EXHIBIT 1: Program and expenditure Plan Face Sheet

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

County: Nevada Date: March 13, 2007

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Nevada County
Mental Health Services Act
Community Services and Supports
Three Year Plan

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

Section I: Planning Process

Overview

The MHSA Planning Process for Nevada County aimed initially, in the Community Input phase, at educating and involving as many people as possible in a community discussion about mental health service needs, and then, in the Community Planning phase, defining the discussion in terms of the requirements of the MHSA-CSS.

1. COMMUNITY INPUT. Community input for the Nevada County MHSA-CSS planning process focused on the period May 1, 2005 through September 1, 2005. An additional planning phase occurred from August 2006 through Jan 2007, in response to suggestions for MHSA Plan revisions from the Department of Mental Health.

Nevada County contracted with SPIRIT Mental Health Peer Empowerment Center to provide outreach to un-served and under served populations. In addition, the County contracted with the SPIRIT Center Outreach Director as Lead Facilitator for the Community Input process.

Trained peer counselors from SPIRIT Center worked with MHSA staff to:

1. Present a media information campaign
2. Offer presentations to a variety of community organizations and agencies
3. Organize and facilitate meetings of eleven different focus groups
4. Prepare and distribute a survey questionnaire to a broad section of the population.
5. Invite mental health service proposals from the community.

The goal of this phase was to inform and involve as many people as possible in expressing their needs and goals in terms of mental health services. Residents were informed about the basics of the Mental Health Services Act and asked what services they considered most pressing.

The objectives of this phase were to establish a community discussion:

- Open, inclusive, and as transparent as possible, in order to overcome any obstacles created by the stigma against mental health and any negative attitudes about existing Nevada County Department of Behavioral Health (NCBH) services.
- Supported by but not centered in the NCBH.
- Independent and honest, with opportunities to correct any misinformation.
- Setting long term goals for mental health services in Nevada County that reflects the needs and direction of a broad base of the population.
- Driven by consumers and supported by family and providers.

By September 1, 2005, a significant number of residents were involved in the MHSA planning process. In a small rural county of 93,000, 1434 individuals, or 1.5%, had completed the survey questionnaire or attended a meeting or focus group.

MEDIA. All local media cooperated with the MHSA project, including: commercial radio KNCO, community radio KVMR, commercial newspaper The Union, online YubaNet, and community television NC-TV, all in western Nevada County, and The Sierra Sun and Moonshine Inc in Eastern Nevada County.

This included planning for and coverage of the Town Hall meeting, the survey, and Focus Groups, as well as op ed pieces in The Union about general mental health needs and MHSA.

PRESENTATIONS were offered at twenty-two community organizations, including brainstorming about service needs and distribution of the survey questionnaire.

FOCUS GROUPS included eleven different age, geographic, or interest areas: Children, Youth, Adult, Older Adult, Judicial-Adult, Judicial-Children, Law Enforcement, Medical, Emergency Department, Truckee, and the San Juan Ridge.

SURVEY: The results of the survey questionnaire indicated support for affordable, accessible mental health services. Peer counselors distributed 7,000 copies of the survey questionnaire; by September 1, 670 (9.5%) were completed and returned. Of those 670, 40% were consumers or parents of consumers.

Respondents were able to choose up to three services in each of the five age categories: General, Child, Youth, Adult, and Older Adult.

In General, respondents chose: 1, affordable counseling, 2, a short-term center for people in serious crisis, and 3, affordable psychiatric evaluation and diagnosis.

For Children, respondents chose: 1, early intervention counseling for children and/or families, 2, support and training for at risk parents who are struggling, and 3, affordable family therapy.

For Youth, respondents chose: 1, integrated services for substance abuse and mental health issues, 2, a youth center with health and social services, and 3, psychological counseling at school.

For Adults, respondents chose: 1, a drop in counseling, support and empowerment center, 2, a safe house for people in transition, and 3, a homeless shelter.

For Older Adults, respondents chose: 1, respite care for caregivers that need time off, 2, early intervention counseling for consumer, family, and caregivers, and 3, someone to talk to.

5. PROPOSALS: The Community Input phase also resulted in seventeen proposals or recommendations for MHSA funding: recommendations from each of the eleven Focus Groups and six individual proposals from community organizations, including NAMI, SPIRIT Center, and Hospitality House for the homeless.

2. COMMUNITY PLANNING. September through November 2005.

Nevada County organized an MHSA Steering Committee to set priorities based on community input and to prepare a proposal for MHSA-CSS.

To insure the full participation of consumers and family members, the Steering Committee was structured with a majority of consumers and family members. Each of the focus groups selected consumer or family members as its representatives to the Steering Committee. The Committee consisted of 29 voting members representing various interest groups, with MHSA and NCBH staff present and participating, to assure accurate information, but not voting.

This committee met in eight two-hour sessions from September through November 2005.

At the outset, the Steering Committee chose for its leadership four co-chairs: two consumers, one family member, and one provider. This group met weekly to: plan the agenda for the upcoming Steering Committee meeting, choose facilitators for the meeting, assess progress, and establish training presentations re the requirements of the MHSA.

Later in its process, the Steering Committee broke into two separate Work Groups, one for Children and TAY and the other for Adults and Older Adults; the Children's Work Group met four times and the Adult Work Group met five times to hammer out priorities.

By November 30, the Steering Committee had assessed the 17 proposals, learned the MHSA requirements, and established a service plan and budget for Nevada County. It also established ongoing MHSA committees to look at training and education, oversight and accountability, and finances.

By January 6, 2006 the MHSA-CSS three-year plan program concepts were approved via email by the members of the Steering Committee and sent to the local Mental Health Board. The plan was open for public viewing February 10 – March 13 and a public hearing was held on March 17, 2006.

The MHSA Steering Committee Co-Chairs meet several times with the Director between August 2006 and January 2007 to make MHSA Plan revisions. Some editing to the MHSA Plan came about via email correspondence between this working group. The full MHSA Steering Committee met on February 7, 2007, to review the revised MHSA Plan, make comments, and share information.

In addition to meeting the specific service requirements of the MHSA-CSS planning process, the Steering Committee also achieved several broader goals of the MHSA through a dynamic interactive process.

1. Major participants of the health services community, including Sierra Nevada Memorial Hospital, the only hospital in Western Nevada County, and three Federally Qualified Rural Health Clinics (Miner's Clinic, the Sierra Family Medical Clinic, and Chapa-De Indian Health Service, the only clinics for low income residents), came to the table. The clinics offered innovative proposals for providing integrated physical and mental health services, and the hospital proposed to provide follow up to mental health clients in crisis who had been seen in its Emergency Department.

2. Latino services were integrated into plans for all age groups, underscoring the growth of that community in a predominately Caucasian county.

3. Substance abuse was accepted by focus group and steering committee members as an issue impacting mental health services across the board. All understood that services need to address co-occurring disorders.

4. Truckee and the San Juan Ridge, geographic areas apart from the population center of Grass Valley-Nevada City, were actively advocating for full county services.

5. Several focus groups emphasized the long-term goal of establishing a family resource center or community center. This need was consistent through the three geographic areas – Grass Valley-Nevada City, the San Juan Ridge, and Truckee.

Planning Response

1. Community Program planning must include meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified tasks.

Consumers and family members have been actively involved in planning of CSS from the outset. This small rural community includes a client base of peer counselors at the new SPIRIT Mental Health Peer Empowerment Center, other consumers at SPIRIT, and consumers and family members active in the local chapter of NAMI. Through these mental health advocates, other consumers and family members have become involved in the MHSA process.

Consumers and family members make up a majority of the 29-member MHSA Steering Committee, a group that has become an overseer of MHSA and an avenue for ongoing networking among mental health stakeholders.

1. Nevada County Department of Behavioral Health contracted with the Outreach Coordinator of SPIRIT Center to act as lead facilitator of the MHSA community input process.

2. PLAN TO PLAN. Consumer peer counselors were actively involved in the Plan to Plan.

At the weekly outreach group, peer counselor consumers brainstormed how to create an effective outreach process that would reach un-served and underserved populations.

Peers discussed driving and walking out to areas where homeless people are known to spend time, reaching certain streets and wooded areas, Laundromats, coffeehouses, etc.

Peers decided to approach homeless people at the weekly free meal served at Pioneer Park and participate in the Homeless Count in June 2005.

3. SURVEY QUESTIONNAIRE. Consumers and family were actively involved in the development and distribution of a survey questionnaire.

During several sessions, peer counselors and others brainstormed and developed a list of over 50 needed mental health services for each of the four age categories, plus a category for general.

A peer counselor provided an effective logo for the cover of the survey, printed in bright yellow in half page format with an insert explaining the purpose of MHSA. “You Can Help Decide How to Spend the New Money for Mental Health in Nevada County, Community Survey 2005.”

Peers and supporters brainstormed how and where to distribute the questionnaire, expanding previous planning lists.

Peers and supporters tabled at local supermarkets on a Saturday in May and four Saturdays in September.

Peers participated in the Homeless Count in June, taking copies of the questionnaire as they added their strength in an organized effort to reach homeless people. They then joined the free dinner at Pioneer Park, talking with and involving approximately 35 homeless there.

Peers distributed a total of 7,000 surveys to low income apartment complexes in Grass Valley, Laundromats, barber shops, beauty salons, trailer parks, faith organizations, the Senior Center, the Miners Clinic, Sierra Family Medical Center, the Emergency Department of Sierra Nevada Memorial Hospital, other medical offices, convalescent and nursing homes. The results, by September 1, 2005: of 670 respondents, 40% were consumers or family members.

Peers, in cooperation with the Nevada County Superintendent of Schools, distributed the survey to each of the over 450 teachers in the county, following up with an offer to make the survey available for use with students in the classroom.

Consumers organized and manned a table during Disability Day at the Nevada County Fair in August 2005.

4. HOMELESS. Consumers and family members continue to be involved in aggressive outreach to people who are homeless.

Peer counselors, consumers at SPIRIT Center, and parents of consumers joined in the effort to count the homeless. Organized by people organizing Hospitality House, the count included searching on foot and in a car in areas, including wooded areas near stores, at the Yuba River, Laundromats and coffeehouses, where some homeless individuals say there are others.

Peer counselors, consumers at SPIRIT Center, and others also participated in the weekly free meal for homeless at Pioneer Park, where they conversed with homeless and administered the MHSA questionnaire.

A SPIRIT peer counselor who had been homeless in Nevada County for four years participated in several live radio interviews on KVMR and KNCO; she also participated as a panel member in a live on air town hall meeting about homelessness in Nevada County.

5. LATINO. Consumers and family were involved in outreach to the growing Latino community. In western Nevada County, the Colaborando, a network of Latino outreach workers met to discuss how to best reach Latino families regarding MHSA, and assisted in the translation of the survey questionnaire to Spanish by a native Spanish speaker.

In Eastern Nevada County, where there are a larger number of Latino families, some of the same outreach workers are in coordination with the Tahoe Truckee Community Collaborative in efforts to provide more outreach. All assisted in distributing the Spanish version of the survey questionnaire.

6. NATIVE AMERICAN. The small but significant population of Maidu were involved in giving input to the MHSA process.

MHSA staff met with local TsiAkim Maidu tribal members at a tribal meeting and in other discussions with tribal leaders. MHSA staff participated in a series of discussions among a group of Maidu and other tribal members about mental health issues they see as unique to their Native American culture. Local Maidu representatives participated in several live on air discussions on community radio KVMR about “Healing Soul Wounds.”

Representatives of Chapa-De Indian Health Service met with MHSA staff to discuss possible joint efforts, including support groups for diabetes and eating addiction.

7. INCARCERATED PEOPLE. Residents at Juvenile Hall and providers at both the Wayne Brown Correctional Facility and the Carl Bryan Juvenile Hall were all directly and actively involved in the MHSA CSS planning process.

MHSA lead facilitator brainstormed with and administered the questionnaire survey to the senior staff at Juvenile Hall and to both A Pod and B Pod of residents at Juvenile Hall. A request by residents for feedback to staff resulted in a full staff-resident feedback session.

From the local correctional facilities, staff was actively involved in the Law Enforcement Focus Group.

8. MEDIA OUTREACH. Consumers and family were actively involved in media outreach.

In May 2005, peer counselors and other family and consumers were involved in four hour long live radio programs on KVMR Community Radio, focused in each of the four age groups. They discussed the mental health challenges and needs of their own age group or, as family, the issues of their children. The broadcasts included live call ins.

Peer counselors were actively involved in the planning and presentation of a Town Hall meeting on mental health needs, broadcast live on KVMR-FM May 20, 2005, excerpted for rebroadcast on commercial radio KNCO and rebroadcast on NCTV Community Television. Peers and family were among the speakers at the Town Hall.

Peer counselors helped prepare press releases explaining the MHSA community input process and followed up with the local newspaper, The Union, online news at YubaNet, KNCO, KVMR, and Truckee media.

Consumers also appeared on a live radio program on KVMR in September to discuss the results of the questionnaire-survey.

9. Consumers and family were actively involved in COMMUNITY MEETINGS and FOCUS GROUPS.

Peer counselors were actively involved in the Adult Focus Group.
Consumers and family, including NAMI consumers, were actively involved in meetings of the (Transitional Age) Youth Focus Group.
Family members, including NAMI members were actively involved in meetings of the Children's Focus Group.
NAMI members were actively involved in meetings of the Judicial – Children's Focus Group.
Peer counselors and NAMI members were actively involved in meetings of the Judicial- Adult Focus Group.
Family, including NAMI members, were actively involved in meetings of the Medical Focus Group.
A peer counselor helped initiate and other consumers continued to be active in the San Juan Ridge Focus Group.
Consumers and family, NAMI members, were active in meetings of the Truckee Focus Group.

10. Involvement of consumers and family in the MHSA STEERING COMMITTEE.

The Steering Committee consists of 29 voting members, including 15 consumers or family, for over 50% representation.

The Steering Committee includes two consumers or family members from each of the four age specific focus groups and from Truckee, one from San Juan Ridge, plus one consumer peer counselor from SPIRIT, one family member from NAMI, and one consumer on the open seat. In addition, consumers or family represent various interest groups, including drug and alcohol, domestic violence, disability, and the Mental Health Board.

The Steering Committee chose as its leadership four co-chairs, including two consumers, one family member, and one provider. The chairs met weekly with two staff, the Project Director and the lead facilitator, to plan the agenda for the weekly Steering Committee.

Members of he MHSA Steering Committee continue to develop a broad network of consumers and providers to discuss mental health issues relevant to MHSA, such as the role of local community clinics in assuring physical as well as mental health assessment and treatment.

2. Community Program Planning must be comprehensive and representative…must include active participation by stakeholders in the county.

The CPP in Nevada County was comprehensive and representative of the variety of stakeholders by providing a variety of easy means to participate.

In this rural county, with two geographical areas located at a distance from the major population hub in Western Nevada County, MHSA staff decided to organize a series of open input groups at a variety of locations and to advertise the survey questionnaire in the local media. In addition, MHSA staff succeeded in providing an open discussion with a brainstorming process in the meetings and focus groups that encouraged open participation.

The result, in a county of 93,000, was participation of 1434 stakeholders.

1. SURVEY QUESTIONNAIRE.

An effort to reach as many residents a possible in this small, rural county of 93,000 people focused on wide distribution and media support for an attractive, easy to complete survey questionnaire. The questionnaire was distributed with an addressed envelope, no postage required. It was bright yellow with an attractive logo created by a consumer. Distribution was 7,000 copies;

Surveys were distributed to: each of the 450 teachers in Nevada County and every medical doctor on staff at the local hospital. Surveys were distributed to medical clinics and professional offices, social service providers, private psychotherapists, service organizations, many churches and faith based organizations, service providers, random sampling through tabling at local supermarkets and drug stores, and attendees at every MHSA meeting.

The survey is easy to reach on the Nevada County website with links from all local media.

2. PRESENTATIONS were offered April-July 2005 to a variety of stakeholders at their regular organizational meetings.

Nevada County organized an MHSA Steering Committee. The discussions were interactive. Surveys were distributed to all participants.

