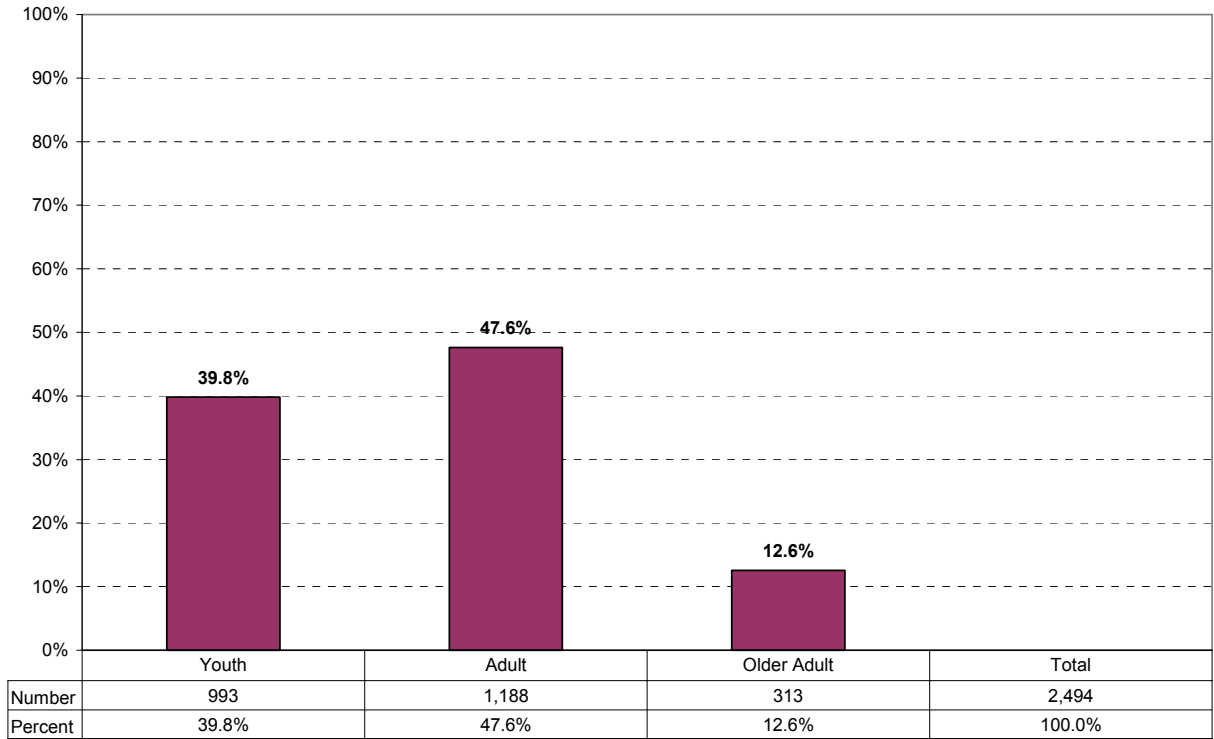


Figure 10 shows the number and percent of Medi-Cal beneficiaries in Trinity County by age for FY 2002/03. Approximately forty percent are 0-17 years of age, 47.6% are 18-64, and 12.6% are ages 65 and older.

Figure 10
Trinity County Medi-Cal Beneficiaries by Age
FY 2002/03

(Source: California Department of Mental Health)



Children and youth ages 0-17 represent 18.8% of the general population and 39.8% of the Medi-Cal beneficiary population.

Diagnosis:

Clients receiving mental health services in Trinity County had the following types of primary psychiatric diagnoses:

Total Number of Mental Health Clients in FY 04/05 (includes Crisis Services)

	Youth (0-17)	Transition Age (16-25)	Adults (18-59)	Older Adults (60+)	Total Clients
ADHD	12	2	1	0	13
Anxiety	13	4	28	1	42
Bipolar	1	5	26	2	29
Conduct Disorder	33	5	3	1	37
Depression/Mood Disorder	16	11	55	1	72
Schizophrenia/Psychotic	0	2	21	7	28
Deferred	4	2	4	0	8
Other	41	13	44	2	87
Total Clients	108	42	181	14	303

The mix of diagnoses is representative of most public mental health systems. The most prevalent diagnosis was Depression and Mood Disorder. Conduct Disorder is the most common diagnosis for children and youth.

Crisis and Inpatient Utilization (Fiscal Year 2004/05):

Additional information from the overall analysis of our utilization data includes:

Approximately 100 people utilized crisis services. Of the 12 youth who received Crisis Services, 9 were Caucasian, 1 was American Indian, and 2 were other race/ethnicity. Of the 80 adults who received Crisis Services, 62 were Caucasian and 5 Latino. For older adults, 5 were Caucasian and 3 were other race/ethnicity.

Of the 15 individual receiving Inpatient Services, 12 were adults, and 3 were older adults. There were no youth hospitalized in the Fiscal Year.

At any given point in time during 2004, there were 8 adults receiving Board and Care facility services.

Unserved Populations:

Estimating the number of unserved and underserved is difficult. At the present time, we do not systematically assess clients' need using data. The data in Chart A are estimates of the fully served and under served clients who received services in FY 04/05 by age, gender, and race/ethnicity. The table shows an estimate of the number of fully served, underserved, and total served by age, gender, and race/ethnicity.

A key utilization issue that Trinity County Mental Health has been analyzing is the amount of service received in relationship to clinical need. While data is available to examine the number of service contacts received by a client, evaluating 'clinical

need' is more complex. However, the concept of underserved implies that a client does not receive all of the services that he/she needs. At the present time, we do not have a systematic method for identifying fully served clients.

The best 'proxy' is to set a benchmark for the number of services received and assess the number of individuals who received that amount of services. For purposes of this analysis, we have identified twenty-four or more services contacts in a twelve month period as meeting the criteria for 'fully served' and less than twenty-four (24) service contacts as 'underserved'. It should be acknowledged that some clients only receive a quarterly medication appointment and are successfully living independently with only four service contacts per year (thus could be considered as 'fully served'). However, in attempting to identify 'fully served' populations, we have selected twenty-four (24) as the minimum benchmark. This calculation provides information on the number of clients who averaged two or more services per month for the twelve month period.

As we continue to transform our mental health system, matching the amount of services to the client's needs will become more refined and scientific. The development of this level of evaluation sophistication will enable us in the future to better match clinical need to an appropriately intensive level of service.

Please note: for the purposes of this document, persons receiving twenty-four (24) or more services in a fiscal year were considered to be 'Fully Served'. All individuals who received less than twenty-four (24) services were considered underserved/inappropriately served.

CHART A

TRINITY COUNTY

Children & Youth 0-17 years old	Fully Served		Total Fully Served		Underserved/ Inappropriately Served		Total Served by Gender		Total Served		County Population	
	Male	Female	Number	% of TOTAL SERVED	Male	Female	Male	Female	Number	%	Number	%
Total	39	32	71	48.0%	41	36	80	68	148		2,659	
African American	0	1	1	0.7%	1	0	1	1	2	1.4%	4	0.2%
Asian-Pacific Islander	0	0	0	0.0%	0	1	0	1	1	0.7%	33	1.2%
Latino	1	0	1	0.7%	3	1	4	1	5	3.4%	234	8.8%
American Indian	7	4	11	7.4%	0	3	7	7	14	9.5%	187	7.0%
White	28	24	52	35.1%	33	29	61	53	114	77.0%	2,005	75.4%
Other	3	3	6	4.1%	4	2	7	5	12	8.1%	196	7.4%

Transition Age Youth 16-25 years old	Fully Served		Total Fully Served		Underserved/ Inappropriately Served		Total Served by Gender		Total Served		County Population	
	Male	Female	Number	% of TOTAL SERVED	Male	Female	Male	Female	Number	%	Number	%
Total	20	19	39	43.8%	26	24	46	43	89		1,827	
African American	1	0	1	1.1%	0	0	1	0	1	1.1%	4	0.2%
Asian-Pacific Islander	0	0	0	0.0%	0	0	0	0	0	0.0%	58	3.2%
Latino	2	1	3	3.4%	4	3	6	4	10	11.2%	118	6.5%
American Indian	2	2	4	4.5%	1	1	3	3	6	6.7%	123	6.7%
White	15	15	30	33.7%	14	19	29	34	63	70.8%	1,462	80.0%
Other	0	1	1	1.1%	7	1	7	2	9	10.1%	92	5.0%

Adults 18-59 years old	Fully Served		Total Fully Served		Underserved/ Inappropriately Served		Total Served by Gender		Total Served		County Population	
	Male	Female	Number	% of TOTAL SERVED	Male	Female	Male	Female	Number	%	Number	%
Total	53	77	130	54.9%	49	58	102	135	237		7,343	
African American	2	0	2	0.8%	1	0	3	0	3	1.3%	53	0.7%
Asian-Pacific Islander	0	2	2	0.8%	0	0	0	2	2	0.8%	92	1.3%
Latino	3	5	8	3.4%	2	6	5	11	16	6.8%	381	5.2%
American Indian	3	1	4	1.7%	1	2	4	3	7	3.0%	411	5.6%
White	43	69	112	47.3%	36	44	79	113	192	81.0%	6,145	83.7%
Other	2	0	2	0.8%	9	6	11	6	17	7.2%	261	3.6%

Older Adults 60+ years old	Fully Served		Total Fully Served		Underserved/ Inappropriately Served		Total Served by Gender		Total Served		County Population	
	Male	Female	Number	% of TOTAL SERVED	Male	Female	Male	Female	Number	%	Number	%
Total	5	8	13	72.2%	3	2	8	10	18		3,543	
African American	0	0	0	0.0%	0	0	0	0	0	0.0%	3	0.1%
Asian-Pacific Islander	0	0	0	0.0%	0	0	0	0	0	0.0%	12	0.3%
Latino	0	0	0	0.0%	0	0	0	0	0	0.0%	69	1.9%
American Indian	0	0	0	0.0%	0	0	0	0	0	0.0%	121	3.4%
White	5	8	13	72.2%	2	0	7	8	15	83.3%	3,236	91.3%
Other	0	0	0	0.0%	1	2	1	2	3	16.7%	99	2.8%

Total	Fully Served		Total Fully Served		Underserved/ Inappropriately Served		Total Served by Gender		Total Served		County Population	
	Male	Female	Number	% of TOTAL SERVED	Male	Female	Male	Female	Number	%	Number	%
Total	97	117	214	53.1%	93	96	190	213	403		13,545	
African American	2	1	3	0.7%	2	0	4	1	5	1.2%	60	0.4%
Asian-Pacific Islander	0	2	2	0.5%	0	1	0	3	3	0.7%	137	1.0%
Latino	4	5	9	2.2%	5	7	9	12	21	5.2%	684	5.0%
American Indian	10	5	15	3.7%	1	5	11	10	21	5.2%	719	5.3%
White	76	101	177	43.9%	71	73	147	174	321	79.7%	11,386	84.1%
Other	5	3	8	2.0%	14	10	19	13	32	7.9%	556	4.1%

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

Children / Youth

All children served by the Trinity County mental health services are considered eligible for a full array of services. However, there are opportunities for improvement in the processes to ensure that they are receiving the services needed to address their mental health conditions and achieve positive outcomes. We are working to improve the coordination between all social services agencies who are serving children and families. This coordination will enhance outcomes for children and families in foster care, juvenile justice, and in the schools.

As shown in Chart A, 71 of the 148 children and youth (48.0%), ages 0-17, are considered fully served. This leaves an estimated 52% as underserved. At the present time, underserved children include young children ages 0-17; children who are in foster care; youth who are in the juvenile justice system; and, while small in numbers, children who are homeless. Service to improve the conditions and outcomes for children and youth who are considered 'high risk' were among the priority issues defined through the needs assessment process and selected for priority attention for programs developed. It is anticipated that at least 10% of these young children will be Latino and 10% will be American Indian.

Transition Age Youth

Nearly every group of respondents who participated in the needs assessment/ survey gathering process identified transition age youth as a high priority for MHSA attention. The major gaps identified in the services to this age group included lack of skills building to prepare youth for adulthood as they leave foster care or juvenile hall and/or a children's system of care. There is also a lack of housing options for these Transition Age Youth and few supportive services to assist them in finding employment or continuing with their education.

As shown in Chart A, 39 of the 89 transition age youth (43.8%), ages 16-25, are considered fully served. This leaves an estimated 56.2 % as underserved. An example of the underserved population is those youth who drop out of school. In Trinity County, 9.2 % of Caucasians drop out. These are high-risk individuals who have a higher probability of gang involvement and unemployment.

Another unserved population for this age group is youth who are Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ). This age is when youth begin recognizing their sexuality and benefit from a support system to help them address their fears.

Adults

As shown in Chart A, 130 of the 237 adults (54.9%), ages 18-59, are considered fully served. This leaves an estimated 45.1 % as underserved. The unserved/underserved adults in Trinity County include those individuals who are uninsured or underinsured, and undocumented individuals. Individuals who are geographically isolated are also unserved. They can not obtain services because of lack of reliable transportation. There are approximately 39 homeless adults in the county, with an estimate of 30-50% with a serious mental illness. These individuals are unserved. Linda Wright agreed to provide # of CMSP recipients. These are unemployed adults without children—I suspect one of our most vulnerable populations.

Older Adults

As shown in Chart A, 13 of the 18 older adults (72.2%), ages 60+, are considered fully served. This leaves an estimated 27.8% as underserved. At the present time, few older adult individuals access public mental health services (N=18). As a result, most of the older adults with a serious mental illness are unserved in Trinity County. This includes individuals who are geographically isolated and lack reliable transportation and/or a support person to assist them with transportation to services. One of the barriers to services is the stigma attached to mental illness and a lack of recognition of mental illness among family members and seniors. Improving services to this population is a high priority for the MHSA.

Rural and Non-English Speaking Individuals

Trinity County is a small, rural community which is primarily Caucasian. Persons who are Latino and American Indian comprise the other race/ethnicity groups in this county. It is difficult to recruit bi-lingual and bi-cultural individuals to this community to serve Latino persons needing services possibly due to the small number of community members. However, with MHSA funding, we will strive to hire individuals who represent the different cultures in the county who can provide culturally appropriate services.

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

As evident in Chart A above, half of the individuals who receive mental health services are underserved. Using the criteria of 24 or more contacts in a fiscal year, over 46.8% of all clients are underserved/inappropriately served. This data was consistent for children, transition age youth, and adults.