NAMI board meeting and general meeting (30 consumer/family members),
Adult and Family Services Commission (25 stakeholders),
Long Term Care Council (20 stakeholders),
Foster care luncheon (48 stakeholders).
Elder Care Coalition (30 stakeholders),
Forensic Task Force (15 stakeholders)
Tahoe Truckee Community Collaborative (12 stakeholders),
Children's Mental Health staff (14 providers),
Behavioral Health staff (24 providers),
Child Protective Services staff (16 providers),
Child Abuse Prevention Council (10 stakeholders),
Family Care Collaborative (24 stakeholders)
Senior staff at Juvenile Hall (5 providers)
NC Behavioral Health Crisis Team (8 providers)
Public meeting at Lake of the Pines (10 stakeholders)
Meeting with both pods of residents at Juvenile Hall (20 potential consumers)
The Colaborando of Western Nevada County (5 providers)
Palm Tree Group (22 stakeholders)
Meeting with Friday Night Live staff (3 stakeholders)
North San Juan Collaborative (11 providers and consumers)
NC Superintendent of Schools and Assistant Superintendent (2 stakeholders)
Maidu tribal meeting (25 stakeholders)

3. FOCUS GROUPS were organized to insure stakeholder involvement.

Members of law enforcement established their own focus group, which included representatives from Nevada County Sheriffs Office, Wayne Brown Correctional Facility, Carl Bryan Juvenile Hall, Nevada City Police Department, Grass Valley Police Department, and Truckee Police Department.

The Judicial Adult Focus Group (aka the Forensic Task Force) included: NC District Attorney's Office, Public Defender's Office, Juvenile Hall, Probation, NC Sheriffs Office, Grass Valley PD, Nevada City PD, NAMI, SPIRIT Center, County Counsel, NC Behavioral Health, NCBH Crisis Team, Adult Protective Services, Alzheimer Outreach Group, NC Superior Court.

The Judicial Children's Group (aka the Palm Tree Group) included: NC Family Court, NC Mediation, NC Director of Human Services, NC Director of Behavioral Health, CASA (Children's Court Advocate), Probation, Charis Youth center, NAMI, NC Children's Mental Health Services, Children's Protective Services.

Representatives from education were unsuccessful in organizing an education focus group.

The Medical Focus Group included: Sierra Nevada Memorial Hospital staff, including the public relations officer, director of the Emergency Department, and case managers, consumers, Hospice of the Foothills, NAMI, Sierra Nevada Home Care, Alzheimer Outreach Project.

The Emergency Department Focus Group included: the director of the ED, a medical doctor, nurses, and administrative staff.

The Children's Focus Group included: NC Community Health staff, Sierra Nevada Children's Services, Child Protective Services, First 5 Commission, Sierra Adoption Services, N C Planning Council, Nevada County Court Services, NAMI, NC Community Health, Child Advocates, Domestic Violence and Sexual Assault Coalition, Child Care Council, NC Behavioral Health, Child Protective Services, Colaborando of Western Nevada County, Family Connection, and individual parents.

The Youth Focus Group included: Charis Youth Center, Sierra Adoption Services, NAMI, Community Recovery Resources (CoRR), FREED, Hospitality House, Alta Regional Center, NC Probation, NC Behavioral Health, individual consumers and family.

The Adult Focus Group included: CoRR, NAMI, FREED, Hospitality House, Adult and Family Services Commission, SPIRIT Center, and individual providers and consumers.

The Older Adult Focus Group included: Long Term Care Council, Elder Care Coalition, Adult Day Care Center, Alzheimer Outreach Project, Brunswick Village, Gold Country Community Center, Hospice of the Foothills, Sierra Services for the Blind, Adult Protective Services, League of Women Voters, Adult and Family Services Commission, CoRR, and consumers.

The North San Juan Focus Group included: Sierra Family Medical Clinic, private therapists, North San Juan Community Center, and individual consumers.

The Truckee Focus Group included: the Truckee Tahoe Community Collaborative, Truckee office of NCBH, Truckee office of Sierra Nevada Children's Services, Probation, Wellspring Counseling, NAMI, NCBH Crisis Team, NC Department of Rehabilitation, Tahoe Truckee Union School District, Truckee Tahoe Seniors Council, Boys and Girls Club of Truckee, NCBH, and Tahoe Women's Services.

The Latino Focus Group included: Child Advocates, Colaborando of Western Nevada County, Foothill Healthy Babies, PCAC, Sierra Nevada Children's Services, and Spanish Counseling Services.

4. THE MHSA STEERING COMMITTEE includes a variety of stakeholders among its 29 voting members: domestic violence, substance abuse (CoRR), disabilities (FREED ILC), SPIRIT Center, NAMI, Latino (the Colaborando of Western Nevada County), Wellspring Counseling, Tahoe Women's center, Sierra Family Medical Clinic, NC Public Defender's Office, NC Family Court, Sierra Nevada Home Care, NC Schools, NC Mental Health Board, Charis Youth Center, Sierra Nevada Children's Services, and the Long Term Care Council. Nonvoting members included: NC Behavioral Health staff, MHSA staff, Child Protective Services, NC Human Services, and NC CEO's office.

5. EDUCATION. Because Nevada County's MHSA community outreach began in April, near the end of the school year, the education community was the first to be contacted.

The Superintendent of Schools agreed and MHSA staff organized distribution of the surveys to each of the 450 teachers in the county system.

The Assistant Superintendent of schools participated on the panel at the Town Hall meeting May 20, 2005, broadcast live on KVMR community radio and rebroadcast on NC-TV community television.

Several individual teachers requested additional copies of the survey to use in their classroom, and parents encouraged specific teachers to use the survey as a teaching tool in their classrooms.

General media outreach through local radio, television, internet and newspaper increased the awareness and involvement of individual teachers in the MHSA process.

Tahoe Truckee Unified School District, which is separate from the Nevada County School District, was represented in the Truckee Focus Group. That district also made its conference room available for MHSA meetings.

Teachers in the San Juan Ridge district participated in the San Juan Ridge Focus Group.

An Education Focus Group was suggested, but not completed, due to other demands on the participants.

Three representatives from Nevada County Department of Education participated as voting members in the MHSA Steering Committee: the Director of Health Education and the Director and Assistant Director of Special Education.

The Superintendent of the Nevada Union High School District has been invited to coordinate with MHSA staff to offer training for her teachers on mental health issues.

6. OUTLYING GEOGRAPHICAL AREAS – TRUCKEE AND SAN JUAN RIDGE

TRUCKEE. The Tahoe –Truckee Community Collaborative, a community action group including the major stakeholders in the mountainous area, brought together its network of providers and consumers for an initial meeting. That group evolved into a focus group and included additional stakeholders. Two consumer participants and one provider became members of the MHSA Steering Committee.

SAN JUAN RIDGE. With minimal existing community organization, this population responded to the call for input to MHSA. A local resident called a meeting in which a medical doctor of the community clinic participated. The group evolved into a MHSA focus group and continues as the San Juan Ridge Health Collaborative. One provider and one consumer became voting members of the MHSA Steering Committee.

In summary, Nevada County has succeeded in reaching a number of un-served and under served residents through the MHSA planning process. A number of consumers and family members continue to participate enthusiastically with other stakeholders in the network developed through the MHSA process. In a small rural county with limited resources, the MHSA planning process reached all major stakeholders.

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.

MHSA Project Director Doug Bond, NCBH Program Chief and Children's Program Manager, had managerial responsibility for MHSA up until July 2006. He devoted 50% of his time to MHSA. Subsequent to Doug's departure from employment with Nevada County, Michael Heggarty,

Behavioral Health Director, assumed project responsibility. Newly appointed MHSA Coordinator Bob Gillaspie will take over these duties and implementation tasks during the Spring of 2007.

Robert Erickson, as Director of Nevada County Department of Behavioral Health, provided direction and supervision up until his retirement in May 2006.
Lead Facilitator was Joan Buffington, as independent contractor with NCBH. She devoted 55% of her time to MHSA, and carried primary responsibility for community input.

Gail Gordon supplied administrative support at .5 FTE to MHSA.

Peer counselors at SPIRIT Mental Health Peer Empowerment Center, through an independent contract with NCBH, provide and support outreach efforts.

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

General education and training about mental health issues and the MHSA process were made available to the public through a media campaign that enlisted the cooperation of all locally produced media - local print media, local commercial and community radio and local community television, and the local online news service.

Specific training papers were available at all public meetings, focus groups, and in the binder given each of the members of the Steering Committee. They include 1, Background on the Public Mental Health System and Systems of Care, 2, Cultural Competence, and 3, Concepts of Recovery and Resiliency from Psychiatric Disability.

In addition, the Steering Committee meetings included a series of presentations by consumers and family members and providers on the Committee concerning issues and challenges of their populations. The co-chairs planned and Steering Committee members participated in panel presentations and discussions about specific aspects of the MHSA.

Section II: Plan Review

Plan Review in the Nevada County CSS Plan is divided into two sections. The first section describes the chronological progression of community comment/review and the second outlines the Mental Health Board response to public comment.

PLAN REVIEW CHRONOLOGY

Public Review. The draft MHSA-CSS proposal from Nevada County was available for public review February 10, 2006 through March 17, 2006. The proposal was and continues to be available on the Nevada County government website at http//:www.mynevadacounty.com/bh. Hard copies of the proposal were available at the Rood Center and the three behavioral health offices in Grass Valley, Nevada City, and Truckee. Reference copies were and are available at the three public libraries, in Grass Valley, Nevada City, and Truckee.

The public review process was publicized through press releases to, and coverage in, the local daily newspaper The Union. Interviews occurred on local commercial radio KNCO, community radio KVMR-FM, and online news YubaNet.com.

Media coverage included a one hour live on air discussion of the proposal by a consumer, a family member of the MHSA Steering Committee, and the Project Director, interviewed by the MHSA Lead Facilitator and host of radio program, "Who Cares?" on KVMR on February 10, 2006. MHSA staff maintained a log of written and telephone public input.

Public Hearing. The public review period ended March 17, 2006 with a Public Hearing at the Helling Library in Nevada City. The two-hour hearing was broadcast live on KVMR-FM to listeners in both Eastern and Western Nevada County. One consumer volunteer was available by cell phone for call in comments, which she relayed immediately to the immediate and listening audience. The Public Hearing was videotaped by three cameras for archive purposes and for rebroadcast on public television NC-TV, Channel 11.
Members of the Mental Health Board of Nevada County and the Director of the Nevada County Department of Behavioral Health sat at the front of the room during the Public Hearing in order to receive input. The MHSA Lead Facilitator moderated the hearing. Approximately seventy people were present, and thirty-three offered comments (including five phone calls). Some of the speakers offered written comments, which are attached to this document.

Mental Health Board. The Mental Health Board met on March 23, 2006 and April 12, 2006 to discuss and compose its written response to public comments. That response is available in this document. The Mental health Board recommended to the Director of Behavioral Health that the MHSA-CSS proposal and appendices be sent to the Nevada County Board of Supervisors for final approval. The Board of Supervisors unanimously approved the MHSA-CSS proposal on April 25, 2006.
The LMHB reviewed and commented on the current MHSA Plan revisions on February 6th, 2007.

Steering Committee. The MHSA Steering Committee, which had taken a break since November 30, 2005, reconvened. The MHSA Education Subcommittee of the Steering Committee met on February 22, 2006, March 15, and March 29 to discuss and make recommendations regarding how to utilize One Time Funding. The full Steering Committee met on March 1, April 5, and April 12 to consider those recommendations. The Steering Committee approved twelve budgets for One Time Funding for each of the twelve plans in the CSS proposal. For the balance of the One Time Funding available, the Steering Committee is developing guidelines for an RFP in order to provide coordination of trainings. Several community organizations involved in the MHSA-CSS process, including CoRR, SPIRIT Center, and Sierra Family Medical Clinic, offered proposals which were set aside by the Education Subcommittee until the full Steering Committee developed a plan for their consideration.
The full Steering Committee recently met again on February 7th, 2007 to review and comment on the revised MHSA Plan.

MENTAL HEALTH BOARD RESPONSE TO PUBLIC COMMENT

The Nevada County Final Draft Community Services and Supports (CSS) Plan, a required document of the Mental Health Services Act (MHSA), was released for thirty days public viewing on February 10, 2006. On March 17, 2006 a public hearing was held by the Mental Health Board (MHB) for public comment on the plan. Prior to that date the Mental Health Department accepted written comments on the plan. On March 23 and April 12, 2006 the MHB met to discuss both written comments and comments made at the public hearing. Fourteen shared community issues or themes were identified in the process. These seemed to focus on whether a specific issue received adequate focus in the plan or whether it was addressed at all.
Mental Health Board Response

1) Housing – Housing is addressed as part of the ACT Program and also in the one time funding. The one-time funding request will include $70,000 to be used in various ways for rapid access to housing, for example stipends, security deposits, first and last months rent. Long term goals include developing and implementing collaborative approaches to supportive housing with community stakeholders. Persons in the Truckee area who are homeless or at risk of being homeless due to serious mental illness, will be eligible for this funding, as well as ACT services, along with those in western Nevada County.

2) Homeless, Hospitality House (homeless shelter) – services for persons who are homeless or at risk of becoming homeless due to serious mental illnesses are addressed under the ACT Program. Such persons can be referred to the ACT Program. Additionally, the ACT program will be contractually obligated to provide outreach and active engagement for persons who are homeless or at risk of becoming homeless due to mental illness. This shall be done in connection with Hospitality House and elsewhere in the community.

3) Youth (TAY), High School and Community College Students –There was a discussion of whether or not there was enough focus on the Transition Age Youth (TAY) in the plan. Under MHSA we are required to address all four age groups: Children, Youth (TAY), Adults, and Older Adults. We are not required to separate out programs for each of the four age groups. We need to look at each group's unique needs, but are not required to have separate services for them. To create additional programming for the TAY population would likely involve an RFP and additional funding. In lieu of a dedicated service program for the TAY population, they will be a special focus of training using one time funding. This training will be directed to ACT staff and other community staff and stakeholders. Additionally, the special issues of TAYs will be spotlighted through the on-going planning and oversight processes.

The Transition Age Youth (TAY) are addressed in the ACT Program (age 18-24).
The Wraparound Program addresses children ages 16 – 18 and Foster Care youth. Under the CSS Plan, SPIRIT will provide outreach and a weekly support group for TAY (age 18-24). The Court Liaison strategy in the WRAP program also addresses the TAY especially Foster Care youth in placement who are aging out of the system. Assisted Outpatient treatment and Mobile Crisis Intervention would also provide services to this population as components of the WRAP Team and the ACT Team.

4) Dual Diagnosis (co-occurring disorders) – The ACT Program addresses those with dual diagnosis. Those with dual diagnosis will be addressed on an individual basis by the ACT team. The Wraparound Program also addresses this issue with children and adolescents. SPIRIT is doing a support group for adults. One time funding will also be used for training on co-occurring disorders.

5) People with Disabilities – There is agreement that people with disabilities could be better addressed by the CSS plan. The plan recommends that a study be done in the first year to find out what the needs of this population are and then develop a strategy to address what those needs are. Current Nevada County contract language requires a contract provider to be ADA compliant. There are ADA issues with SPIRIT. SPIRIT continues to work on these issues utilizing community contractors and service groups.

6) Agency Responsible for Children's Wraparound – The Wraparound program includes therapists and Care Coordinators who will provide services throughout Nevada County. These services also include psychiatric services.

The identity of the provider (community or county) is a point of discussion and has not been decided. The CSS plan does not require a decision on this issue in order to submit the plan. There is commitment to coordination of the several children and youth oriented aspects of the CSS Plan.

7) Use of 2005 Survey Questionnaire Results – The MHSA survey was created with input from many community providers and had over 60 different service possibilities. The survey is part of the long-range vision for mental health services. The focus of our first 3-year plan is to serve people with serious mental illness. The Steering Committee used the results of the survey in plan development. Suggestion is that a summary/narrative be compiled for future reference. A graph of the survey results will be included in the CSS plan as an addendum.