The county's sole threshold language is Spanish. As shown above, about 8 of the 21 Latino clients who received mental health services in FY 04/05 were underserved/inappropriately served. This trend was consistent for children, transition age youth, and adults. The data shows that 72.2% of older adults are fully served.

In addition to examining data to assess persons who are underserved/ inappropriately services, the number of persons who are *unserved* in the county is also important. The prevalence data shows that fewer people are being served than expected for adults, older adults, and the American Indian and Caucasian populations. The MHSA funding provides the county with an opportunity to improve access and increase the total number of persons in the county who receive mental health services.

A number of objectives have been identified for MHSA Services:

1. To improve access for persons of all cultures especially those of Latino, American Indian and Caucasian heritage. To successfully meet this objective, we also have the objective of hiring additional staff, consumers, and family members. We hope to recruit individuals who are bilingual and bicultural. This accomplishment will help reduce the barriers to access for culturally-diverse populations.
2. To deliver services in collaboration with other community organizations and co-locate services whenever possible. Our primary mental health clinic is co-located on the same campus with Social Services and, CalWORKS program. This co-location makes it easy for individuals to access several different programs in one convenient location. The Hayfork clinic is located in the Hayfork Community Center adjoining the continuation school, and in conjunction with employment, nutritional and domestic violence programs outposted there by partner agencies.
3. To deliver services in the individual's community. Outreach and engagement activities and system develop services will require that staff deliver services in the individual's home, and offer services in diverse community settings (e.g., churches, schools, and other rural community locations).
4. To reduce disparities in services for the American Indian and Latino populations, including monolingual Spanish-speaking individuals. It will be an objective to reduce disparities and continue to improve cultural competence in our services. The MHSA services will engage and serve American Indians and Latinos, with a goal that 5% of new MHSA clients are American Indian or Latino.
5. To increase the number of bicultural mental health staff by hiring more Latino individuals who are bilingual and bicultural, when possible. We also hope to hire staff who are American Indian.

6. To conduct additional cultural competence training programs for mental health staff and collaborative community partners.
7. To provide culturally and linguistically appropriate services for Latino and American Indian family members.
8. To develop outreach and education activities focused on providing information about mental health services for groups and organizations known to serve high numbers of Latinos and American Indians (i.e., Health Services, churches, tribes, etc.).

Section III. Identifying Initial Populations for Full Service Partnerships

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

Within the first three years of the MHSA, Trinity County will develop Full Service Partnership programs for two age groups. These two Full Service Partnership programs will be initiated in the second year, with full implementation beginning the third year. The two Full Service Partnership programs will serve:

- Transition Age Youth (ages 16-25) (Work Plan I); and
- Adults (ages 18-59) (Work Plan II).

These Full Service Partnership programs will be described below.

Children (ages 0-17) and Older Adults (ages 60+) will receive some funding to conduct Outreach and Engagement Activities and System Development services to these underserved populations. As we develop subsequent CSS plans, we will develop full service partnership models for children and older adults.

Full Service Partnership: Transition Age Youth (Ages 16-25) (Work Plan I)

Trinity County will develop a Full Service Partnership Transition Age Youth Team to serve youth ages 16-25 (often with co-occurring mental health and substance abuse disorders) who are currently not served, who are not adequately served, or at risk. From Chart A, 10 of the 89 TAY currently served are Latino. Three are calculated to be Fully Served. For the six American Indian TAY served, four are calculated to be Fully Served. Similarly, 63 of the TAY served are Caucasian, with 30 calculated to be Fully Served. As supported by the data and stakeholder input, the TAY Program will focus on seriously emotionally disturbed individuals who meet the following criteria:

- (1) Transition Age Youth (ages 16-25) who have a serious emotional disturbance and who have experienced school disciplinary problems, are likely to drop out of school, are at risk of out-of-home placement, involved in the juvenile or criminal justice system in the past year, have co-occurring mental health and substance abuse disorders, or are homeless; and/or
- (2) Transition Age Youth (ages 16-25) who are uninsured or underinsured and who are at serious risk of or have a history of psychiatric hospitalization,

residential care, or out-of-home placement, due to their mental health diagnosis; and/or

- (3) Transition Age Youth (ages 16-25) who are ready to be released from Juvenile Hall or residential placement (e.g., foster care, group homes) and are returning to the community and have inadequate services and supports to successfully transition to adulthood.

The core factors which will be used to identify TAY will be those youth ages 16-25 who are within six months of being released from Juvenile Hall, or returning to the community from an out-of-home placement. This population will also include those youth ages 16-25 who are aging out of the juvenile justice or child welfare systems. Traditionally, these youth do not receive adequate services within the adult mental health program and are at high risk of becoming homeless, hospitalized, or entering the adult justice system before seeking mental health services. Many of these youth have co-occurring substance abuse disorders.

High priority will be given to serving Transition Age Youth who are Latino or American Indian, as well as those who are at risk of psychiatric hospitalizations and/or homelessness. Youth with co-occurring disorders (mental health and substance abuse) will also be a priority for services. We will provide Full Service Partnership services to two (2) Transition Age Youth in Year II and an additional two (2) will be served in Year III, for a total of 4 individuals served in Full Service Partnership by the end of Year III.

Ethnic disparities will be reduced by the following strategies:

- (1) The team staffing pattern will include a ratio of bilingual/bicultural mental health professionals and staff, if possible.
- (2) Staff consultations and team supervision will provide opportunities to discuss culturally appropriate options for care.
- (3) Team staff, including community partners, will receive regularly scheduled training on issues related to cultural competence.

Individuals and families served will drive the plan of care with attention to personal choices, including cultural issues such as location of housing, employment, and education.

Full Service Partnership: Adults (Ages 18-59) (Work Plan II)

Trinity County will develop a Full Service Partnership Adult Team to serve adults ages 18-59 (often with co-occurring mental health and substance abuse disorders) who are currently not served, or who are not adequately served. From Chart A, 16 Latino adults were served, with eight calculated to be Fully Served. For American Indian adults, seven were served, with four calculated to be Fully Served. Similarly, 192 Caucasian adults were served, with 112 calculated to be Fully Served.

Based on the above data and stakeholder input, the core factors which will be used to identify persons for the Adult Program will be adults ages 18-59 who are at serious risk or have a history of psychiatric hospitalization, history of placements in a residential care facility, involvement with the criminal justice system, co-occurring mental health and substance abuse disorders, and/or out-of-home placement, due to the combinations of financial difficulties and levels of development and sustainment of independent living skills.

At the present time, a level of concern exists that some adults with a serious mental illness receive fewer mental health services than what would be required to optimize levels of function. Some individuals continue to be sustained through traditional medication management and case management services. Ideally, more intensive levels of support both in frequency and the array of service options could enhance levels of functioning and overall quality of life. Those individuals who are at risk of hospitalization, those with co-occurring disorders, and those involved in the criminal justice system represent the unserved and underserved adults in this county. Some of these individuals may also be at risk of hospitalization and/or homelessness.

The three populations in Trinity County which will be identified for the Adult Full Service Partnership Program are:

- (1) Adults who have been admitted to a psychiatric hospital in the past two years, or are at risk of hospitalization; and/or
- (2) Adults with co-occurring mental health and substance abuse disorders; and/or
- (3) Adults with a serious mental disorder who have been involved in the criminal justice system in the past year and are being discharged into the community.