8) Nevada County Administrative Cost of 15% - Mental Health Board members asked where the 15% comes from. This is based, in part, on a Medi-Cal guideline. Medi-Cal allows this amount of overhead. Additionally, the MHSA act includes an allowance for reasonable administrative costs for the county to administer the program. The question of what is reasonable was asked of the State Department of Mental Health.

The State replied that the Medi-Cal guideline of 15% is acceptable. The State also replied that if those costs exceed 15% it needs to be justified. The administration of programs does cost the county money and given the budget deficit situation it was decided in consultation with the CEO's office that 15% is the amount we should request. The question of what this covers was asked. The CSS Plan lists what the expenses cover on page 173.

9) Assisted Outpatient Treatment – Nevada County entered into a legal agreement with the Wilcox family that the CSS proposal will include elements of "Laura's Law". Our proposal includes a part time clinical position as a liaison between the court and the ACT Program. The ACT Program would provide the bulk of the services for those referred by the courts. The liaison would be a part time clinician to provide assessment, referral, and direct treatment as a member of the ACT Team.

Protection and Advocacy, Inc. (PAI) has sent a letter stating their position of opposition to the proposal. They are opposed to the involuntary treatment aspect and that the CSS plan requirements specify the voluntary aspect of any service to be funded under MHSA. They also oppose it on the grounds that the county's decision to include it was made outside the parameters of the community input process. The California Network of Mental Health Clients also sent a letter stating their position that MHSA funding should not be used for involuntary services. The Board of Supervisors settlement decision was made prior to the passage of the Mental Health Services Act. Nevada County's community input process does include Steering Committee members and members of the public who do want Assisted Outpatient Treatment to be included in our proposal.

10) Latinos in Eastern Nevada County – Our CSS plan includes services for the Latino population in both eastern and western Nevada County. There is bilingual/bicultural counseling available at Wellspring Counseling Center. Latino services will be a collaborative effort between Colaborando en Espanol, Empiezos Maravillosos, Truckee Collaborative, community providers and Behavioral Health. Services will include psychiatric treatment, case management, peer services, training, counseling by licensed therapist, and community outreach.

11) Support for Families of Consumers – Peer Family Support is included in our CSS Plan on page 160. In addition, the ACT program contract will address that program's responsibility to provide support to families as well as consumers. Families of full service partnership consumers will be given priority for this support.

12) Accountability –The State will provide oversight requirements that Nevada County will comply with in ongoing consultation with the MHSA Steering Committee and the Mental Health Board.

13) Crisis – Included in our proposal is follow up for those evaluated at the Emergency Room who do not meet 5150 criteria. Follow up will occur within 72 hours of discharge by a licensed mental health professional. Referrals will be made to the WRAP or ACT Teams as appropriate.

14). Older Adults – It was noted that older adults suffer disproportionately from depression and suicide and that the CSS services plan does not include a proposal dedicated to older adults. In review, it was agreed that these issues need to be addressed in connection with the community-wide training effort that is envisioned as part of our one-time funding request.

General Comments
All CSS plans will strive toward cultural competency, consumer and family driven treatment, community wellness, and stakeholder collaboration.

All seventeen original CSS proposals were included with the final CSS Plan. The initial approved MHSA Plan had 12 Work Plans, the final revised MHSA Plan had only 2 Work Plans, with several strategies included in those Work Plans from the original 12.
The five unfunded proposals will be included as "plans awaiting funds".

The CSS Plan will reflect minor refinements with no major variations of theme or substance from the final draft.

Action

The Mental Health Board recommends that the Mental Health Director submit the CSS Plan to the Board of Supervisors, for approval of submission to the state Department of Mental Health.
Moved, seconded and adopted April 12, 2006.
Ayes 4, No 0, Absent 2.

PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

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

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.)

County/Community Issues Identified in the Public Planning Process:incarseration

Children/Youth	Transition Age Youth	Adults	Older Adults
1.School failure *	1.Incarceration. *	1.Incarceration. *	1.Isolation. *
2.Involvement with the juvenile justice or child welfare systems. *	2.Isolation and inability to manage independence. *	2.Homelessness. *	2.Insitutionalization. *
3.Inability to mainstream school. *	3.Homelessness. *	3.Involuntary Care *	3.Involuntary care. *
4.Hospitalization *	4.Involuntary care. *	4.Frequent Emergency room visits. *	4. Inability to manage independence. *
5.Peer and family problems. *	5.Insitutionalization. *	5.Insitutionalization. *	5. Homelessness *

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.)

Criteria consideration for all four groups centered on severely mentally ill individuals who were at risk for: 1) incarceration, 2) hospitalization, 3) homelessness, or 4) death. Four basic themes intertwined with all age groups were access/sufficient treatment, co-occurring substance abuse issues, justice system involvement, and stigma issues.

Children

Access seemed limited for children at critical sites, or points of their lives. Needs identified by the steering committee focused on better access/outreach and involvement at juvenile hall, school sites, child welfare, and with aging out foster youth.

Co-occurring Substance Abuse Disorders – that often families become dysfunctional because of substance use in the home by parent's use/abuse or by the child trying to cope with illness by self-medicating.

Justice System – Often children or families are involved in /with the justice or welfare systems. This involvement can foster negative or positive outcomes dependent on the situation. Juvenile hall and the foster youth program seemed to be points of contact to be taken advantage of. Ensuring smooth mental health transitions for aging out juvenile hall wards and foster youth is important. Creating opportunities of access to mental health need assessments for the juvenile justice and child welfare populations is critical.

Stigma – Stigma creates isolation and often creates a reluctance to engage the mental health system. Isolation and lack of service engagement increase the inability of children to mainstream in the school system. Education and training around mental health, mental illness, and the recovery process are needed at all levels.

Transition Age Youth (TAY)

Access – Access to, and sufficient treatment for, mental health services needs to be better in juvenile hall and in the jail. Outreach to those reluctant to engage or isolated is needed in the community where TAY normally spend time not at the clinic.

Co-occurring Substance Abuse Disorders – Nevada County has a methamphetamine epidemic. This particular drug plays havoc with individuals who have a severe mental illness. The TAY group because of isolation, peer and family relationships, and lack of service desire are particularly at risk for abuse.

Justice System – The first contact with the adult system of care is often the jail. Nevada County needs to expand assessment/transition services to this population. Released without treatment easily translates to hospitalization or reoffendeing.

Stigma - Stigma prevents this group from engaging services, and lack of education/training prevents the community from recognizing and referring individuals in need.

Adults

Access – Access needs to be provided in the jail. The Nevada County homeless population currently has little or no access to mental health services. Homeless access to services needs to be user friendly and community based.

Co-occurring Substance Abuse Disorders – Co-occurring substance abuse/mental illness treatment needs to be available to the severely mentally ill. Treatment interventions would reduce emergency room visits and 5150's with drug involvement. A 5150 that is "meth" induced/aided almost never ends in a positive treatment experience. It is important to treat both disorders jointly.

Justice System – Nevada County Courts in collaboration with Mental Health and the community provide a Mental Health Court. This has been a successful attempt to provide mental health intervention to severely mentally ill involved with the justice system. This type of collaborative effort needs to be expanded.

Stigma – Stigma prevents adults from seeking treatment. The Spirit Center (a peer counseling program) has provided a bridge for these individuals to cross and access services. Community based peer program/interventions successfully reach out to the reluctant to engage.

Older Adults

Access - Isolation is a major issue for older adults. Outreach and community based program delivery is needed to engage this population. Programs that involve older adults in outreach and support to help other older adults seem indicated as an intervention.

Co-occurring Substance Abuse Disorder – Isolation and substance abuse go "hand in hand" with mental illness for this group. In prior NCBH attempts to engage this population denial and distrust of the system seemed powerful deterrents to treatment. Again it appears a peer-driven, community-based intervention would be indicated.

Justice – Conservatorships often create legal difficulties for this group. Some sort of legal/community support for the older adult would be helpful.

Stigma – Stigma seems to help create the isolation and distrust of the system for this group. User friendly peer supported interventions would help educate and engage older adults.

An area of outreach and engagement for all four age groups are those individuals with special needs/disabilities who are also experiencing SED/SMI issues. An accurate assessment of mental health needs and numbers for this group will occur in the first year of the CSS plan.

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.

Nevada County has one threshold language which is Spanish. The Latino population represents 5 percent of the general population. In most cases different populations reflect proportionate percentages as the general population. Examples being a) 276 Foster Care kids, 93% Caucasion, 5% Latino, 2% other. b) Juvenile Hall residents 338 total, 91% Caucasian, 7% Latino, 2% other. c) Medi-Cal recipients 92.8% Caucasian, 5.4% Latino, 1.8% other.

There are no federally recognized tribes in Nevada County. The TsiAkim Maidu are seeking federal recognition and have received recognition from Nevada County.

The Latino population represents only 1.72% of the total mental health caseload. Anticipated efforts to increase Hispanic penetration/participation in mental health services is documented in another section of this document.

Section II: Analyzing Mental Health Needs in the Community

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

- **Nevada County Homeless** – A "point in time" count of the homeless was conducted on June 30, 2005 by the Hospitality House Count Committee. There were 238 homeless persons in western Nevada County. Of these, 168 were unsheltered (having no housing alternatives), and 76 were sheltered (in temporary housing with the expectation of being unsheltered at the end of their stay). Ethnicity reflected 222 observed to be Caucasian, 6 Hispanic, 5 American Native, 1 Afro-American, and 3 other. All age groups were involved with 46 youth, 176 TAY and adult, and 16 seniors. This group currently has limited or no access/outreach to, or easily accessible assessment for mental health service needs.

- **Latino Population** - There is an expanding Latino population in Nevada County. While this population is predominantly clustered in eastern county there is a growing presence in Western County. While representing 5% of the population Latinos represent only 1.72% of the total mental health caseload. There is a large contingent of Latino families that are unserved. Issues to be addressed include outreach efforts to reach reluctant or fearful clients, services in the community not just in county facilities, peer counselor presence, and adequate human resources (bilingual). Across the four age groups the average unmet need is 94% of the estimated Latino population needing services.

- **"Aging Out of the System" Kids/Young Adults** – In the year 2004 there were 338 children admitted to Nevada County Juvenile Hall. 127 of those children were 17 years of age. In 2004 there were 276 children involved in the Foster Care process in Nevada County. Of these Foster Care children 26 were 17 years of age or older, and 51 were over 16 years of age. In Nevada County CPS staff estimates that 50% of Foster Care youth need some form of mental health type services. These aging out kids in juvenile hall and Foster Care represent a significant number of high risk children that would likely benefit from mental health intervention/prevention services. If these children age out of the system (probation or child welfare) without resources, services, and social infrastructure the likelihood of incarceration, homelessness, or institutional episodes increases tenfold. This issue affects both youth and TAY groups.

- **High Risk Adults and Seniors** – Serious mentally ill (SMI) individuals who service needs are unmet or so minimally met they fall into the unmet category placing them at risk of incarceration, institutionalization, homelessness, or involuntary care. These are individuals who are 5150 and then receive no follow up services (by choice, chance, or system overload). They are SMI individuals who do not receive coordinated services in jail and then discharge to no treatment. Nevada County has 33 LPS conservatees in placement (almost always out of county). These individuals could benefit and perhaps come back to our community with more focused service delivery. SMI seniors live in our community in isolation often with co-occurring medical or substance abuse issues. SMI individuals in this group often have substance abuse issues. Nation wide estimate is that 40% of individuals with mental illness also have a substance abuse issue (a point in time study at a residential treatment center here in Nevada County a few years back found that approximately 65% facility residents in that year were dual diagnosed).

Methamphetamine abuse represents a major concern in Nevada County and seems to lend itself to increasing/expanding negative outcomes for individuals with mental health issues. Engaging this group of individuals with co-occurring disorders in ongoing treatment beyond emergency room visits is of the utmost importance.

Unserved Population Estimates
Nevada County 2005

Children & Youth Unserved Population Estimates

	Population Total	Prevalence Rate (2000)	Prevalence Total (2000)	Clients (2004-5)	Unmet Unserved	% Unserved
Latino	1923	7.82	150	11	139	92
White	18190	7.06	1285	333	952	74
Afro Am	84	7.62	6	4	2	33
Native Am	181	8.31	15	5	10	66
Asian	136	7.97	11	0	11	100
Other	763	7.49	56	3	53	94
TOTAL	**21277**		**1523**	**356**	**1167**	76
Male	11195		805	221		
Female	10082		718	135		

Transition Unserved Population Estimates

	Population Total	Prevalence Rate (2000)	Prevalence Total (2000)	Clients (2004-5)	Unmet Unserved	% Unserved
Latino	281	5.54	15	0	15	100
White	5124	5.75	295	66	240	78
Afro Am	11	6.41	1	1	0	0
Native Am	51	4.12	2	0	2	100
Asian	51	5.55	3	0	3	100
Other	99	6.54	6	0	12	100
TOTAL	**5628**		**322**	**66**	**272**	80
Male	2741		155			
Female	2887		167			

Adult Unserved Population Estimates

	Population Total	Prevalence Rate (2000)	Prevalence Total (2000)	Clients (2004-5)	Unmet Unserved	% Unserved
Latino	2454	5.54	133	17	116	87
White	45498	5.75	2616	826	1790	68
Afro Am	98	6.41	6	5	1	17
Native Am	441	4.12	18	7	11	61
Asian	441	5.55	24	3	21	87
Other	147	6.54	10	9	1	10
TOTAL	**49079**		**2797**	**867**	**1940**	69

Male	24049		1044	353		
Female	25030		1753	514		

Senior Unserved Population Estimates

	Population Total	Prevalence Rate (2000)	Prevalence Total (2000)	Clients (2004-5)	Unmet Unserved	% Unserved
Latino	803	5.54	44	0	44	100
White	14878	5.75	855	54	801	94
Afro Am	32	6.41	2	0	2	100
Native Am	144	4.12	6	0	6	100
Asian	144	5.55	8	0	8	100
Other	48	6.54	3	1	2	66
TOTAL	**16049**		**918**	**55**	**863**	94
Male	7864		346	14		
Female	8185		572	44		

2) Underserved Population – 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 and race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity.

No Nevada County resident is fully served in Nevada County. There are no AB2034 type homeless programs, no Full Service Partnerships, and no Wraparound services for youth provided in Nevada County. Resources in our rural county are limited and do not adequately accommodate the mental health service need in the community. The loss of Children System of Care funds decreased the ability of the community to coordinate care among different systems for severely disturbed youth. Discontinued Dual Diagnosis funds limit the ability to address the issue of co-occurring mental illness and substance abuse. Consumers are underserved at all four levels: youth, transition, adult, and senior.

Chart A: Service Utilization by Race/Ethnicity

CHILDREN AND YOUTH	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	**0**	**0**	**221**	**135**	**356**	**100**	**6295**	**100**	**21277**	**100**
African American	**0**	**0**	**4**	**0**	**4**	**1**	**7**	**001**	**84**	**004**
Asian Pacific Islander	**0**	**0**	**0**	**0**	**0**	**0**	**63**	**009**	**136**	**006**
Latino	**0**	**0**	**8**	**3**	**11**	**3**	**981**	**16**	**1923**	**9**
Native American	**0**	**0**	**2**	**3**	**5**	**1**	**148**	**2**	**181**	**1**
White	**0**	**0**	**204**	**126**	**333**	**94**	**4858**	**77**	**18190**	**85**
Other	**0**	**0**	**0**	**3**	**3**	**1**	**238**	**4**	**763**	**4**

TRANSITION AGE YOUTH	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	0	0			67	100	2309	100	5628	100
African American	0	0	0	1	1	1	7	003	11	002
Asian Pacific Islander	0	0	0	0	0	0	20	007	51	009
Latino	0	0	0	0	0	0	173	7	281	5
Native American	0	0	0	0	0	0	26	1	51	009
White	0	0	34	32	66	99	1932	84	5124	91
Other	0	0	0	0	0	0	151	7	99	2

ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	0	0	353	514	867	100	10000	100	49079	100
African American	0	0	4	1	5	006	33	003	98	002
Asian Pacific Islander	0	0	1	2	3	004	89	007	441	1
Latino	0	0	5	12	17	2	764	8	2454	5
Native American	0	0	2	5	7	1	116	1	441	1
White	0	0	338	488	826	95	8559	86	45498	92
Other	0	0	3	6	9	1	439	4	147	002

OLDER ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	0	0	14	41	55	100	3610	100	16049	100
African American	0	0	0	0	0	0	12	003	32	001
Asian Pacific Islander	0	0	0	0	0	0	33	007	144	1
Latino	0	0	0	0	0	0	284	8	803	5.6
Native American	0	0	0	0	0	0	43	1	144	1
White	0	0	14	40	54	98	3175	88	14878	92
Other	0	0	1	0	1	2	63	2	48	003

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 and Youth
Of interest in this category is that the population served is predominantly male. This group contains our school programs and it might be that male children act out more physically at younger ages and come to the attention of the system quicker. By contrast our adult and senior groups caseload is predominantly female. The school system is often the family's initial contact with mental health service. The engagement of Latino youth is lower than the threshold population designation indicates it should be. Service delivery at the front end of the mental illness process is highly productive.