Two (2) adults will be served in the Full Service Partnership program in Year II and an additional two (2) will be served in Year III, for a total of 4 individuals served in Full Service Partnership by the end of Year III.

Ethnic disparities will be reduced by the following strategies:

- (1) The team staffing pattern will include bilingual/bicultural mental health professionals and staff.
- (2) Staff consultations and team supervision will provide opportunities to discuss culturally appropriate options for care.
- (3) Team staff, including community partners, will receive regularly scheduled training on issues related to cultural competence.

Individuals and families served will drive the plan of care with attention to personal choices, including cultural issues such as location of housing.

System Level Plan to Reduce Ethnic Disparities

It is anticipated that through the MHSA program service expansions, individuals can be diverted from criminal behavior and repeat offences and encouraged to complete

their education. The Full Service Partnership programs will develop services and programs directed at the cultural and behavioral needs of these individuals to ensure that Trinity County Mental Health has an impact on the ethnic disparities in this county.

Trinity County Mental Health plans to develop and deliver culturally sensitive services and programs which provide linguistically appropriate services to individuals in our community. By hiring bilingual, bicultural staff whenever possible, by embracing and implementing the values of our cultural competence plan, and through ongoing training at all levels of the organization, we will strive to improve the ethnic disparities in this community.

The MHSA services will create excellent opportunities to link and coordinate services with community partners and cultural leaders. This coordination will improve access and deliver services to Latinos and American Indians, as well as persons from all ethnic communities.

Services for Children (Ages 0-17)

System development funds and Outreach and Engagement funds will be used to expand the existing children's service system during this initial three year period to improve the mental health system and to serve unserved and underserved children and their families in the county. Children ages 0-17 will receive some funding to conduct Outreach and Engagement Activities and System Development services. As we develop subsequent CSS plans and additional funding, we plan to develop a full service partnership model for children.

Services for Older Adults (Ages 60+)

Older Adults (ages 60+) will receive some CSS funding to conduct Outreach and Engagement Activities and System Development services to this underserved population. As we develop subsequent CSS plans, we plan to develop a full service partnership program for older adults.

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

Transition Age Youth (TAY)

Different data and information from a wide range of sources were considered to assist in the selection of the initial TAY populations for the first three years. The information considered and used to select the priority Transition Age Youth groups included:

- a) Service utilization data, prevalence data, and data on the estimate of those individuals who were fully served were reviewed. The combination of these data provided a systematic view of the number of those who were served and how many mental health services they received.
- b) Feedback from MHSA information gathering / needs assessment process.
- c) Data from juvenile justice and Health and Social Services on youth in out-of-home placement.
- d) Expertise of the MHSA Steering Committee with representatives of stakeholders including family members, Probation, Education, Health and Social Services, and Substance Abuse providers.
- e) Consensus from the MHSA Leadership Team.

This information clearly identified the gaps in needs for TAY youth., (redundant). Our first challenge is to develop linkages to our cultural communities to help identify those youth who could most benefit from the TAY services and eventually from full service partnership services.

****change paragraphing** Working with probation, juvenile hall staff, and Health and Social Services will help identify TAY youth with a serious emotional disturbance who need additional services to help them live successfully in the community.

Identifying TAY youth who are at risk for hospitalization, incarceration, and/or homelessness will provide the opportunity to reach out and serve individuals who do not traditionally access mental health services as they age out of the children's mental health system. TAY with co-occurring disorders (mental health and substance abuse) will also be identified from both the mental health program and the substance abuse program as well as from referrals in the schools and community partners.

Adults

Various data and information from a wide range of sources were considered to assist in the selection of the initial adult populations for the first three years. The information considered and used to select the priority Adult groups included:

- a) Service utilization data, prevalence data, and data on the estimate of those individuals who were fully served were reviewed. The combination of these data provided a systematic view of the number of those who were served and how many mental health services they received.
- b) Feedback from MHSA information gathering / needs assessment process.
- c) Expertise of the MHSA Steering Committee with representatives of stakeholders including consumers, family members, Probation, and Substance Abuse providers.
- d) Consensus from the MHSA Leadership Team.

This information clearly identified the gaps in needs for adults, especially those who are Latino, American Indian, and Caucasian. Our first challenge is to develop

linkages to these cultural communities to help identify those adults who could most benefit from mental health services and eventually from full service partnership services. Working with probation and substance abuse services will help identify adults with a serious mental illness who need additional services to help them live successfully in the community.

Identifying adults who are at risk for hospitalization, incarceration, and/or homelessness will provide the opportunity to reach out and serve culturally diverse individuals who may not traditionally access mental health services. In addition, those individuals with a history of psychiatric hospitalization, co-occurring disorders and/or those involved in the criminal justice system were also considered high priority for mental health services.

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

It is anticipated that through the MHSA program service expansions, individuals can be diverted from criminal behavior and repeat offences and encouraged to complete their education or to engage in meaningful work or volunteer activities. The Full Service Partnership programs will develop services and programs directed at the cultural and behavioral needs of these individuals to ensure that Trinity County Mental Health has an impact on the ethnic disparities in this county.

Trinity County Mental Health is committed to develop and deliver culturally sensitive services and programs which provide linguistically appropriate services to individuals in our community. Unfortunately, at the present time, there are disparities in access for Latinos and American Indians in this county. We plan to build a culturally competent mental health system with good access for these unserved populations. By hiring bilingual, bicultural staff whenever possible, by embracing and implementing the values of our cultural competence plan, and through ongoing training at all levels of the organization, we will strive to improve the ethnic disparities in this community.

The MHSA services will create excellent opportunities to link and coordinate services with community partners and cultural leaders. This coordination will improve access and deliver services to persons from all ethnic communities.

Section IV. Identifying Program Strategies

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

All Full Service Partnership programs will only utilize the strategies outlined in the MHSA CSS document.