Transition Age Youth
The caseload in this section is close to 50/50 for male/female ratio. There is almost no ethnic diversity in this caseload. Nevada County population contains limited ethnic diversity. To increase access to services and engagement with these diverse populations new engagement strategies need to be developed. This age group is at high risk for substance abuse, incarceration, homelessness, and institutional care. Engagement is critical.

Adult
The adult caseload is predominately female. Latino utilization is low. Question of why we are not engaging more men into treatment? Perhaps men are more likely to get incarcerated or involved in the criminal justice system or become homeless. The Nevada County homeless survey revealed a predominantly male homeless population. New outreach, engagement, and recovery focused treatment strategies need to be developed for the underserved in this group.

Seniors
This group is predominantly female which might be reflective of women living longer than men and reflects the cultural norms of this generation. Isolation, engagement, transportation, substance abuse, and medical issues are major themes in this group.

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.

Nevada County has one threshold language which is Spanish.

- Increase linguistically competent staff in Spanish.

- Increase overall access for Latinos by outreaching and delivering services in the Latino community. Contract with existing providers and primary care givers who have a relationship/standing in the community.

- By working collaboratively expand service delivery opportunities in outlying physical locations for all age groups.

- Develop a Latino peer counseling program.

- Develop new strategies of outreach and engagement to provide all seniors better access to services and existing support networks.

- Consult with Native American groups/service organizations on outreach strategies for service delivery opportunities.

- Increase consumer participation in developing focus on client culture throughout the Nevada County mental health services at all levels. Develop collaborative training/education programs on client culture for all staff.

- Working collaboratively with family, consumer, provider, and community develop culturally appropriate and peer driven substance abuse counseling for all ages.

- Increase success opportunities for children and young adults aging out of the system by delivering new coordinated, focused, and all encompassing treatment.

- Increase the success opportunities for transition age, adults, and seniors in jail, institutions, or hospitals by delivering new coordinated, focused, and all encompassing treatment.

- Examine/assess the needs of SED/SMI individuals with co-occurring disabilities in the community and develop strategies to address those needs.

Data Sources:
U.S. Census 2000 Data
DMH CA Prevalence Data
DMH Information Technology Web Services (ITWS) - Production/service reports
June 2005 CSI Nevada County submittal file
DMH Approved Claims Summary Data
Nevada County Foster Care Eligibility Data
Nevada County Homeless Study (Hospitality House Committee)
Juvenile Probation Detention Data
Nevada County Remote Placement Data
California Health Interview Survey

Section III: Identifying Initial Populations for Full Service Partnerships

Please address each of the following questions pertaining to the identification of initial populations to be fully served during the first three years.

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

In the first three years of the MHSA Nevada County will develop and implement two basic Full Service Partnerships with community members of all four groups (children, TAY, adults, seniors) having access to Full Service Partnership services. The first year will consist of the planning process and partial implementation/start up of our programs. Second year will see full implementation of services. Full Service Partnerships will concentrate on:

1. Children (0-17)
2. Adults (18-60+)

Transition Age Youth and seniors will have access to both of these Full Service Partnerships where they are age appropriate to the groups and will receive specialized individual services and supports. Outreach and engagement services will occur to both these groups as well as the Latino community to ensure participation opportunities.

Children Full Service Partnership

Stakeholder recommendations and data indicate a focus on seriously emotionally disturbed and seriously mentally ill individuals. These individuals who because of their mental health diagnosis will:

- Be at serious risk of or have a history of psychiatric hospitalization, residential care, or out of home placement.
- Children who are homeless or at risk of being homeless.
- At risk of aging out of the juvenile justice system or foster care with no care or support.
- Be at risk for dropping out of school, experiencing academic failure or school disciplinary problems.
- At risk of involvement with the criminal justice system.

The Children's Full Service Partnership will utilize a Children's System of Care approach to serving these high-risk children and youth age 0-25. Seventeen-year-old transition age youth could access this system and transition smoothly to the adult supports and services, or remain on the WRAP Team if that level of care is more appropriate to their specific developmental stage. A community based policy group will develop policy and direction for the Children's System of Care. A multi disciplinary collaborative team will have responsibility for services delivered. This dynamic process will feature family teams, coordinated care, and stress family empowerment strength based recovery.

Plan services and supports will include:

Plan I

- Psychiatric services.
- Outreach and Engagement activities throughout the county, but particularly for Latinos, Truckee, and North San Juan
- Wraparound services and supports.
- Case Management, rehabilitation and care coordination
- Peer/Family support, training, and education.
- Integrated treatment for co-occurring disorders

Wraparound services would serve approximately 12-15 child/youth and families in year one, and be at full capacity of 50 in years two and three.

Court liaison services would provide outreach, referral, intervention, and engagement services to court, juvenile hall, schools, and foster children. Services designed to locate and intervene with unserved or underserved Full Service Partnership children and youth. First year would serve 30 individuals. Year two and three 60 individuals per year.

Latino outreach and engagement services are designed to locate and intervene with unserved or underserved Full Service Partnership eligible individuals and families at community sites/homes.

Adult Full Service Partnership

Stakeholders recommendations and data indicate focus on Seriously Mentally Ill (SMI) individuals who service needs are unmet or so minimally met they fall into the unmet category placing them at risk of incarceration, institutionalization, becoming homeless or are currently homeless, or involuntary care. These are individuals who are 5150 and then receive no follow up services (by choice, chance, or system overload). They are SMI individuals who do not receive coordinated services in jail and then discharge to no treatment. Nevada County has 33 LPS conservatees in placement (almost always out of county). These individuals could benefit and perhaps come back to our community with more focused service delivery. SMI seniors live in our community in isolation often with co-occurring medical or substance abuse issues.

Adult Full Service Partnership Services and supports would include:

Plan II
A Full Service Partnership based on the Assertive Community Treatment (ACT) model. Features clinical/community based team coordinated care. Full fidelity to the Assertive Community Treatment (Rural Team Model) by third year. Would include services to adults, seniors, and TAY in ACT slots, over the age of 18.

First year start up and partial implementation would serve 12-15 SMI individuals. Second and third year full implementation to 50 SMI individuals.

- Peer/Family counseling
- Drop in services
- TAY support and peer counseling
- Assisted Outpatient Treatment
- Gay and Lesbian peer services
- Psychiatric Services
- Rehabilitation, Case Management, and Care Coordination
- Outreach/engagement services to homeless

SPIRIT Peer Supportive Services – Peer driven and staffed empowerment center focused on the SMI individual.

Implementation of Assisted Outpatient Treatment. Engaging treatment resistive SMI individuals who are not involved with the criminal justice system.

Other CSS strategies included in the WRAP and ACT Teams include Mobile Crisis Intervention, Latino Outreach, Emergency Department Follow Up, Area specific Truckee and San Juan Ridge projects will affect all groups and very often will affect Full Service Partnership members. These plans will be outlined in the program plan exhibits.

Ethnic disparities will be reduced by several action items.

1. Bilingual staff will be a priority to include on clinical teams.

2. Latino specific outreach/engagement will occur as through CSS funded programs.

3. Staff and community partners will receive regular and ongoing scheduled training on issues related to cultural competence.

4. Services will occur in the community and not be clinic or facility bound.

2) Please describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years.

Selection of initial populations were based on stakeholder input/recommendations and available data. Continuos evaluation of our MHSA programming by staff and stakeholders will provide population focus through the coming years. Part of our plan is to continue doing surveys and maintain the Steering Committee as an active body in the transformation process.

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

Nevada County is committed to develop and deliver culturally sensitive services which provide linguistically appropriate services to community members. Outreach and engagement activities will introduce Full Service Partnership services to diverse ethnic populations. Once introduced to Full Service Partnership concepts, culturally sensitive services will create an ease of access.

The MHSA process and program development has offered many excellent opportunities to coordinate and link community mental health efforts with community/cultural leaders/partners. This awareness and coordination of effort will improve Latino access and continuity of care.

Specific outreach to the Latino population by grassroot organizations will create an atmosphere of safety and easy access. Latino participation in the MHSA and population selection process has introduced a familiarity with the ethnic disparity issue to the community that did not exist before. This participation, recognition, in conjunction with outreach and training/education efforts will reduce ethnic disparities.

Section IV: Identifying Program Strategies

The majority of strategies to be utilized by Nevada County are included in the recommended strategies outlined in the Community Services and Supports document. One exception is that Nevada County will also include a plan to implement Assisted Outpatient Treatment or “Laura’s Law”.

Plan for Assisted Outpatient Treatment

Nevada County proposes to implement Laura's Law, also known as Assisted Outpatient Services, (Chapter 1017, Statutes of 2002) by use of MHSA Act funds to support a 0.50 FTE Licensed Mental Health Professional to act as the Director's designee and be a member of the ACT Team. The Directors designee will liaison between the court and the Full Service Partnership program described elsewhere in this plan.

The required services, as described in Welfare and Institutions Code (WIC) Section 5348 shall be provided by the Full Service Partnership Program, as needed for persons ordered by the court to participate in Assisted Outpatient Services.

The local Mental Health Director shall function as the as Assisted Outpatient Services Director.

The 0.50 FTE Licensed Mental Health Professional shall have the following duties:

1. Process referrals from persons who are authorized to make such referrals

2. Review the available treatment history of, and personally examine, the referred persons as to suitability for this program and develop treatment plans

3. Conduct investigations and file petitions and affidavits with the Court

4. Cause personal service of a copy of the petition and accompanying documents to the persons subject to the petition, the county patient's right advocate and the current health care provider for the person who is subject to the petition.

5. Facilitate linkage of the person with the Full Service Partnership team for delivery of services, as needed, if either the court orders Assisted Outpatient services or the person voluntary elects to receive appropriate services.

6. File periodic reports to the court

7. Apply to the court for orders authorizing continued assisted outpatient treatment, if indicated.

8. Gather and report requested and required data to the state Department of Mental Health

9. Provide training in consultation with the department, client and family advocacy organization, and other stakeholders, to mental health professionals, law enforcement officials, certification hearing officials

Also Refer to Page 30 revision for Court Liaison Services dated April 30, 2007 attached to the end of this 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.

Adequate human resources and sufficient number of available services are an ongoing challenge in a small rural county. Positions such as casemanagers, therapists, nurses, managers, and doctors are hard to fill on a consistent basis. As an agency we try to offer rich training programs and other operational benefits to maintain quality staff. Locating bi-lingual staff has been a daunting task with limited success. Nevada County currently has one threshold language (Spanish).

Nevada County has one organizational provider and a limited number of individual contractors. All provider applications request information on cultural and linguistic areas of competence. In quarterly provider meetings cultural and linguistic availability is always on the agenda. Currently there is one bilingual (Spanish) contract therapist that works both in western and eastern Nevada County. The organizational provider can meet threshold requirements as well for adolescents.

Nevada County Behavioral Health staffing and ethnic makeup is as follows:

Human Resources Assessment Data (12/02/05)

A. Current Composition – Nevada City Site (Nevada County Behavioral Health has two sites for Mental Health services – Nevada City and Truckee)

Nevada City Site

Ethnicity By Function

Administration	5	Caucasian	
Direct Services	38	Caucasian	
Support	13	Caucasian	
	1	Asian	
Interpreters	2	Caucasian	(Spanish)
Staff Consumers	5	Caucasian	
Contract Crisis Workers	13	Caucasian	

Bilingual Staff by Function and Language

Administration	0	
Direct Services	1	German
Support Services	1	Cantonese
Interpreters	2	Spanish
Staff Consumers	0	

Staff Proficiency in Reading/writing in a language other than english

Administration	0	
Direct Services	1	German
	1	Signing (for hearing impaired)
Support	1	Cantonese
Interpreters	2	Spanish

B. Current Composition – Truckee Site

Ethnicity By Function		
Administration	1	Caucasian
Direct Services	3	Caucasian
	1	Asian
Support	0	Caucasian
Interpreters	2	Caucasian
Staff Consumers	0	

Bilingual Staff by Function and Language

Administration	0	
Direct Services	1	Vietnamese
	1	Spanish
	1	French
Support Services	1	
Interpreters	2	Spanish
Staff Consumers	0	

Staff Proficiency in Reading/writing in a language other than English

Administration	0	
Direct Services	1	Vietnamese
	1	Spanish
	1	French
Support	0	
Interpreters	2	Spanish

The addition this year of a bilingual staff therapist (spanish) and the aforementioned contract therapist has greatly increased our capacity to deliver services to our threshold population.

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.

Currently two of forty-one direct service staff (4%) can deliver services to our threshold population in Spanish. That number increases when interpreters are utilized. An exciting development for Nevada County is the involvement in the MHSA process of two grass roots collaboratives Colaborando en Espanol in western county, and Empiezos Maravillosos in eastern

county. These two groups in conjunction with a third collaborative in Truckee will be providing outreach and engagement services and counseling to the Latino population.
The growth of these particular movements create a milestone in Nevada County's ability to deliver culturally relevant, as well as, linguistically correct services. These services are part of the Community Services and Supports plan for Nevada County and will encompass the entire county.

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.**

Human resources with the relevant experience and ethnic diversity in a rural setting are difficult to locate and maintain. Bordering counties Placer, Sutter/Yuba, and El Dorado all pay higher salaries. Nevada County has at times been referred to as a "training" county where once trained staff take higher paying positions in surrounding counties. Another ongoing issue with staff retention is the absence of affordable housing (which also is an issue with our mental health population). One approach to staff retention is offering/creating a better training/education plan that allows for continual professional growth and advancing personal education goals. A training committee is being created by the MHSA steering committee to address mental health training/education needs countywide. Aiding in staff retention and training will be one of their considerations.

Another possible barrier is the process of change itself. Behavioral health staff, teachers, administrators, law enforcement, and the community at large needs to change the culture of mental health care. Educating these groups in recovery/wellness/resiliency will be an ongoing task. As a response to this need a Training/education Committee was created in the MHSA steering committee process. The task of this training/education committee is to develop a short and long-term training policy/curriculum that keeps the transformation concept at the forefront of peoples thinking.

In addition to the Training/Education Committee Nevada County is fortunate to have the Spirit Empowerment Center to further the goal of transformation. This peer operated non-profit provides peer counseling education and training while maintaining an ongoing drop in peer counseling service. Recovery/wellness/resiliency are major components of their community education efforts.

Distance represents another possible barrier. Nevada County is a physically large rural county. Traveling between Truckee in the east, Grass Valley/Nevada City in the west, and other outlying areas such as the Ridge require time and often face weather issues. Individuals from these areas were represented on our steering committee (often by video hook up). Plans were designed that were specific to each of these areas. Telepsychiatry as an intervention/treatment tool for these areas is quite possible in the MHSA plan development.