Section V. Assessing Capacity

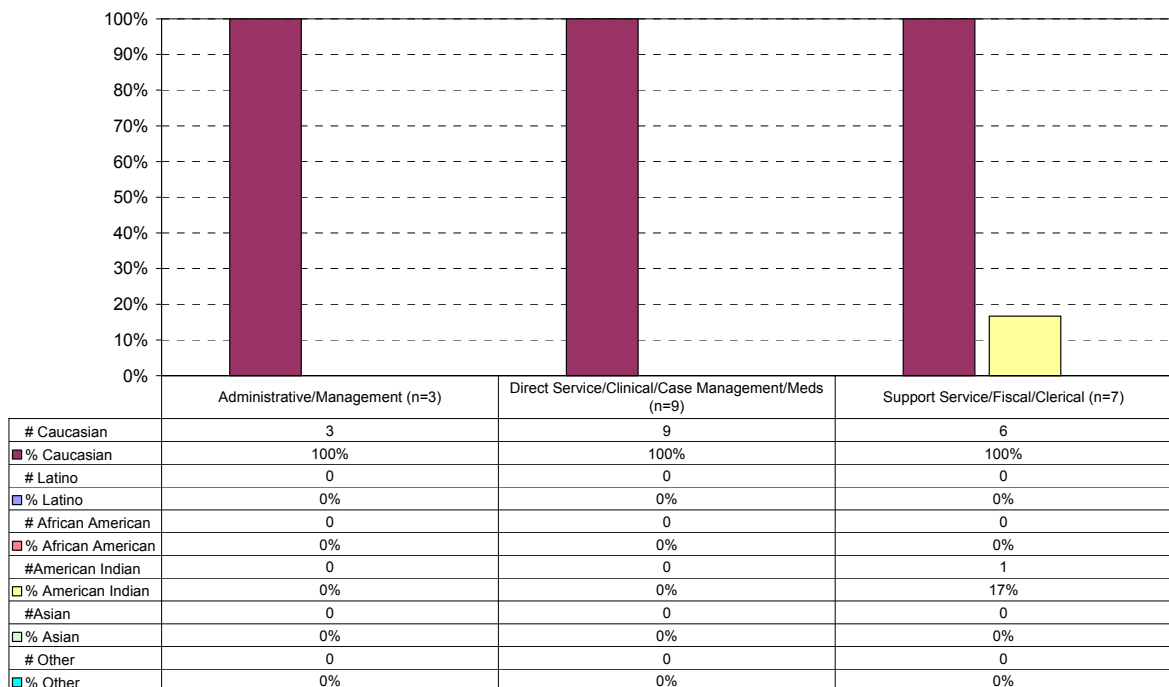
- 1) *Provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county. This analysis must address the bilingual staff proficiency for threshold languages.*

The Mental Health staff and organizational providers are predominately Caucasian. The Latino Population represents 5% of our population and 5% of our service population. However, we feel that we can improve access to all race/ethnicity groups by strengthening our staff and service delivery system. A comparison of staffing and the population reflects a disparity between the Latino population and mental health provider staffing.

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

Figure 13 shows the race/ethnicity of the nineteen mental health staff in Trinity County. Of the three Administrative/Management staff, all are Caucasian. Of the nine Direct Service staff, all are Caucasian. Six of our Support Services staff are Caucasian and one is American Indian.

Figure 13
Staff by Race/Ethnicity and Function – Locations (2005 Survey)
N = 19



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

Our biggest barrier to implementation will be to hire ethnically diverse staff. We are very isolated and have difficulty recruiting staff to this remote area. Although salaries are comparable to those of surrounding counties, the lack of ethnically diverse communities, lack of affordable housing and lack of employment for trailing spouses along with concerns about the viability of the health care system have traditionally hindered recruitment at all levels for direct care and management staff. Another anticipated barrier is the ability to hire consumers and family members to work with staff to deliver MHSA services. Given the small population of the county, there are fewer persons from which to hire staff. We will need to work with our county personnel office to develop appropriate job classifications to improve our ability to hire consumers and family members.

We will also need to conduct training on the recovery model. Some of our staff have worked in the mental health field for many years and deliver traditional mental health clinic model services. Training and supervision will assist staff in embracing this system transformation and exploring alternative strategies for meeting the needs of the individual. Training and supervision on strategies for promoting family and consumer voice will also be required to fully implement the vision of the MHSA.

The Children's System of Care services, which we developed over the past several years, provided an excellent model for developing collaborative relationships with allied agencies. Our multi-agency team worked closely together for several years to meet the needs of children and families in our system. This system model will now be utilized to develop and enhance multiple agency collaboration to improve access and services for adults with a serious mental illness in our county.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Trinity	Fiscal Year: 2005/06 – 2007/08	Program Work Plan Name: Transition Age Service Team
Program Work Plan #: I		Estimated Start Date: April 2006
<p>Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i></p>	<p>Trinity will develop a Transition Age Team that will provide culturally sensitive services to youth and families who are unserved or underserved. These services will be youth-and family-centered, strength-based, needs driven, and utilize best practice models of service delivery. The program will initially utilize general system development funds and eventually full service partnership funds to improve services for youth and families. This will help to change our service delivery model, and build transformational programs and services.</p> <p>The Transition Age Team will help reduce ethnic disparities, provide education and advocacy services, and values-driven, evidence-based practices to address each youth and family’s needs. These services will offer integrated services for youth and families. Initially, Outreach and Engagement and System Development funds will be used to develop the core services and to offer outreach services to youth who are currently unserved or underserved. By Year II, youth will begin being identified for full service partnership (FSP). The FSP will help identified youth and their families achieve their desired outcomes through the delivery of individualized youth and family driven mental health services and supports. The TAY youth will have access to the Wellness Center. This is a community based drop-in center which will be the site for specialized TAY services and group activities. In addition, TAY services will be delivered in the individual’s community to provide ‘whatever it takes’ to help these youth transition to adulthood, develop resiliency skills, and live successfully in the community. These components may include flex funds for clothing, rent stipends, transportation vouchers, group memberships, etc. A range of services will be available based upon the youth and family’s needs and desired outcomes. Services will be voluntary and client-directed, strength-based, employ wellness and recovery principles, address both immediate and long-term needs, and delivered in a timely manner that is sensitive to the cultural needs of the youth and family. A bi-lingual, bi-cultural Parent Partner/Peer Mentor will be hired, if possible.</p>	

<p>Priority Population: <i>Describe the situational characteristics of the priority population</i></p>	<p>Youth ages 16-25 who have a serious emotional disturbance and</p> <ol style="list-style-type: none"> (1) Transition Age Youth (ages 16-25) who have a serious emotional disturbance and who have experienced school disciplinary problems, are likely to drop out of school, are at risk of out-of-home placement, involved in the juvenile or criminal justice system in the past year, have co-occurring mental health and substance abuse disorders, or are homeless; and/or (2) are uninsured or underinsured and who are at serious risk of or have a history of psychiatric hospitalization, residential care, or out-of-home placement, due to their mental health diagnosis; and/or (3) are ready to be released from Juvenile Hall or residential placement (e.g., foster care, group homes) and are returning to the community and have inadequate services and supports to successfully transition to adulthood.
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Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Outreach and Engagement – Staff will work closely with schools, child welfare services, foster care families, Probation, Substance Abuse, and other community agencies to identify youth who qualify for the program. Special attention and outreach will occur in the Latino and American Indian communities to address ethnic disparity.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination – Staff and/or the Parent Partner/Peer Mentor will provide linkage to services and supports, including assistance with transportation, development of housing and educational opportunities, and supportive services 24/7.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning - Youth and family self-directed Wellness Recovery Action Plans will be developed to outline the youth’s goals and vision of wellness.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive Services – The team will have smaller case loads, be knowledgeable of all youth and families, and provide ‘whatever it takes’ to meet the needs and outcomes of the child and family. A wraparound service delivery model will be utilized.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Collaboration - Based on the youth and family needs and expressed goals, team members will work with community partner	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

organizations to deliver services.							
Culturally appropriate services – Culturally appropriate services to reach the Latino and American Indian communities, as well as persons of other racial/ethnic groups will be available. Services will be coordinated with ethnic specific organizations to coordinate care in the most appropriate manner.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Education - Education for youth and family members to maximize individual choice about all treatment options including medications, services, expected benefits, and the potential side effects as well as alternatives to medications.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence Base Practices - Values driven, culturally competent evidence-based or promising clinical services that are integrated with service planning, housing, education, social skills, and employment activities. A wraparound service delivery model will be utilized.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation: Coordination with existing services to assist FSP youth in obtaining transportation to needed health and mental health services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

The Transition Age Team will provide youth and family based services to youth and families who are unserved or underserved. These services will be strength based, needs driven, and utilize best practice models of service delivery. The program will initially utilize outreach and engagement and general system development funds and eventually full service partnership funds to improve services for youth and families.

This will build a transformational program which will be recovery based and develop resiliency skills for both youth and family. The Transition Age Team will help reduce ethnic disparities, provide education and advocacy services, and values-driven, evidence-based practices to address each youth and family’s needs.

Initially, outreach and engagement and System Development funds will be used develop the core services and to offer outreach services to engage youth who are currently unserved and underserved. By Year II, youth will begin being identified for full service partnership (FSP). The FSP will help identify youth and their families to achieve their desired outcomes through the delivery of individualized, family driven mental health services and supports. These services will provide ‘whatever it takes’ to help these youth reach positive outcomes, transition into adulthood, and achieve positive outcomes within the community.

A range of services will be available based upon the youth and family's needs and desired outcomes. Supportive housing, promotion of the development of job skills and supportive employment, and assistance to utilize educational resources will be available to the youth.

Services will be voluntary and client-directed, strength-based, and youth focused to meet the needs of the youth and build lasting supports in the community. Services will be delivered in a timely manner and will be sensitive to the cultural needs of the youth.

The program will build upon the existing Children's System of Care service model and community collaboration to maximize the potential of the Full Service Partnership program. Whenever possible, community agencies and organizations, faith-based groups, businesses, and the individual's natural supports (family, friends, and community networks) will work together. Staffing will include a part-time position for a youth as a Peer Mentor. The second staff position will be a part-time clinician. This individual will provide comprehensive coordinated services. Assessments will be strength-based, provide gender and culture-specific evaluations to develop a Wellness Plan for each youth and family. The Transition Age Team will incorporate evidence-based and best practice models to develop a culturally appropriate, coordinated care plan.

By Year II, individuals will begin being identified for full service partnership (FSP). Because our MHSA funding is small, we will start "small and smart" in identifying individuals to the FSP. By the end of the second year, we plan to identify two (2) youth for the FSPs and to be at full capacity by the end of the third year with three (3) youth and their families identified as FSP.

The FSP will help youth achieve outcomes through the delivery of individualized youth and family driven mental health services and supports. Services will include collaboration with other child serving agencies; community-based services in the school, home, and other supportive environments; coordination, clinical and medications services, as needed; services for youth with co-occurring substance abuse disorders, benefits advocacy; medical care; and other community resources. The program will provide the necessary housing supports to ensure success for youth and families, including assistance with finding housing, rent subsidies, and foster the necessary skills to promote the most independent, least restrictive housing possible in the community. We will collaborate with the Department of Social Services to discuss the possibility of developing a Wraparound program to meet the needs of youth and families in this small county.

The core outcomes for the TAY youth will be:

- At home
- In school or engaged in meaningful employment or volunteer activities

- Out of trouble
- Healthy
- Strong social support network

The Transition Age Team will utilize the same facility developed for the Adult FSP, using a different section of the building or coming at different times of the day/week. This community-based location will help integrate these services into the community and help improve access. The development of a drop-in center concept in a central location and close to other services will help integrate the program into the community and promote a wellness and recovery philosophy. Youth will be encouraged to spend time at the program and participate in a variety of activities and classes from which they can choose.

The program goals include community integration, independent living, and improved access to mental health care and physical health care. Program objectives include decreased hospitalization, incarceration, and homelessness; and increased education and employment. Therapeutic and support groups will be available.

Housing and employment services will be a critical component of the Full Service Partnership. We will employ a ‘housing first’ model, while developing a number of different housing options. This model places a client in a living situation as soon as possible. It does not wait for the youth to exhibit “readiness” for living independently; it provides the support necessary to be successful while the youth lives in the placement. Supportive housing services will be provided, including supports for independent living such as permanent and affordable housing. An array of supportive services will be available that are intended to promote housing stability, recovery, and resiliency. Participation in these support services will be voluntary and will not be a requirement for rent subsidies.

Employment and educational opportunities for youth will be developed in partnership with departmental staff, community providers, and the Peer Mentor. The program will utilize community organizations to help the individual achieve success. It is expected that opportunities will include competitive work force employment, supportive employment, and other options. Staff will work closely with youth to identify and pursue their individual vocational goals. A “work first” approach will be utilized to place a youth at a job site as soon as possible. This model places a youth at a job site and then provides the necessary support and coaching to help the youth be successful on the job. It does not require that the client has all of the prerequisites to a job (e.g., resume, clothing, hygiene skills, interview skills).

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

It is difficult to estimate the average cost of a FSP youth at this early stage of implementation. The projected cost per youth for the Full Service Partnership program is \$20,000 per year, based upon experience from other county programs. It is anticipated that this figure will decrease as the individual achieves his/her outcomes over time. As we gain more experience, we hope to be able to be more accurate in our estimation of costs.

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

Operating from the philosophies and strategies developed with the Children's System of Care program models, staff, Peer Mentors, youth, and family members will work together to foster recovery/resiliency. All staff will be trained in the values and techniques of recovery. Staff will also be trained in using best practice models to provide quality services.

It is anticipated that staff, the Peer Mentor, and family members will participate in trainings to develop these system transformation skills. The children's coordinator (is this the clinician assigned to the TAY team or someone else?) will also be actively involved in the implementation of this program to develop and ensure a wellness recovery model of care. Peer Mentor and Clinician will work closely with the youth and family to aid in the full implementation of the recovery and resiliency model. The Peer Mentor will serve in a leadership role for the youth to offer a vision of wellness and recovery. Whenever possible, bilingual, bicultural persons will be hired to assure the successful implementation of a culturally competent system.

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

This Transition Age Team will expand the existing Trinity County Children's System of Care. (No longer exists—this was disbanded 6/04 and replaced with Child Welfare Redesign activities and leadership) This collaborative, coordinated model provides an excellent foundation for embracing the values of the MHSa and full service partnership. With the ability to fully utilize flexible funds to provide 'whatever it takes', youth and family members will be able to meet their goals and outcomes. By fully utilizing community agencies, we will be able to deliver culturally sensitive services. We will also improve our collaboration with our Wraparound Program with Health and Social Services. By utilizing this model and collaborating with program staff, we will be able to effectively meet the needs of youth and families.

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

As noted above, the Peer Mentor and family members will be an integral part of the Transition Age Team. With limited funding, we are only able to have one part-time

clinician position for this team, in addition to the one part time Peer Mentor position. These individuals will provide family support, supportive services, linkage to services, rehabilitation services, and transportation. Staff will provide an important role in encouraging participation in supporting families and engaging them in recovery efforts and activities.

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

The Children's System of Care provides an excellent foundation for building collaborative efforts with other stakeholders. This is critical to the success of this program. We will expand on already existing partnerships and cultivate broader relationships in developing a Transition Age Team. This requires the close coordination of resources in this small community. The development of relationships with allied partners to access benefits and services; to improve collaboration with Probation and Social Services; identify affordable housing for the youth; offer services for co-occurring disorders; and coordinate care are all critical for developing a successful wellness and recovery program and obtain positive outcomes. We do not currently have a Wraparound Program in Trinity County, but will investigate options for developing these services.