Section VI: Developing Work Plans with Timelines and Budgets/Staffing

Summary Information on Programs to be Developed or Expanded

1) Please see Exhibits 1, 2, and 3 for summary information related to the detailed work plans contained in the Program and Expenditure Plan.
2) Small counties are exempt from this requirement.
3) 0% of individuals are estimated to receive services through System Development Funds for each of the three fiscal years.
4) We expect to conduct Outreach and Engagement activities with approximately 45 individuals in year 1, and 150 individuals for years 2 and 3. In year 1, 5/45 individuals would be referred to one of the Full Service Partnerships, in years 2 and 3 15/150 individual would be referred to one of the Full Service Partnerships.
5) Wraparound services are under development in Nevada County. We expect to complete implementation within the next 3 years.

CSS PLAN BUDGET OVERVIEW - 3-YEARS

County: Nevada

#	Program Work Plan Name	CSS Funding	Medi-cal Revenue	CSS + Medi-Cal		15 % of CSS Admin Expense (5c)	Program Expense (5a)
	FY 2005/06						
1	**Wraparound Program**						
2	**Assertive Community Treatment**						
	One-Time Funding						
	Total	**-0-**	**-0-**	**-0-**	**-0-**	**-0-**	**-0-**
	FY 2006/07						
1	**Wraparound Program**	**107,254**	**38,528**	**$ 145,782**		**$ 16,088**	**$ 129,694**
2	**Assertive Community Treatment**	**153,383**	**37,266**	**$ 190,649**		**$ 23,007**	**$ 167,642**
	One-Time Funding	**$ 751,800**		**$ 751,800**			**$ 751,800**
	Total	**$ 1,012,437**	**75,794**	**$ 1,088,231**		**$ 39,095**	**$ 1,049,136**
	FY 2007/08						
1	**Wraparound Program**	**439,410**	**154,111**	**$ 593,521**		**$ 65,912**	**$ 527,609**
2	**Assertive Community Treatment**	**632,538**	**149,063**	**$ 781,601**		**$ 94,881**	**$ 686,720**
	Total	**1,071,948**	**303,174**	**$ 1,375,122**		**$ 160,793**	**$ 1,214,329**

Balance to MHSA CCS Budget Worksheets as noted:

		FY 05/06	FY 06/07	FY 07/08			
1	**Wraparound Program 5a**	**0**	**218,981**	**373,498**			
2	**Assertive Community Treatment - 5a**	**0**	**388,154**	**537,657**			
	Administrative - 5c	**0**	**405,302**	**160,793**			
	Total	**0**	**1,012,437**	**1,071,948**			

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

Fiscal Year : 2005/006

County: Nevada		TOTAL FUNDS REQUESTED By Fund Type				FUNDS REQUESTED			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	**Wraparound Program**				$ -				
2	**Assertive Community Treatment**				$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
					$ -				
		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

Fiscal Year : 2006/07

County: Nevada		TOTAL FUNDS REQUESTED By Fund Type				FUNDS REQUESTED			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	**Wraparound Program**	**$ 51,666**	**$ 2,500**	**$ 37,000**	**$ 91,166**	**$ 73,155**	**$ 18,011**	**$ -**	**$ -**
2	**Assertive Community Treatment**	**$ 26,876**	**$ 32,500**	**$ 71,000**	**$ 130,376**	**$ -**	**$ 17,154**	**$ 91,011**	**$ 22,211**
3	**Administrative 5c**				**$ 39,095**	**$ 12,910**	**$ 6,205**	**$ 16,061**	**$ 3,919**
4	**One-Time Funding**				**$ 751,800**	**$ 248,252**	**$ 119,330**	**$ 308,848**	**$ 75,370**
		$ 78,542	**$ 35,000**	**$108,000**	**$ 1,012,437**	**$ 334,317**	**$ 160,700**	**$ 415,920**	**$ 101,500**

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

Fiscal Year : 2007/08

County: Nevada		TOTAL FUNDS REQUESTED By Fund Type				FUNDS REQUESTED			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	**Wraparound Program**	**$331,258**	**$ 2,673**	**$ 39,567**	**$ 373,498**	**$ 287,198**	**$ 86,300**	**$ -**	**$ -**
2	**Assertive Community Treatment**	**$426,976**	**$ 34,755**	**$ 75,926**	**$ 537,657**	**$ -**	**$ 59,823**	**$ 385,371**	**$ 92,463**
3	**Administrative 5c**				**$ 160,793**	**$ 65,912**	**$ 25,727**	**$ 53,075**	**$ 16,079**
		$758,234	**$ 37,428**	**$115,493**	**$ 1,071,948**	**$ 353,110**	**$ 171,850**	**$ 438,446**	**$ 108,542**

EXHIBIT 3: FULL SERVICE PARTNERSHIP POPULATION – OVERVIEW

Number of individuals to be fully served:

FY 2005-06: Children and Youth: 0 Transition Age Youth: 0 Adult: 0 Older Adult: 0 TOTAL: 0

FY 2006-07: Children and Youth: 8 Transition Age Youth: 4 Adult: 10 Older Adult: 3 TOTAL: 25

FY 2007-08: Children and Youth: 34 Transition Age Youth: 16 Adult: 40 Older Adult: 10 TOTAL: 100

PERCENT OF INDIVIDUALS TO BE FULLY SERVED									
	% Unserved				%Underserved				
	%Male		%Female		%Male		%Female		
Race/Ethnicity	**%Total**	**%Non-English Speaking**	**%Total**	**%Non-English Speaking**	**% Total**	**%Non-English Speaking**	**%Total**	**%Non-English Speaking**	**%TOTAL**
2005/06									
% African American									
% Asian Pacific Islander									
% Latino									
% Native American									
% White									
% Other									
Total Population									
2006/07									
% African American									
% Asian Pacific Islander									
% Latino	**3%**	**10%**	**2%**	**10%**					**5%**
% Native American									
% White	**23%**		**24%**		**22%**		**24%**		**94%**
% Other	**1%**		**1%**						**1%**
Total Population	**27**	**10**	**27**	**10**	**22**		**24**		**100**
2007/08									
% African American									
% Asian Pacific Islander									
% Latino	**3%**	**10%**	**2%**	**10%**					**5%**
% Native American									
% White	**23%**		**24%**		**22%**		**24%**		**94%**
% Other	**1%**		**1%**						**1%**
Total Population	**27**	**10**	**27**	**10**	**22**		**24**		**100**

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Nevada	Fiscal Year: 2006	Program Work Plan Name: Wraparound
Program Work Plan #: 1		Estimated Start Date: 4/1/2007
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	This program will advance the goals of the MHSA by providing community and field based services and supports that are individualized, built on strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school, and community. These services will be culturally competent, build on the unique values, preferences, and strengths of children and families, and their communities. Families will be full and active partners in every level of the wraparound process. The approach is a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan. The child and family teams will have adequate, flexible approaches and funding. The individualized service plans will include a balance of formal services and informal community and family resources. An unconditional commitment to serve children and families and a 'whatever it takes' philosophy is integrated into this program. The plan will be developed and implemented based on an interagency, community-based collaborative process. Outcomes will be determined and measured for the system, for the program, and for the individual child and family.	
Priority Population: *Describe the situational characteristics of the priority population*	This program will serve seriously emotionally disturbed Children and Youth age 0-16 and seriously mentally ill Transition Age Youth age 16-18. The majority of these individuals will be involved in the probation and foster care system, either currently in out of home placement or at high risk of out of home placement. Some individuals may be living in the community and at home, but pose a high risk for out of home placement and/or danger to self or others. Many of these individuals will have substance abuse issues, child abuse or neglect, legal problems, family conflict, and school problems.	

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
Strength-based, family-based services to individual with multiple, complex problems	X	X	X	X	x	☐	☐
Single individualized services and support plan, across systems	X	☐	☐	X	X	☐	☐
Youth involvement in planning and service development	X	☐	☐	X	X	☐	☐
Culturally sensitive outreach and services at schools	☐	☐	X	X	X	☐	☐
Services and supports provided at school, in the community, and in the home	X	☐	☐	X	X	☐	☐
Infrastructure for Children's System of Care program	X	X	☐	X	X	☐	☐
Mobile crisis services	X	X	☐	X	X	☐	☐
Peer support with peers and family members as providers in clinical settings	X	☐	☐	X	X	☐	☐
Integrated County/community service planning	X	X	☐	X	X	☐	☐
Integrated physical and mental health services	X	X	☐	X	X	☐	☐
Partnerships with ethnic-specific community providers and programs	☐	☐	X	X	X	☐	☐
Integrated services with law enforcement, probation, and the courts	X	X	☐	X	X	☐	☐

II. Programs to be Developed or Expanded—the following information is required for each program. Since the review process may approve individual program work plans separately, it is critical that a complete description is provided for each program. If a particular question is not applicable for the proposed program, please so indicate. **For each program, please provide the following:**

1) Complete Exhibit 4

See completed Exhibit #4, Work Plan 1 Wraparound Program.

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

Work Plan 1 Wraparound Program.

Nevada County proposes a comprehensive Wraparound Treatment Team that will provide services 24/7, utilize small team-based caseloads, provide field based services, and emphasize individual and family strengths. The Team will focus on reducing/preventing out of home placement through close interagency collaboration, an individualized treatment plan, and a full range of services available within the Team.

The Wraparound Treatment Team will provide, or arrange for, child specialty psychiatric services, psychotherapy, psychoeducation, rehabilitation, case coordination, family support and advocacy, and substance abuse services. Specialized service components and strategies include assessment, evaluation and liaison with the courts, outreach services to Latinos, mobile crisis services, emergency department outreach and engagement, peer counseling, family support services, and improving accessibility and linkage to the more geographically separated county areas of Truckee and North San Juan. Services will include the ability to utilize telepsychiatry as a means of providing service to remote locations.

Peer and family support services will likely involve Transitional Age Youth (16-25) only, and these policies will be developed after additional training for staff and peers. Our use of the term “support’ in the context of peer and family support, is not meant to imply a level of licensing or certification. Similarly, our intent is to recruit peer support staff from several available agencies, individuals, and organizations.

The Wraparound services model will deliver services to children and families with severe and multiple problems being served by multiple agencies. Wraparound services refer to an individually designed set of services provided to high risk children/youth with serious emotional disturbance (SED) or severe mental illness (SMI), and their families. These services may include treatment services and personal support services, or any other supports necessary to maintain the child/youth in the family home. Services are delivered through an interagency collaborative approach that includes family participation as equal and active team partners.

Nevada County will have Wraparound Care Coordinators in both the western and eastern parts of the county. These team leaders will be “single points of responsibility” for the treatment teams and coordinate wraparound family services. The Coordinators will provide and/or arrange for all necessary services as indicated by individual need. Substance abuse treatment will be integrated within the context of overall service delivery by the Wraparound Team. The existing eastern and western county SMART teams (multidisciplinary treatment teams) would provide clinical overview.

Wraparound services will become the cornerstone and building block for the Nevada County Children’s System of Care (CSOC). The Palm Tree Group (a monthly meeting of agencies, community providers, courts, and various stakeholders) will designate a core membership that will serve as a policy group to the CSOC that includes Wraparound Services.

Court Liaison Services

Staffing will include assignments to the Palm Tree Group consisting of a half time psychologist, and Care Coordinators in both western and eastern Nevada County. A full time Coordinator will be assigned to the western portion of the county, and a part time Care Coordinator in the eastern portion. These individuals will work closely with the family courts and be charged with locating, assessing, referring, and performing some brief counseling with high risk SED/SMI children/youth and their families who are in juvenile hall, the foster system, or involved with the courts. Psychological assessments would occur when indicated. Aging out youth would be assessed and connected with appropriate services. These services would serve as a portal to other Children’s System of Care services in addition to the Wraparound Service.

Our plans include providing Wraparound services to Transitional Age Youth (TAY) age 16-25 whenever necessary and appropriate. The age limits and boundaries for inclusion in Wraparound services are intentionally flexible and will be directed by individual and family circumstances and needs. Additional policies will be developed following extensive training regarding full service partnerships for TAY.

Latino Outreach

Additional team resources will include part time bilingual/bicultural local family advocates and service providers at community services agencies in the eastern portion of the county, supervised by a bilingual/bicultural therapist on the Wraparound Team. Comprehensive recruitment and training for bilingual peer counselors and outreach staff will be provided locally.

In western Nevada County, some counseling and coordination services will be provided by bilingual/bicultural staff to track referrals, releases, resource and referral out, and follow up for Latino SED/SMI clients referred to the Colaborando en Espanol collaborative. Two local part-time bilingual/bicultural community members will be recruited and trained in peer counseling and family support and function as members of the Wraparound Team.

Outreach activities integrated with the Wraparound Team will occur in western Nevada County sponsored by Colaborando en Español.

Mobile Crisis Intervention Services
Mobile Crisis Intervention services will be provided to the members of the Wraparound Team. Whenever necessary and practical, this response will be coordinated with law enforcement, responding as a team to mental health crisis in the community. The goal is to deliver a more effective, appropriate, and rapid response at the start of a crisis episode and thus reduce trauma to the individual and the need for hospitalization or institutionalization. Ongoing specific training for mobile crisis intervention will be provided for participating law enforcement officers and crisis workers. Funds allotted to this service would allow the existing Crisis Service to expand its crisis worker response capacity.
Mental health stabilization services in the Juvenile Hall would provide preventive interventions to individuals experiencing symptoms of serious mental illness. One to one interventions may provide enough support to stabilize or deescalate the emergent nature of a crisis situation and prevent an unnecessary hospitalization. These services will be closely coordinated with the Wraparound Team and move toward providing for urgent services, on site in the community, 24 hours/day, 7 days/week for those members of the Wraparound Team.

Emergency Department Outreach and Engagement
An estimated 40% of mentally ill patients being seen at the Emergency Department (ED) are repeatedly utilizing the ED resource. In an effort to increase the quality of care for these patients, and to reduce ED visits, a follow-up service has been visualized and will be instituted.

This service would provide follow-ups and preventative care to children and youth exhibiting the symptoms of serious mental illness who are treated and released from the hospital ER and who do not, at that time, meet 5150 criteria. It would assess the level of need and then provide warm handoffs to appropriate community services. This will be administered through Sierra Nevada Home Care, a division of Sierra Nevada Memorial Hospital, in collaboration with the Wraparound Team. One-to-one follow-up by licensed mental health professionals will be offered to individuals experiencing the symptoms of serious emotional disturbances or mental illness within 72 hours of ED release. These children and their families will receive a phone call and an in home visit by staff trained in serious mental illness which includes the areas psychiatric medications, symptom management, community resource referrals, and family support. Any individual needing the services of the Wraparound Team will be expeditiously referred. The intent is to increase quality of care and seamless collaboration with the Children's System of Care and other community providers.

Truckee Outreach, Engagement, and Liaison
To assure that people do not fall through the cracks of the mental health system there is a need for someone to help them navigate through the system. For many people, accessing and qualifying for services can be a very daunting process. This service component creates a Mental Health Care Coordinator position to help link and support people in accessing and utilizing the mental health system, and serve as a contact point for people wanting to get mental health services. Our hope is that this person will help bridge the services and create a unified and coordinated system rather than a collection of individual services.

The Interagency Service Integration Team (ISIT) working in conjunction with the Care Coordinator will be able to collaborate to provide referrals to the newly integrated Truckee PACT and SMART Model and through the new Peer Support Program.

Currently Truckee is undergoing a service integration process to integrate all of its services to its community members. The Community Collaborative of Tahoe Truckee (CCTT) currently collaborates with over 30 health, social services, and educational organizations to service the population of Truckee. SMART would be utilized for high-risk children and youth that are enrolled in school through the Tahoe Truckee Unified School District. The ISIT is currently looking at integrating services for individuals with severe mental health illness, co-morbid diagnoses, social/emotional issues, people who have private or no insurance and people who are covered under Medi-Cal, Healthy Families, and Medicare.