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

The Transition Age Team will include staff who are bilingual and will rely on the youth and family's natural support system. Whenever possible, we will hire staff and Peer Mentors who are bilingual and bicultural. In addition, we will extend efforts to infuse cultural knowledge and understanding throughout our community system. We will seek opportunities to train TAY staff in culturally competent service delivery. To be culturally competent requires the entire community to embrace cultural differences and understand cultural heritage. This goal includes involving the Latino community and the American Indian community. It also includes the lesbian, gay, bisexual, transgender, questioning community and the consumer culture. Whenever possible, natural supports in the community will be identified to create the most comfortable environment for the youth and family.

Program staff will strive to deliver services within the youth and family's own community. In addition, the team will place a high value on the relationship between staff/ Parent Partner, and family member and take the time to learn about the family's culture – how it is similar and how it differs from each staff person. It is incumbent upon the team to ensure the approaches that they use are culturally appropriate and that outreach to these local communities is culturally sensitive.

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

The Transition Age Team will be sensitive to the youth's sexual orientation and have experience in helping youth address and develop their own personhood. We also plan to explore the possibility of developing a Lesbian, Gay, Bisexual, Transgender, and Questioning group in collaboration with the local high school to offer a supportive, safe environment for youth to discuss and develop strategies for building positive gender roles. We anticipate positive outcomes for our youth.

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

As a small community, Trinity County staff have developed networks of resources to meet the needs of youth when they are in out-of-county residences. Whenever possible, we will strive to develop local resources to help youth stay in their community of choice, near family and support persons. Whenever feasible for individuals residing out of county to return to our community, re-entry will be facilitated in a planned, supportive, and coordinated manner.

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

All strategies are included in the MHSA guidelines.

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

It is anticipated that this program will begin staff recruitment and implementation of team building strategies in April 2006. Individuals will be enrolled in the FSP in Year II, with full capacity of three (3) members by June 2008.

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

- 13) *Work plans and most budget/staffing worksheets are required at the program level. Consistent with the balance of the work plans, some services may not be part of a comprehensive program and should be budgeted as a stand-alone program and work plan. An example of this is Mobile Crisis. It is a countywide service available to a broad service population and may not necessarily be part of another program for a priority population.*

- 14) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements. Strategies are approaches to provide a program/service. Multiple strategies may be used as an approach for a single service. No budget detail is required at the strategy level. Examples of strategies include self-directed care plans, integrated assessments for co-occurring disorders, on-site services in child welfare shelters, and self-help support.*
- 15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.*

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Trinity	Fiscal Year: 2005/06	Program Work Plan Name: Wellness Center (
Program Work Plan #: 2		Estimated Start Date: February 2006
<p>Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i></p>	<p>Trinity will develop a drop-in center, the Wellness Center that will utilize general system development funds and eventually full service partnership funds to improve our adult services program, change our service delivery model, and build transformational programs and services. The Wellness Center will help reduce ethnic disparities, and provide peer support, education and advocacy services, and provide values-driven, evidence-based practices to address each person’s special needs and mental health. These services will emphasize recovery and resilience and offer integrated services for clients and families. Initially, Outreach and Engagement and System Development funds will be used to develop the core services and offer outreach services to engage persons who are currently unserved. By Year II, individuals will be identified for full service partnership (FSP). The FSP will help identified individuals achieve their desired outcomes through the delivery of individualized client/family-driven mental health services and supports. These services will provide ‘whatever it takes’ to help these individuals recover and live successfully in the community. Activities will include wellness recovery action planning, peer-led self-help/support groups, supported employment, anti-stigma events, and housing support. Services for co-occurring disorders are available for clients with mental health and substance abuse disorders. We plan to have a psychiatrist available at the Wellness Center at least one day per week. Therapeutic and support groups will be available. Services will be voluntary and client-directed, strength-based, employ wellness, resiliency, and recovery principles, and address both immediate and long-term housing needs. These services will be delivered in a timely manner that is sensitive to the cultural needs of the individual. Bi-lingual, bi-cultural staff will be hired, whenever possible. Staffing includes a part-time clinician, a part-time substance abuse specialist, and two part-time consumer PSC positions.</p>	
<p>Priority Population: <i>Describe the situational characteristics of the priority population</i></p>	<p>Adults ages 18-59 who have a serious mental illness and are at risk of hospitalization, involvement in the criminal justice system, and/or homelessness. Priority will be given to those individuals who are currently unserved, inappropriately served, and/or who have a co-occurring diagnosis of substance abuse and/or medical complications.</p>	

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Outreach and Engagement – The Personal Services Coordinator (PSC) and staff will meet the individual in the place where he/she resides (homeless location, board and care, home) and will begin to build a relationship, encouraging discussion and participation in planning and choice.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coordination – For individuals in a residential placement, the PSC will attend discharge meetings and will assist in the development of a discharge plan from existing placement. For individuals residing in the community, the PSC will coordinate services with any agency which is currently providing services. The PSC will provide transition services to ensure the individual does not get lost in the system upon discharge.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Planning. Client self-directed Wellness Recovery Action Plans will be developed with the individual to outline the person’s goals and vision of wellness.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
24/7 Services - PSC will be available to FSP to provide linkage to services and supports, including assistance with transportation and home visitation. The PSC will provide interventions in urgent needs situations.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Comprehensive Services: Rehabilitation services including supportive housing, supportive employment services, advocacy, and peer education.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Culturally appropriate services - Values-driven, culturally competent evidence-based or promising clinical services that are integrated with service planning, housing, and employment activities. Services will be integrated with ethnic specific community-based organizations.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coordinated Services - Coordinated mental health and substance abuse services will be available to help individuals recover and thrive. There will also be coordinated services with law enforcement, probation, and the courts to develop alternatives to jail. Services will be coordinated with other persons, depending on the client’s needs (e.g., physician, religious leader)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Learning Classes - Education for clients and family members to maximize individual choice about medications, expected benefits, and the potential side effects as well as alternatives to medications.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Evidence Based Practices - Values-driven, culturally competent, evidence-based or promising clinical services that are integrated with service planning, housing, and employment activities.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The Wellness Center (working title only) will build upon existing community collaborations to develop a Full Service Partnership program with community agencies and organizations, local law enforcement agencies, faith-based groups, businesses, and the individual’s natural supports (family, friends, community networks). The Wellness Center will offer a community based alternative that provides a more casual, drop-in alternative to our traditional clinic atmosphere. Staffing will include paid consumers and family members as Personal Service Coordinators, clinical staff, and a substance abuse specialist. Assessments will be strength-based, focus on consumer engagement, and will provide gender and culture-specific evaluations to develop a Wellness Recovery Action Plan with each individual. The Wellness Center will incorporate the values of many evidence-based and best practice models.

Initially, Outreach and Engagement and System Development funds will be used to develop the core services and to offer outreach services to engage persons who are currently unserved. The Wellness Center will offer a broad range of classes and learning opportunities to help individuals and their families to recover and develop the resiliency necessary to achieve positive outcomes.

By Year II, individuals will be identified for full service partnership (FSP). Because our MHSA funding is small, we will start “small and smart” in identifying individuals to the FSP. By the end of the second year, we plan to identify two (2) individuals for the FSP and to be at full capacity by the end of the third year with three (3) persons identified as FSP.

The FSP will help identified individuals achieve their desired outcomes through the delivery of individualized client/family-driven mental health services and supports. Services will include community integration activities; including coordination and access to medications, clinical services, substance abuse services, vocational rehabilitation, benefits advocacy, medical care, and other community resources. The program will provide the necessary housing supports to ensure success for program members, including assistance with finding housing, rent subsidies, and foster the

necessary skills to promote the most independent, least restrictive housing possible in the community.

A community-based location for the adult program is planned to help integrate these services into the community and to help improve access. The development of a wellness clinic in a central location and close to other services will help integrate the program into the community and promote a wellness and recovery philosophy. Clients and family members will be encouraged to drop into the program and participate in a wide-range of activities and classes. The Wellness Center will offer outreach efforts by mental health staff to homeless individuals in need of mental health services, but who may be reluctant to engage in service delivery in a more traditional office/clinic setting.

The program goals include community integration, independent living, and improved access to mental and physical health care. Program objectives include decreased hospitalization, incarceration, and homelessness; and increased education and employment.

Housing and employment services will be a critical component of the Full Service Partnership. We will employ a ‘housing first’ model, while developing a number of different housing options. Rent subsidies with supportive housing services will be provided. An array of support services will be available that are intended to promote housing stability, recovery, and resiliency. Participation in these support services will be voluntary and will not be a requirement for eligibility for rent subsidies. We will also collaborate with community agencies (e.g., In Home Supportive Services) when possible to provide additional support to achieve optimal outcomes.

Employment opportunities will be developed in partnership with other community agencies and businesses. The program will utilize Personal Service Coordinators and family members to help the individual achieve success. It is expected that opportunities will include a range of options, including traditional competitive work force employment and supportive employment. Staff will work closely with consumers to identify and pursue their individual vocational goals. A “work first” approach will be utilized to place a client at a job site as soon as possible. This model places a client at a job site and then provides the necessary support and coaching to help the client be successful on the job. It does not require that the client has all of the prerequisites to a job (e.g., resume, clothing, hygiene skills, interview skills).

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

The projected cost per client for the Full Service Partnership program is \$20,000 per year, based upon experience from other county programs.

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

Operating from the philosophies and strategies developed under the AB 2034 and Children's System of Care program models, staff and members will work together to identify individualized Wellness Recovery Action Plans. The program will look beyond "business as usual" and embrace the concepts of recovery, instilling hope, promoting empowerment, taking responsibility, and securing meaningful roles. Concepts such as wellness, welcoming, harm reduction, housing first, work first, recovery, and whatever it takes, will be promoted throughout the program. It is anticipated that staff, clients, and family members will participate in trainings to develop these system transformation skills. Staff will be actively involved in the implementation of this program to develop and ensure a wellness recovery model of care. Personal Service Coordinators will aid in the full implementation of the recovery and resiliency model. Whenever possible, bilingual, bicultural persons will be hired as Personal Service Coordinators to assure the successful implementation of a culturally competent system.

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

This is a new program for Trinity County Adult Services. The MHSA Comprehensive Adult Services Program will hire consumers and family members as Personal Service Coordinators. Personal Service Coordinators are a critical component of the service team. In addition, these services will expand the traditional clinical model to develop supportive vocational activities, as well as to develop creative housing alternatives and supports for the individuals. The program will utilize flexible funds to provide 'whatever it takes' to help individuals meet their goals as outlined in their Wellness Recovery Action Plans. We will also endeavor to deliver culturally sensitive services in collaboration with community partners and cultural leaders. The development of a service location within the community will promote a wellness concept and help decrease the barriers to accessing mental health services by blending them into other community agencies.

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

Clients and family members will be an integral part of the service team. Some clients and family members will be employed as county staff with benefits. As Personal Service Coordinators, they will participate in delivering services through outreach and engagement activities from the time a client enters the program, throughout the service delivery program, and until discharge. These individuals will provide peer support, supportive vocational services, linkage to services, rehabilitation services, and transportation.

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

Collaboration with other stakeholders is critical to the success of this program. To develop a comprehensive adult service network of care requires the close coordination of resources in this small community. The development of relationships with local businesses for employment and vocational opportunities; with allied partners to access benefits and services; with landlords and property management to secure safe, affordable housing; and utilizing in-home supportive services are all critical to assisting clients to achieve their individual goals and obtain positive outcomes. Close communication with law enforcement and courts will help prevent jail utilization and develop alternatives to help keep clients safely in the community.

Collaboration with the local churches and religious organizations will help to identify service need and also help to reduce the stigma associated with mental illness. Coordinating services with the community and spiritual leaders and traditional healers will help reduce barriers and increase the likelihood of positive outcomes.

Through close collaboration with allied partners, we can be effective at helping individuals be stable in their housing, gain and/or maintain employment, stay out of jail, reduce substance use, decrease hospitalizations, and develop the resiliency to recover and manage their illness.

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

Whenever possible, we will hire staff who are bilingual and bicultural. In addition, we will extend efforts to infuse cultural knowledge and understanding throughout our community service system. We will seek opportunities to train our staff in culturally competent service delivery.

To be culturally competent requires that the entire community services and leadership groups to embrace cultural differences and understand cultural heritage. This goal includes not only the Latino and American Indian communities, but the lesbian, gay, bisexual, transgender, questioning community and the consumer culture.

Program staff will strive to deliver services within the persons' own community. In addition, the team will place a high value on the relationship between staff, client, and family member and take the time to learn about the individual's culture – how it is similar and how it differs each person.

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

Adult service staff are sensitive to an individual's sexual orientation and have experience in helping individuals address and develop their own personhood. We plan to develop a Lesbian, Gay, Bisexual, Transgender, and Questioning group to discuss and develop strategies for promoting positive gender roles and attitudes about sexual and gender issues within the community. We anticipate positive outcomes for our adult gender-specific groups. In areas such as housing and residential treatment, appropriate advocacy and accommodations will be made based upon personal preferences.

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

As a small community, Trinity County staff have developed networks of resources to meet the needs of clients when they are in out-of-county residences. Whenever possible, we will strive to develop local resources to help clients stay in their community of choice, near family and support persons. Whenever it is feasible for individuals residing out of county to return to our community, re-entry will be facilitated in a planned, supportive, and coordinated manner. Additional service coordination to monitor progress and promote a supported return to their community will be available.

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

All strategies are included in the MHSA guidelines.

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

It is anticipated that this program will begin staff recruitment and implementation of team building strategies in April 2006. Individuals will be enrolled in the FSP in Year II, with full capacity of 3 members by June 2008.

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

- 13) *Work plans and most budget/staffing worksheets are required at the program level. Consistent with the balance of the work plans, some services may not be part of a comprehensive program and should be budgeted as a stand-alone program and work plan. An example of this is Mobile Crisis. It is a countywide service available to a broad service population and may not necessarily be part of another program for a priority population.*

- 14) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements. Strategies are approaches to provide a program/service. Multiple strategies may be used as an approach for a single service. No budget detail is required at the strategy level. Examples of strategies include self-directed care plans, integrated assessments for co-occurring disorders, on-site services in child welfare shelters, and self-help support.*
- 15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.*