North San Juan Outreach, Engagement, and Liaison
Similar to the Truckee strategy, we propose specific outreach and engagement activities for this geographically isolated part of the county. The Wraparound Team will collaborate with the Sierra Family Medical Clinic (SFMC) to implement a variety of ideas to improve access to necessary mental health services, such as contracting with individual therapists, consulting with SFMC staff, and scheduling on site office time for Wraparound staff to review and receive new referrals. SFMC has an integrated behavioral health model in which the primary care providers oversee management of all patients, but the providers are able to get prompt consultations with the psychiatrist and therapist on staff if it is indicated. Additional details of this strategy will be developed following the training process.

Peer and Family Support/Advocacy Services
The Wraparound Team will include Peer and Family support/advocacy services. These staff will help assure that provided services are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family. Family advocates would work directly with families experiencing mental health issues.
In addition, these staff will: 1) Support families who need to go to court, probation, deal with schools, or seek county mental health services; 2) Advocate for assessment and diagnosis by qualified and licensed mental health professionals; 3) Prepare and assist families for assessment, diagnosis, and subsequent treatment process; 4) Work with Wraparound Team members and Care Coordinators; 5) With the involvement of the family, advocate for flexible and individualized service planning; and 6) Provide education to schools, providers, the criminal justice system, and families.

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

Flexible funding for housing supports is included in this strategy. Whatever may be needed by the child, youth, or family member in order to maintain placement in the home, may be addressed with these funds. Some examples might include child care, cleaning services, furniture or appliances, and structured activities or classes. Housing services will also be provided or arranged for by Child Welfare Services, the Probation Department, or Special Education 3632/26.5 services as describe in an Individual Education Plan. Some individuals may receive housing services as part of a more comprehensive treatment package that includes residential treatment services coordinated with the placing authority.

TAY may be offered the full range of available Adult Residential Treatment programs, including board and care and rental subsidies for independent living expenses.

Employment and pre-employment services will be provided by staff on the Wraparound Team to TAY who are transitioning out of school or ready to approach the workforce. Supported employment services may also be offered to other family members, as part of the individualized service plan and as needed to keep the family intact and the child or youth living at home.

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

With an estimated 50 participants and total full year program cost of $527,609, cost per participant will be $10,552.

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

Wraparound services are an emerging best practice model with promising treatment outcomes for this population. Many of the Children/TAY have been previously unserved in Nevada County, but this community based, intensive treatment team, focused on strength based interventions, will offer hope and foster resiliency in the participants and their families.

By locating and providing an opportunity of engagement to services, the Court Liaison Services will enable high risk SED/SMI children/youth to receive needed services where historically they have not. By reaching individuals prior to their aging out of the system these services will create a bridge to the next recovery “step”. Once that step is taken, the beginnings of a recovery culture are established.

Latino outreach and engagement prescribes easily accessible, culturally and linguistically competent Child/TAY services delivered in the community to enhance the recovery process for the individual as well as the community. Outreach and engagement to the Latino population will increase the accessibility of this full service partnership to unserved and under-served members of the community.

By providing mobile crisis intervention services in the home and field, the individual has an opportunity to remain in the community and to reduce unnecessary hospitalizations. Being able to remain in the community creates a situation where community and family supports can be developed and utilized. The recovery process occurs more naturally in the individual’s own community.

Crisis stabilization services in Juvenile Hall ensure that individuals receive the appropriate kind of service for their mental health issues, integrates their in-custody and out-of-custody treatment, and promotes continuity of care.

Following a visit to the hospital ED, outreach to the individual’s home will create a portal to more easily access mental health services.

Transportation, isolation, and stigma have been long standing barriers to service delivery in Nevada County. Providing linkage to services from the traditional medical health system creates opportunities of participation and support.

Coordination and ease of access will transform the mental health service delivery system in Truckee. The Truckee CCTI stresses strength-based recovery values with individuals and families. Individual/family driven recovery has consistently been a focus of this collaborative and the MHSA values are being incorporated into an existing community value.

Similarly, easily accessible Children/TAY psychiatric services provided at the SFMC in North San Juan will greatly aid the recovery process. Transportation, stigma and isolation have been barriers to service delivery in this area of Nevada County for years. Providing services here creates opportunities for participation and support that have not existed in prior years. This creation of opportunity will help the development of a recovery community in North San Juan.
The Peer and Family Support/Advocacy program will advance the goals of recovery by providing peer services to individuals and their families in a non-threatening community setting. Ongoing education and training of system personnel, providers, families, and schools will result in community promotion and reinforcement of these values.

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

The Wraparound Team is a new strategy in Nevada County, but some elements existed in previous forms. The Children's Mental Health staff previously assigned a person to liaison with the courts, but there was no evaluation component, and very little treatment was available or offered. There has been no effort at outreach to the Latino population. Mobile crisis intervention is a new service, and builds on an existing traditional emergency room and facility based crisis services. Following up those individuals who are screened in the emergency room for involuntary hospitalization, but not admitted, is a new service. Outreach and service expansion to Truckee and North San Juan is an expansion of some existing efforts. The provision of Child and Family Peer Support/Advocacy services is new to the County Behavioral Health System, when delivered in an integrated manner with direct service delivery staff.

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

Family members will be active and equal members of the Wraparound Team. They will participate in the assessment and treatment planning processes. Family involvement will be incorporated into the individualized treatment interventions wherever possible. Services will be provided in the home, including routine and urgent care. Family empowerment and strength based recovery is the focus of wraparound services.

Peer and Family Support/Advocacy staff represent a significant portion of this service, with plans of expansion in the coming years.

In some instances, family members will be part of a family reunification plan directed by the courts. This plan will be constructed with input from the family, the Child/TAY, NCBH, Special Education Services, Child Welfare Services, and/or the Probation Department.

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

The Wraparound Team is a collaboration of NCBH, community based organizations, Special Education, consumers and family members, Child Welfare Services, Juvenile Probation, and Nevada County Courts. Assisting high-risk children and youth to stay involved with this comprehensive team treatment will increase positive treatment outcomes and prevent hospitalizations, placement, or homelessness.

Collaboration with Coloborando en Espanol, NCBH, Empiezos Maravillosos, Truckee CCTT, and community providers will improve utilization of services by the Nevada County Latino population.

Integration of mental health with traditional medical health services will reduce ED visits and ensure continuity of care. Treating the whole person will increase positive life outcomes.

Integrating traditional medical health with mental health treatment at SFMC in North San Juan will improve access to services, reduce stigma, and foster a more favorable response to treatment recommendations.

The Truckee CCTT working in conjunction with community providers and NCBH will create a specific Eastern Nevada County collaborative system of care.

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

This service will be available in communities where local Latino collaborations are in operation and involved in outreach/engagement efforts. NCBH will provide culturally competent wraparound services by requiring all service staff to participate in initial and ongoing education and training. NCBH will participate in training offered by the California Institute of Mental Health to develop linguistic support by training and recruitment of interpreters.

Recruitment and retention of bilingual and bicultural staff is a high priority, and the County is actively involved in consulting with the State Department of Mental Health training and liaison staff to expand and develop the work force.

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

The entire Wraparound Team will receive extensive Cultural Competency training in the broad context prior to implementation. Staffing characteristics will reflect the community population to be treated and include a gender balance. Training will be provided to promote sensitivity to and understanding of Gay, Lesbian, Bisexual, and Transgender (GLBT) orientations. Services will be equally offered to any person in the GLBT spectrum.

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

The primary focus of the Wraparound Team is directed toward individuals residing within the County. However, children who are placed, or who may be placed, out of the County will be part of the target population and therefore be offered the services of the Wraparound Team. The goal for these individuals will be to return to a less restrictive alternative placement, such as residing with their families within the county.

TAY who may be temporarily placed out of the County in inpatient psychiatric units, IMDs, or PHFs, will continue to be coordinated by the Wraparound Team to facilitate a rapid return to a lower level of care and independent living.

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

Wraparound Services, and the specialized service components, are included in Section IV.

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

We anticipate funding approval about 4/1/2007. Nevada County will be ready to recruit immediately and implement contracts whenever appropriate. Some elements of this Work Plan could be implemented on 4/1/2007, but a full service partnership response and service array will be more practical to start 5/1/2007. This will allow time to provide staff training, develop and approve interagency Memorandums of Understanding, and set up systems and procedure for outcome measurement.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Nevada	Fiscal Year: 2006	Program Work Plan Name: Assertive Community Treatment
Program Work Plan #: 2		Estimated Start Date: 4/1/2007
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The ACT Team directly provides services that include treatment, support and rehabilitation. Those services are individualized and described in a comprehensive service plan. Additional services are available in order to meet housing, employment, substance abuse, and physical health needs. Team members share responsibility for the individuals served by the team. Members may receive services from any staff person on the treatment team. The staff to consumer ratio is small (approximately 1 to 12). The range of treatment and services is comprehensive and flexible. Team staff members provide many different types of services to members, and these services be outside of their respective discipline (within scope of practice if applicable). Interventions are carried out in vivo rather than in hospital or clinic settings. There is no arbitrary time limit on receiving services. Services are available on a 24–hour, 7 day per week basis. The team adopts an assertive attitude and is proactive in engaging those individuals needing care.	
Priority Population: *Describe the situational characteristics of the priority population*	The target population is those individuals 18 and older with serious mental illnesses. In addition, they may be at risk of hospitalization, dangerous to self or others, or unable to provide for their basic needs. Those individuals who receive services from this program have not benefited from traditional approaches to providing treatment. Many of those will have the most serious and intractable symptoms of mental illness and experience the greatest impairment in functioning. Impairments may include difficulties with basic, everyday activities like keeping themselves safe, caring for their basic physical needs, or maintaining safe and adequate housing. They are at risk to be unemployed, have substance abuse issues, be homeless, and increased involvement in the criminal justice system.	

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
Integrated substance abuse and mental health treatment for individual with dual diagnoses	X	☐	☐	☐	X	X	X
Integrated physical health and mental health treatment	X		☐	☐	X	X	X
Integrated services with law enforcement, probation, and the courts	X	X	☐	☐	X	X	x
Intensive community services and supports providing services to consumers where they live, 24/7, with peer counselors as team members	X	☐	☐	☐	X	X	X
On site services in primary care clinics	X	X	☐	☐	X	X	X
Ethnic specific outreach activities	☐	☐	X	☐	X	X	X
Self help and client run programs	X	X	☐	☐	X	X	X
Mobile crisis services	X	X	☐	☐	X	X	X
Peer support services	X	X	☐	☐	X	X	X
Temporary and transitional housing options and support	X	☐	☐	☐	X	X	X
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Please see Exhibit 4, Work Plan #2, Assertive Community Treatment Team.

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

Work Plan #2, Assertive Community Treatment Team.

The ACT Team directly provides services that include treatment, support, care coordination, and rehabilitation. Those services are individualized and described in a comprehensive and culturally competent service plan. Additional services are available in order to meet housing, employment, substance abuse, and physical health needs.

Team members share responsibility for the individuals served by the team. Members may receive services from any staff person on the treatment team. The staff to consumer ratio is small (approximately 1 to 12).

The range of treatment and services is comprehensive and flexible. Team staff members provide many different types of services to members, and these services may be outside of their respective discipline (within scope of practice if applicable). Interventions are carried out in vivo rather than in hospital or clinic settings. There is no arbitrary time limit on receiving services. Services are available on a 24–hour, 7 day per week basis. The team adopts an assertive attitude and is proactive in engaging those individuals needing care. Membership on the Team is maintained as long as the individual desires continued services.

Additionally, the ACT Team will contain some specialized target functions and strategies relating to geographic, ethnic, and other specific community needs.

Latino Outreach
Concerted efforts will be made to outreach and provide services to Latinos and will include case management, peer services, training, counseling by licensed therapists, and community outreach services. Services will be delivered by collaborative efforts in both Western and Eastern Nevada County. Services will be culturally and linguistically competent.

SPIRIT Peer Empowerment Center
The SPIRIT Mental Health Peer Empowerment Center will offer individual peer support, available on a drop in basis and at no cost. These individuals may be unable or unwilling to access traditional services, or can not otherwise afford counseling or psychotherapy. Weekly Support Groups, co-facilitated by two Peer Counselors, or by a Peer Counselor and a trainee will cover various topics such as Dual Diagnosis issues, Gay and Lesbian, Transitional Youth, Men's Group, Women's Group, Spirituality Group, and the Let's Rap Group.
Outreach training will be available to Peer Support Staff and individuals that seek to empower themselves in dealing with the media, potential employers, and other community agencies. Participants learn how to compile a resume, conduct a job interview, produce a fundraising event, produce brochure and marketing tools, and other wise interact with the business community.

Training and supervision of peer support staff will be available at SPIRIT Center. A staff liaison or ACT Team member will attend and supervise peer facilitated weekly Mutual Support Group meetings for emotional support of Peer Support staff and supervise peer facilitated case presentations.

Assisted Outpatient Treatment
Nevada County proposes to make ACT services available to those individuals referred by the courts for Assisted Outpatient Services, to support a 0.50 FTE Licensed Mental Health Professional on the ACT Team to act as the Director's designee. The Director's designee will liaison between the court and the Full Service Partnership program.

The 0.50 FTE Licensed Mental Health Professional shall receive referrals from the court, review the available treatment history, conduct an assessment, and develop treatment plans. If appropriate, the referred individual will receive comprehensive services from the ACT Team. No MHSA funds will be used for law enforcement or court staff.

Mobile Crisis Intervention Services
Mobile Crisis Intervention services will be provided to the members of the ACT Team. Whenever necessary and practical, this response will be coordinated with law enforcement, responding as a team to mental health crisis in the community. The goal is to deliver a more effective, appropriate, and rapid response at the start of a crisis episode and thus reduce trauma to the individual and the need for hospitalization or institutionalization. Ongoing specific training for mobile crisis intervention will be provided for participating law enforcement officers and crisis workers. Funds allotted to this service would allow the existing Crisis Service to expand its crisis worker response capacity.

Mental health stabilization services in the Jail would provide preventive interventions to individuals experiencing symptoms of serious mental illness. One to one interventions may provide enough support to stabilize or deescalate the emergent nature of a crisis situation and prevent an unnecessary hospitalization. These services will be closely coordinated with the ACT Team and move toward providing for urgent services, on site in the community, 24 hours/day, 7 days/week for those members of the ACT Team.

Emergency Department Outreach and Engagement
An estimated 40% of mentally ill patients being seen at the Emergency Department (ED) are repeatedly utilizing the ED resource. In an effort to increase the quality of care for these patients, and to reduce ED visits, a follow-up service has been visualized and will be instituted.

This service would provide follow-ups and preventative care to individuals exhibiting the symptoms of serious mental illness who are treated and released from the hospital ED and who do not, at that time, meet 5150 criteria. Staff will assess the level of need and then provide warm handoffs to appropriate community services. This will be administered through Sierra Nevada Home Care, a division of Sierra Nevada Memorial Hospital, in collaboration with the ACT Team. One-to-one follow-up by licensed mental health professionals will be offered to individuals experiencing the symptoms of serious mental illness within 72 hours of ED release. These individuals will receive a phone call and an in home visit by staff trained in serious mental illness which includes the areas psychiatric medications, symptom management, community resource referrals, and family support.

Any individual needing the services of the ACT Team will be expeditiously referred. The intent is to increase quality of care and seamless collaboration with the Adult System of Care and other community providers.

Truckee Outreach, Engagement, and Liaison
To improve the quality of and access to the ACT Team for residents of the isolated, unserved, and underserved Truckee area, this proposal includes a Mental Health Care Coordinator. This person will ensure that people do not fall through the cracks of the mental health system and assist with navigation through the system. The Care Coordinator will link and support people in accessing and utilizing the mental health system. They will serve as a contact point for people wanting to get mental health services. They will also be the conduit between the Nevada County ACT Team and Wellspring Counseling Center.

North San Juan Outreach, Engagement, and Liaison
Provide direct support for the staff consulting psychiatrist, therapist, and medical staff at the Sierra Family Medical Clinic (SFMC) to ensure that they are able to treat local residents. SFMC has an advanced integrated behavioral health model in which the primary care providers oversee management of all patients, but the providers are able to get prompt consultations with the behavioral health staff if indicated.
NCBH will contract with interested therapists to provide psychotherapy services to adults, in coordination with SFMC ongoing services. Additionally, staff from the ACT Team will provide on site assessment, consultation, and accept referrals from SFMC and contracted staff.

Peer and Family Support/Advocacy Services
Peer and family support/advocacy staff will be integrated on the ACT Team and work directly with families experiencing mental health issues. They help prepare family for assessment, diagnosis and treatment process. They participate in training and provide education to providers, other agency staff, and families. They work closely with the ACT Team and advocate flexibility of services delivery as determined by individualized needs of family members involved.

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

Supportive housing services will be provided by the ACT Team, and efforts will be made to recruit a housing specialist on the team. Money will be provided for rent deposits, damage deposits, first and last month's rent, cleaning services, and furniture and appliance needs. Consideration will be given to creating a housing fund for loan purposes, for those individuals that possess the ability to secure and repay loans.

Employment services are included in this proposal primarily in the area of peer and family support opportunities. Many consumers and family members are expected to be employed on full and part time basis on the ACT Team, at the SPIRIT Peer Empowerment Program, conducting outreach to Latinos, and as consumer and family advocates.

SPIRIT Peer Support staff offer mental health peer assessment, support, and referrals to homeless people participating in a homeless shelter called Hospitality House. SPIRIT staff would visit the Hospitality House location once a week to counsel the homeless individuals that ask for their help and assist in referring them to other available services.

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

With an estimated 50 participants and total full year program cost of $686,720, cost per participant will be $13,734.

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

Assertive Community Treatment is consistent with recovery goals because it represents an evidenced-based practice that allows individuals to who are diagnosed with mental illnesses to live, work, learn, and participate fully in their communities. Treatment Plans are individualized, culturally competent, and involve active participation of the individual and family members. Multiple employment opportunities exist for consumers and family members; resulting employment helps to foster hope and empower the consumer or family member to actively make changes in their lives and in the treatment of their illnesses. Integrating consumers and family members into the treatment by the ACT Team reduces barriers, prevents stigma, and involves consumers and family members in more aspects of the mental health system.

The North San Juan strategy advances recovery principles by increasing access to mental health services in the primary care setting in a geographically isolated community. This strategy also uses emerging and innovative technology (tele-psychiatry) to reduce disparities to unserved and low income families.

The SPIRIT program strategy advances the goals of recovery by providing peer services and employment opportunities to individuals and their families in a safe, friendly, accepting, and home like community setting. Ongoing education and training of new peer support staff, and expansion of services to isolated communities helps promote client, family, and community awareness, promotes self-empowerment, and reduces stigma. Empowerment is fostered by consumers directing and running their own program.

Outreach to the individual's home from hospital ED staff will create an easily accessible portal to ACT services. This will reduce stigma, since many individuals are more comfortable with accessing mental health care through primary health care settings.

The Peer and Family Support/Advocacy program will advance the goals of recovery by providing peer services to individuals and their families in a non-threatening community setting. Ongoing education and training of system personnel, providers, families, and schools will result in community promotion and reinforcement of these values.

All staff, peers, and family members will be required to participate in extensive training in recovery and resiliency principles, including in vivo training with programs like The Village in Long Beach, and other AB2034 programs.

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

The Assertive Community Treatment Team model is a new program strategy fro Nevada County. There are currently, and have never been, Full Services Partnerships available of any type in the County.

The SPIRIT Empowerment Center currently exists with limited funding. The infusion of MHSA funds will expand and improve the program. Additional capacity will be added, quality will be improved, and treatment options will be increased with additional training and the addition of some professional mental health staff. The ACT Team will collaborate closely with the SPIRIT Center to conduct outreach and assessments, and refer into the ACT Team.

Although there are currently a few consumers employed as peer support staff in the mental health system, the MHSA funded strategies referred to as SPIRIT, Latino Outreach, Truckee, and Peer and Family Advocates will greatly increase this number.

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

The ACT Team will have Peer Support staff functioning as full service providers on the Team.

Other strategies have consumers and family members providing services as an extension of the ACT Team. For example, Latino Outreach will involve bilingual and bicultural Latino peers and family members to outreach this unserved and underserved population throughout the County, but primarily in the Truckee area.

Similarly, the Peer and Family Support/Advocacy strategy employees consumers and family members but will likely function as a part of the larger ACT Team.
On the other hand, the SPIRIT Center employs many consumers and family members and is directly run by the consumers. These consumers work on site at the SPIRIT Center, at various other mental health sites, and will be assigned to the ACT Team. Some of the consumers who receive training in the SPIRIT Center will function as part of other treatment programs, including the ACT Team.

More details will be realized, following additional training, including field visits to other peer run programs, after MHSA funding and prior to implementation.

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

The ACT service planning involved a collaboration of NCBH, Probation Department, Social Services, Public Health, community providers, primary care clinics, private hospital, community collaboratives, NAMI and peer/family support organizations, various courts, Public Defender, District Attorney, law enforcement and detention staff, and SPIRIT peer counseling services.

ACT Team single point of responsibility care coordinators, and consumer and family counselors, will assist the individual in navigating this network of provider and agencies.

Latino Outreach includes collaboration with Coloborando en Espanol, Nevada County Behavioral Health, Empiezos Maravillosos, Truckee CCTT, and community providers will improve utilization of services by the Nevada County Latino population.

Assisted Outpatient Treatment interventions are collaborative efforts between NCBH, Nevada County Courts, Forensic Task Force, and community providers. Assisting SMI individuals to stay in treatment will increase positive treatment outcomes and prevent hospitalizations or homelessness

Collaboration with Mental Health and acute hospital medical staff to follow up for patients who present for emergency psychiatric hospitalization, but are released, will reduce ED visits, improve access to less restrictive services, and ensure continuity of care. Treating the whole person will increase positive life outcomes.

The SPIRIT Center strategy will engage intensively with NCBH, NAMI, Hospitality House, primary care providers, community collaboratives, and others to provide training and support for staff, peer support staff, peers, and family members.

In the Truckee strategy, the ISIT working in conjunction with the Care Coordinator, will be able to collaborate to provide referrals to the newly integrated Truckee ACT Team and through the new Peer Support Program.

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

The Latino Outreach strategy, in support of the ACT Team, is the linchpin for providing culturally and linguistically competent services throughout the County.

In eastern Nevada County the plan is to train bilingual local family advocates and service providers at community services agencies in the area.

This collaborative approach among service providers to the Latino community will expand service delivery opportunities as well as unite our current system of support services. Peer counselors will collaborate to plan, promote and provide culturally appropriate community outreach and engagement activities. Trained counselors will become access points to mental health services for a wider array of people seeking services in other agencies. These staff will meet regularly with the ACT Team and be a primary referral source for new members. This program would be supervised by a Bilingual/Bicultural therapist on the ACT Team. Comprehensive bilingual peer counseling training will be provided locally.

Other actions to promote a culturally competent service delivery system are reflected by Nevada County recently reclassifying a non-MHSA funded position assigned to the Truckee clinic, as Bilingual/Bicultural Only.

In Western Nevada County, counseling services provided by a bilingual/bicultural therapist will be available in the community. Case Management/coordination services will be provided to track referrals, releases, aftercare, and follow up for Latino clients referred to the Colaborando en Espanol collaborative.

Local bilingual/bicultural community members would be recruited and trained as peer counselors. Informational presentations will be given by the peer counselors with an emphasis on the ethnic specific issues affecting the Latino individual and their families.

Outreach activities will occur in Western Nevada County sponsored by Colaborando en Espanol. These outreach activities would be conducted in collaboration with the overall mission of the ACT Team.

Additional training for all of these programs and strategies will be done after peers, family members, and staff are hired and prior to program implementation.

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

The ACT team will be sensitive to the individual's sexual orientation and have experience/education in addressing development of one's personhood. Services will be supportive and provide a safe environment for youth/adults/older adults to develop strategies for building or maintaining positive gender roles. NCBH and the Steering Committee training committee will facilitate ongoing education.

The SPIRIT Center will continue to provide a peer support group for Gay/Lesbian/Bisexual/Transsexual individuals. Staff recruitment and hiring will target applicants that demonstrate strengths in these areas, and additional training will be required for successful applicants.

The entire ACT Team will receive extensive Cultural Competency training in the broad context prior to implementation. Staffing characteristics will reflect the community population to be treated and include a gender balance. Training will be provided to promote sensitivity to and understanding of Gay, Lesbian, Bisexual, and Transgender (GLBT) orientations. Services will be equally offered to any person in the GLBT spectrum.

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

Care Coordinators on the ACT Team will maintain responsibility for their consumer partners, even while placed out of county, hospitalized, or receiving treatment in an Institute for Mental Disease. Care Coordinators will facilitate access to treatment, provide case management, engage in aftercare planning with the facility, and help prepare the consumer to return to their homes and less restrictive placement as soon as possible.

Consumers will be offered a choice of placement options, whenever possible, with every effort made to provide for a local, in county, living arrangement. If an out of county placement is considered as an option, the consumer will be informed of the pros and cons of this decision.

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

Due to the involuntary nature of Assisted Outpatient Treatment, it has been noted by some to be outside of the intent of the Mental Health Services Act. However, the goal of Nevada County's ACT Team is to provide access to evidenced based practices, improve services, and increase services to unserved and underserved individuals.

Individuals referred by the courts under AOT have not benefited or utilized conventional treatment approaches. Nevada County values consumer choice and individual responsibility, and will not discriminate enrollment in this full service partnership based on legal status. Individuals who are conserved, on probation, on parole, or committed under AOT will be welcomed into the voluntary array services provided by the ACT Team in an unlocked setting.

Nevada County does not wish to deny access to this unique, effective and proven treatment modality to those individuals judged by the courts to meet the criteria for AOT.
13) Please provide a timeline for this work plan, including all critical implementation dates.

We anticipate funding approval about 4/1/2007. Nevada County will be ready to recruit immediately and implement contracts whenever appropriate. Some elements of this Work Plan could be implemented on 4/1/2007, but a full service partnership response and service array will be more practical to start 5/1/2007. This will allow time to provide staff training, develop and approve interagency Memorandums of Understanding, and set up systems and procedure for outcome measurement.

NEVADA COUNTY MHSA
COMMUNITY SERVICES AND SUPPORT PLAN

MHSA Budget Narrative – Wraparound Program

The following is a narrative explaining the budgets for the Wraparound Program. We are anticipating an April 2007 implementation; therefore the fiscal year 2006-07 budget represents 3 months of service or 25% of the annual program cost. All one-time expenses have been included in the fiscal year 2006-07 budget. The following fiscal year 2007-08 budget is for 12 months of service.

Work Plan #1 Wraparound Treatment Team

Program Summary: Nevada County proposes a comprehensive Wraparound Treatment Team that will provide services 24/7, utilize small team-based caseloads, provide field based services, and emphasize individual and family strengths. The Team will focus on reducing/preventing out of home placement through close interagency collaboration, an individualized treatment plan, and a full range of services available within the Team.

The Wraparound Treatment Team will provide, or arrange for, child specialty psychiatric services, psychotherapy, psychoeducation, rehabilitation, case coordination, family support and advocacy, and substance abuse services. Specialized service components and strategies include assessment, evaluation and liaison with the courts, outreach services to Latinos, mobile crisis services, emergency department outreach and engagement, peer counseling, family support services, and improving accessibility and linkage to the more geographically separated county areas of Truckee and North San Juan. Services will include the ability to utilize telepsychiatry as a means of providing service to remote locations.

Line A. 5. Explanation of Total Expenditures when Services Provider is not known
Total Program Cost $527,609

Professional Services: $ 464,360

1.0 FTE Team Leader/BH Supervisor I/II	$ 40 per hr	2,080 hrs	$ 83,200
The Team Leader will lead the treatment teams to coordinate a full range of wraparound individual and family services.			
1.0 FTE Behavioral Health Licensed Therapist	$ 35 per hr	2,080 hrs	72,800
2.25 FTE Behavioral Health Worker I/II	$ 25 per hr	4,680 hrs	117,000
0.5 FTE Psychiatrist	$ 100 per hr	1,040 hrs	104,000

This team will be the coordinator and/or provider of services throughout the wraparound services and specialty components, including Court Liaison Services; Latino Outreach; Mobile Crisis; Emergency Department, Truckee and North San Juan Outreach and Engagement.

2.8 FTE Peer Specialist(s) $ 15 per hr 5,824 hrs $ 87,360

Peer and Family Specialists will function as members of the wraparound team. Their duties will include, but not be limited to, support to consumers and their families, advocacy, education, and training.

7.55 Total FTE's

Other Operating Expenses: $ 63,249

Travel and Transportation	$ 8,109
Client Vouchers	$ 10,000
Translation and Interpreter Services	$ 4,000
General Office Expenditures	$ 5,000
Rent Utilities and Equipment	$ 10,000
Medication & Medical Support	$ 2,500
Other Expenses to Meet Client Needs	$ 23,640

Wraparound Treatment Team
Total Program Revenue: $527,609

MHSA	$ 373,498
Medi-Cal	$ 77,055
EPSDT	$ 77,056
Total Revenue	$ 527,609

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

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

Program Workplan #: 1 | Date: 2/5/07

Program Workplan Name: Wraparound Treatment Team | Page 1 of 1

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

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

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 0 | Telephone Number: 530-470-2411

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

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

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

Program Workplan #: 1 | Date: 2/5/07

Program Workplan Name: Wraparound Treatment Team | Page 1 of 1

Type of Funding: 1. Full Service Partnership | Months of Operation: 0

Proposed Total Client Capacity of Program/Service: 0 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 0 | Telephone Number: 530-470-2411

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	0.00		$0
C. Total Program Positions		0.00	0.00		$0

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

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

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

Program Workplan #: 1 | Date: 2/5/07

Program Workplan Name: Wraparound Treatment Team | Page 1 of 1

Type of Funding: 1. Full Service Partnership | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$129,694			$129,694
6. Total Proposed Program Budget	**$129,694**	**$0**	**$0**	**$129,694**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$19,264			$19,264
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds	$19,264			$19,264
d. Other Revenue				$0
e. Total New Revenue	$38,528	$0	$0	$38,528
3. Total Revenues	$38,528	$0	$0	$38,528
C. One-Time CSS Funding Expenditures	**$127,815**			**$127,815**
D. Total Funding Requirements	**$218,981**	**$0**	**$0**	**$218,981**
E. Percent of Total Funding Requirements for Full Service Partnerships				

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

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

Program Workplan #: 1 | Date: 2/5/07

Program Workplan Name: Wraparound Treatment Team | Page 1 of 1

Type of Funding: 1. Full Service Partnership | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
	All Positions Contracted Services				$0
BH Supervisor I/II	*Team Leader*	1.00	1.00		$0
BH Licensed Therapist	*BH Licensed Therapist*	1.00	1.00		$0
BH Health Worker I/II	*BH Health Worker I/II*	2.25	2.25		$0
Psychiatrist	*Psychiatrist*	0.50	0.50		$0
Peer Specialist	*Peer Specialist*	2.80	2.80		$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	7.55	7.55		$0
C. Total Program Positions		7.55	7.55		$0

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

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

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

Program Workplan #: 1 | Date: 2/5/07

Program Workplan Name: Wraparound Treatment Team | Page 1 of 1

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

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$527,609			$527,609
6. Total Proposed Program Budget	**$527,609**	**$0**	**$0**	**$527,609**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$77,055			$77,055
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds	$77,056			$77,056
d. Other Revenue				$0
e. Total New Revenue	$154,111	$0	$0	$154,111
3. Total Revenues	$154,111	$0	$0	$154,111
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$373,498**	**$0**	**$0**	**$373,498**
E. Percent of Total Funding Requirements for Full Service Partnerships				

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

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

Program Workplan #: 1 | Date: 2/5/07

Program Workplan Name: Wraparound Treatment Team | Page 1 of 1

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

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
	All Positions Contracted Services				$0
BH Supervisor I/II	*Team Leader*	1.00	1.00		$0
BH Licensed Therapist	*BH Licensed Therapist*	1.00	1.00		$0
BH Health Worker I/II	*BH Health Worker I/II*	2.25	2.25		$0
Psychiatrist	*Psychiatrist*	0.50	0.50		$0
Peer Specialist	*Peer Specialist*	2.80	2.80		$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	7.55	7.55		$0
C. Total Program Positions		7.55	7.55		$0

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

MHSA Budget Narrative – Assertive Community Treatment Team

The following is a narrative explaining the budgets for the Assertive Community Treatment Team. We are anticipating an April 2007 implementation; therefore the fiscal year 2006-07 budget represents 3 months of service or 25% of the annual program cost. All one-time expenses have been included in the fiscal year 2006-07 budget. The following fiscal year 2007-08 budget is for 12 months of service.

Work Plan # 2 Assertive Community Treatment (ACT) Team

Program summary: The ACT Team directly provides services that include treatment, support, care coordination, and rehabilitation. Those services are individualized and described in a comprehensive and culturally competent service plan. Additional services are available in order to meet housing, employment, substance abuse, and physical health needs.

Team members share responsibility for the individuals served by the team. Members may receive services from any staff person on the treatment team. The staff to consumer ratio is small (approximately 1 to 12).

The range of treatment and services is comprehensive and flexible. Team staff members provide many different types of services to members, and these services may be outside of their respective discipline (within scope of practice if applicable). Interventions are carried out in vivo rather than in hospital or clinic settings. There is no arbitrary time limit on receiving services. Services are available on a 24–hour, 7 day per week basis. The team adopts an assertive attitude and is proactive in engaging those individuals needing care. Membership on the Team is maintained as long as the individual desires continued services.

Line A. 5. Explanation of Total Expenditures when Services Provider is not known

Total Program Cost $686,720

Professional Services $611,000

1.0 FTE	Team Leader/BH Supervisor I/II	$40 per hr	2,080 hrs	$ 83,200
	The Team Leader will lead the treatment teams to coordinate a full range of ACT individual and family services.			
1.0 FTE	Behavioral Health Licensed Therapist	$ 35 per hr	2,080 hrs	$ 72,800
2.25 FTE	Behavioral Health Worker	$ 25 per hr	4,680 hrs	117,000
0.5 FTE	Psychiatrist	$100 per hr	1,040 hrs	104,000
1.5 FTE	Nurse RN	$ 35 per hr	3,120 hrs	109,200

This team will be the coordinator and/or provider of services throughout the ACT Team and specialty components: Latino Outreach; SPIRIT Peer Empowerment Center; Assisted Outpatient Treatment; Mobile Crisis Intervention Services; Emergency Department, Truckee and North San Juan Outreach and Engagement.

4.0 FTE's Peer Specialist	$15 per hr	8,320 hrs	$ 124,800

Peer Specialist and trainees duties will include conducting weekly support groups and cover various topics such as Dual Diagnosis issues, Gay and Lesbian, Transitional Youth, Men's Group, Women's Group, Spirituality Group, and the Let's Rap Group. They will also provide outreach training and individual peer support as needed on a drop in basis and at no cost.

10.25 FTE's Total

Other Operating Expenses: **$ 75,720**

Travel and Transportation	$ 9,000
Client Vouchers	$ 12,000
Translation and Interpreter Services	$ 5,000
General Office Expenditures	$ 10,000
Rent Utilities and Equipment	$ 15,000
Medications & Medical Support	$ 5,000
Other Expenses to meet Client Needs	$ 19,720

Assertive Community Treatment Team

Revenue $686,720

MHSA	$ 537,657
Medi-Cal	$ 149,063
Total Revenue	$ 686,720

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

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

Program Workplan #: 2 | Date: 2/5/07

Program Workplan Name: Assertive Community Treatment Team | Page 1 of 1

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

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

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 0 | Telephone Number: 530-470-2411

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

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

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

Program Workplan #: 2 | Date: 2/5/07

Program Workplan Name: Assertive Community Treatment Team | Page 1 of 1

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

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

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: | Telephone Number: 530-470-2411

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	0.00		$0
C. Total Program Positions		0.00	0.00		$0

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

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

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

Program Workplan #: 2 | Date: 2/5/07

Program Workplan Name: Assertive Community Treatment Team | Page 1 of 1

Type of Funding: 1. Full Service Partnership | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$167,642			$167,642
6. Total Proposed Program Budget	**$167,642**	**$0**	**$0**	**$167,642**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$37,266			$37,266
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$37,266	$0	$0	$37,266
3. Total Revenues	$37,266	$0	$0	$37,266
C. One-Time CSS Funding Expenditures	**$257,778**			**$257,778**
D. Total Funding Requirements	**$388,154**	**$0**	**$0**	**$388,154**
E. Percent of Total Funding Requirements for Full Service Partnerships				

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

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

Program Workplan #: 2 | Date: 2/5/07

Program Workplan Name: Assertive Community Treatment Team | Page 1 of 1

Type of Funding: 1. Full Service Partnership | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
	All Positions Contracted Services				$0
BH Supervisor I/II	*Team Leader*	1.00	1.00		$0
BH Licensed Therapist	*BH Licensed Therapist*	1.00	1.00		$0
BH Health Worker I/II	*BH Health Worker I/II*	2.25	2.25		$0
Psychiatrist	*Psychiatrist*	0.50	0.50		$0
Nurse RN	*Nurse RN*	1.50	1.50		$0
Peer Specialist	*Peer Specialist*	4.00	4.00		$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	10.25	10.25		$0
C. Total Program Positions		10.25	10.25		$0

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

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

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

Program Workplan #: 2 | Date: 2/5/07

Program Workplan Name: Assertive Community Treatment Team | Page 1 of 1

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

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$686,720			$686,720
6. Total Proposed Program Budget	**$686,720**	**$0**	**$0**	**$686,720**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)	$149,063			$149,063
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$149,063	$0	$0	$149,063
3. Total Revenues	$149,063	$0	$0	$149,063
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$537,657**	**$0**	**$0**	**$537,657**
E. Percent of Total Funding Requirements for Full Service Partnerships				

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

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

Program Workplan #: 2 | Date: 2/5/07

Program Workplan Name: Assertive Community Treatment Team | Page 1 of 1

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

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Elsie Durgin

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 530-470-2411

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
	All Positions Contracted Services				$0
BH Supervisor I/II	*Team Leader*	1.00	1.00		$0
BH Licensed Therapist	*BH Licensed Therapist*	1.00	1.00		$0
BH Health Worker I/II	*BH Health Worker I/II*	2.25	2.25		$0
Psychiatrist	*Psychiatrist*	0.50	0.50		$0
Nurse RN	*Nurse RN*	1.50	1.50		$0
Peer Specialist	*Peer Specialist*	4.00	4.00		$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	10.25	10.25		$0
C. Total Program Positions		10.25	10.25		$0

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

One-Time Funding

The MHSA Guidelines provide counties with the opportunity to access One-Time Funds 1) to extend community program planning activities; 2) to build system improvement for programs and services proposed in the plan; and 3) for capital purchases, training and education, and intensive outreach. Nevada County will use MHSA One-Time funding to provide additional support to the proposed programs and further support the mental health case system and the Nevada County Mental Health Department infrastructure as detailed below. The total One-Time Funding request is $751,800.

Wraparound Treatment Team $ 127,815

Travel Allowance / Vehicle		$35,000.
Community outreach, treatment engagement, training, family visits, or treatment meetings		
Emergency Housing		15,000
Housing and supplies for families and children		
Clothing		5,000
Children's clothing needs		
Training		24,000
Training specific to the delivery of wraparound services		
Telepsychiatry Equipment		9,000
Nevada County has geographically separated areas and services will include the ability to utilize telepsychiatry as a means of providing service to remote locations.		
Office Supplies		4,515
General office supplies		
Brochures and Printing		3,400
Printed brochures for outreach		
Psychological Supplies		6,000
Testing and assessment materials		
PDA devices and Cell phones		5,700
To provide communication with service providers while they are outside of the offices		
Computers and Peripheral Equipment		20,200
Printers	$4,000	
5 Desktop Computers and Software	6,000	
5 Laptop Computers and Software	10,200	

Assertive Community Treatment Team $ 257,778

Travel Allowance / Vehicle		$ 35,000
Community outreach, treatment engagement, training, family visits, or treatment meetings		
Housing Stipends and Consumer Furnishings		90,000
This is a declining fund balance to provide supportive housing services		
Emergency Needs		17,000
To provide "whatever it takes"		
Training		33,000
To provide training specific to the ACT Team		
Training Material		10,000
Manuals and videos for peer counselors		
Telepsychiatry Equipment		9,000
Nevada County has geographically separated areas and services will include the ability to utilize telepsychiatry as a means of providing service to remote locations.		
Office Supplies		4,500
General office supplies		
Peer Staff Space		12,000
Repair bathroom to enable Spirit Center to be utilized for peer driven services		
Office Furniture		5,978
Desks and other furniture		
Brochures and Printing		3,400
Printed material for outreach and engagement		
PDA devices and Cell Phones		5,700
To provide communication with service providers while they are outside of the offices		
Job Development		12,000
Vocational services		
Computers and Peripheral Equipment		20,200
Printers	$4,000	
5 Desktop Computers and Software	6,000	
5 Laptop Computers and Software	10,200	

Community Training and Outreach $253,437

This will be a countywide program of community training and education regarding the general subject of mental illness and co-occurring disorders. This is to be directed to the needs of a wide range of target audiences and will cover a broad range of topics in support of the wellness and recovery objective of the MHSA.

Target audiences will include, but are not limited to:

1. Primary Care Providers;
2. Public and private sector specialty mental health and drug & alcohol service providers and administrators;
3. Pre-school through Community College educators and administrators;
4. Law enforcement officers, Correctional Officers, Juvenile Hall Counselors, Probation Officers, and private Security Officers;
5. Officers and staff of the civil and criminal courts;

6. Families of persons with Serious Mental Illnesses with or without co-occurring substance use disorders;
7. Consumers of Mental Health Services;
8. Employers, business organizations, job development agency staff and related organizations;
9. Human service organizations such as assisted care providers, housing providers, senior services;
10. Elected Officials;
11. The General Public.

Examples of content include:

1. Descriptive information regarding the major serious mental illnesses, and co-occurring disorders and current best practices for their management and treatment;
2. Listening and stress de-escalation as alternatives to authoritarian reaction to person with serious mental illness;
3. Local resources for serious mental illness and other community resources including access information;
4. De-stigmatization of mental illness;
5. Recovery principles, their application by persons with serious mental illness and others with whom they interact;
6. The social and vocational value and special needs of persons in mental illness recovery;
7. Cultural Competence; to include specific training related to the Latino population and Gay, Lesbian, Bi-sexual, and Transgendered individuals. Training will include how to best conduct Outreach and Engagement activities, service delivery and organization, and representation in all levels of decision-making in the behavioral health department.
8. Assertive Community Treatment, theory and practice;
9. Wrap-Around Treatment, theory and practice;
10. Civil rights of the mentally ill, e.g. under the Americans with Disabilities Act, Special Education & housing discrimination laws, etc.;
11. Professional to professional consultation methodology.

We propose to work with a consultant; most likely from the California Institute for Mental Health (CIMH) to further design the training components and tie in relevant evidence based knowledge and practice. Following this, we propose to then use an RFP, or similar process, to contract with a coordinating organization. The selected organization would be responsible for organizing these elements and a number of subcontractors to deliver a coherent coordinated and evidence based training program.

Administrative Support for WRAPAROUND and ACT $ 112,770

Travel Allowance / Vehicle		$ 32,000
Computers and Peripheral Equipment		op 22,200
Printers	$ 4,000	
5 Desktop Computers and Software	6,000	
5 Laptop Computers and Software	10,200	
PDA and cell phones	2,000	

Computer Software 58,570

Nevada County Behavioral Health will use One-Time funding to purchase a software program to create and integrate computer based medical records into a central data-base. This will make client assessments, client-directed care plans, progress notes, and medication logs accessible from any shared computer site. The software will maintain full confidentiality and be HIPAA compliant. Clinical staff will have access to information without having to retrieve and refer to a paper chart. Information into the program will become available as soon as it is input.

Total One-Time Cost Allocation $751,800

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

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

Date: 2/5/07

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

COUNTY CERTIFICATION

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

Date: _____ Signature _____

Local Mental Health Director

Executed at _____, California

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

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

Date: 2/5/07

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)		0.50	$10,451
b. MHSA Support Staff		0.50	$4,334
c. Other Personnel (list below)			
i. Administrative Services Officer		0.10	$1,493
ii.Account Technician		0.30	$2,990
iii.			
iv.			
v.			
vi.			
vii.			
d. Total FTEs/Salaries	0.00	1.40	$19,268
e. Employee Benefits			$9,032
f. Total Personnel Expenditures			$28,300
2. Operating Expenditures			
a. Professional Services			$650
b. Travel and Transportation			$260
c. General Office Expenditures			$395
d. Rent, Utilities and Equipment			$390
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			$1,695
3. County Allocated Administration			
a. Countywide Administration (A-87)			$3,900
b. Other Administration (provide description in budget narrative)			$5,200
c. Total County Allocated Administration			$9,100
4. Total Proposed County Administration Budget			**$39,095**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			**$366,207**
D. Total County Administration Funding Requirements			**$405,302**

COUNTY CERTIFICATION

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

Date: _____ Signature _____

Local Mental Health Director

Executed at _____, California

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

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

Date: 2/5/07

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)		0.50	$42,984
b. MHSA Support Staff		0.50	$17,825
c. Other Personnel (list below)			
i. Administrative Services Officer		0.10	$6,139
ii.Account Technician		0.30	$12,297
iii.			
iv.			
v.			
vi.			
vii.			
d. Total FTEs/Salaries	0.00	1.40	$79,245
e. Employee Benefits			$37,149
f. Total Personnel Expenditures			$116,394
2. Operating Expenditures			
a. Professional Services			$2,673
b. Travel and Transportation			$1,069
c. General Office Expenditures			$1,623
d. Rent, Utilities and Equipment			$1,604
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			$6,969
3. County Allocated Administration			
a. Countywide Administration (A-87)			$16,042
b. Other Administration (provide description in budget narrative)			$21,388
c. Total County Allocated Administration			$37,430
4. Total Proposed County Administration Budget			**$160,793**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			
D. Total County Administration Funding Requirements			**$160,793**

COUNTY CERTIFICATION

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

Date: _____ Signature _____

Local Mental Health Director

Executed at _____, California

Plan for Assisted Outpatient Treatment

The Adult Assertive Community Treatment [ACT] Full Service Partnership will include a .50 FTE licensed mental health professional as an integrated part of the ACT team. In addition to other duties shared by the ACT providers, this person will perform the specialty functions of providing assisted outpatient treatment services to those consumers referred to the team by the court. It is expected that these services will be provided to a very limited number of members [less than five out of a team caseload of 50] during Fiscal Year 2007/08. Our estimate is that few individuals will meet Welfare and Institution Code criteria 5345(a) known, or Laura's Law, and more generally (b) known as assisted outpatient treatment. The majority of this staff person's time and service provision will be directed toward the rest of the members of the team, most of whom will be referred via the community and involve the target population of high risk consumers who are in need of intensive treatment services. The ACT target population consists of SMI individuals [Adults, TAY, Older Adults] with a history of, or at risk of becoming homeless, hospitalized, incarcerated, or institutionalized. Since the ACT model employs a shared team caseload concept, this staff person will be responsible to share the entire team caseload and provide services for up to 50 consumers, including those referred under assisted outpatient treatment. Similarly, the rest of the ACT staff will also provide services to those few individuals referred via assisted outpatient treatment. The .50 FTE ACT staff provider will provide assessment, psychotherapy, rehabilitation services, case management, coordination of care, crisis services, and participate in after hours coverage for the team caseload. The .50 FTE will assist members in achieving individualized service plan goals including housing, physical health, substance abuse, and employment. This service will be provided in a manner that is sensitive to gender, culture, ethnicity, and sexual orientation. The staff person will undergo education and training to assure these skills are competent.