Mental Health Services Act
Community Services and Supports

August 1, 2005

THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Fiscal Years 2005-06, 2006-07, 2007-08

CALIFORNIA DEPARTMENT OF
Mental Health

Three-Year
Program and Expenditure Plan Requirements

Mental Health Services Act
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Table of Contents

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MENTAL HEALTH SERVICES ACT
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BACKGROUND

The Mental Health Services Act (MHSA or the Act) represents a comprehensive approach to the development of community based mental health services and supports for the residents of California. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. To provide for an orderly implementation of MHSA, the California Department of Mental Health has planned for sequential phases of development for each of the components. Eventually all these components will be integrated into comprehensive plans with a continuum from prevention and early intervention to comprehensive, intensive interventions for those in need.

The first component to be implemented was the Community Planning Process as described in DMH Letter No.: 05-01. The second component will be those elements of the Act that define the requirements of service delivery to children, youth, adults and older adults with serious emotional disturbances and/or serious mental illnesses. The pertinent sections of the Act are Sections 5, 7, 10 and 15 that add or amend significant portions of the Welfare and Institutions Codes defining program requirements.

County proposals will be evaluated for their contribution to meeting specific outcomes for the individuals served including:

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

Individuals accessing services funded by the Mental Health Services Act may have voluntary or involuntary legal status which shall not affect their ability to access the expanded services under this Act. Programs funded under the Mental Health Services Act must be voluntary in nature. Services provided in jails and juvenile hall must be for the purpose of facilitating discharge.

The Program and Expenditure Plan Requirements recognize the unique needs and resource constraints of small counties, which are under 200,000 total population (based on 2005 projections). Areas where some flexibility in plan requirements is permissible for small counties are noted and discussed in each section of this document.

PURPOSE AND SUMMARY INFORMATION

The MHSA requires that "each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health (DMH) after review and comment by the Oversight and Accountability Commission." The MHSA further requires that "the department shall establish requirements for the content of the plans." The purpose of this document is to set forth the requirements for the first three-year program and expenditure plans to be submitted by counties requesting funding for the Community Services and Supports component under this Act. Annual updates of this plan will be required pursuant to MHSA requirements.

Submission Guidelines

An original and 10 copies of the completed Program and Expenditure Plan should be submitted to:

California Department of Mental Health
MHSA Three-Year Program and Expenditure Plan
County Operations
1600 9th Street, Room 100
Sacramento, CA 95814

1) Program and Expenditure Plans must include the Face Sheet (Exhibit 1). The Face Sheet must be printed in ink or typewritten.

2) Program and Expenditure Plans must include a Program Work Plan Listing (Exhibit 2) and Full Service Partnership Population—Overview (Exhibit 3). These will provide summary information regarding the entire Program and Expenditure Plan. Additionally, a narrative overview must be included to respond to Part II, Section VI, Subsection I, items 2-5.

3) The narrative portion of the Program and Expenditure Plan **must follow the order and format included in Part II, Sections I-V**. Failure to do so could result in postponement of the plan review and delays in approval of funding. There is no page limit to the length of this narrative.

4) Program and Expenditure Plans must include a Work Plan Summary (Exhibit 4) and Budget and Staffing Detail (Exhibit 5) **for each program** for which MHSA funds are being requested.

5) Program and Expenditure Plans must include a work plan narrative **for each program** for which MHSA funds are being requested in the order and format included in Part II, Section VI, Subsection II, items 2-12. There is no page limit to the length of this narrative.

6) Program and Expenditure Plans must be unbound, 3-hole punched, with binder ring in upper left hole. Proposals will not be accepted via fax or e-mail. Proposals must be typed in size similar to 12-point Arial font with one-inch margins or larger. One electronic copy of the proposal must be submitted on either CD or diskette.

7) Final electronic versions of the Exhibits may be used for posting on the Department's web site.

Plan Review Process

County mental health programs must submit a complete Three-Year Program and Expenditure Plan for MHSA Community Services and Supports to the Department of Mental Health (DMH) to receive MHSA funding to implement this component. (Requests for funding for city mental health programs need to demonstrate consistency and collaboration with the overall county mental health Program and Expenditure Plan.) Due to the comprehensive review and approval process for these Program and Expenditure Plans by both the Oversight and Accountability Commission and DMH, the review process is expected to take up to three months. If additional information is needed on any work plan submitted within the Three-Year Plan, the Department will not withhold approval on other acceptable work plans. Therefore, the approval process may be incremental.

Introduction to Program and Expenditure Plan Requirements

These Program and Expenditure Plan requirements are intended to build upon and operationalize the concepts in the Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act. These requirements look beyond "business as usual" and are intended to start building a system where access will be easier; services are more effective; out-of-home placements, institutional care, homelessness and incarcerations are reduced; and stigma toward those who are diagnosed with serious mental illness or serious emotional disturbance no longer exists. These requirements are intended to initiate significant changes including:

- Increases in the level of participation and involvement of clients and families in all aspects of the public mental health system
- Increases in client and family operated services
- Outreach to and expansion of services to client populations in order to eliminate ethnic disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates
- Increases in the array of community service options for individuals diagnosed with serious mental illness and children/youth diagnosed with serious emotional disorders, and their families, that will allow them to avoid unnecessary institutionalization and out-of-home placements

Statutes referenced in the MHSA that inform the Program and Expenditure Plan requirements are Welfare and Institutions (W&I) Code Sections 5801, 5802 and 5806, relating to AB 34 and AB 2034 programs, and W&I Code Section 5850 et seq., which define the core values and infrastructure requirements for Children's System of Care.

In January 2005, counties received DMH Letter No.: 05-01 outlining requirements to request funding to support their local MHSA planning processes. As stated in that document, the goals for local planning are to determine how best to utilize funds that will become available for the Community Services and Supports component of the MHSA. That document clearly outlined requirements for how to conduct a local planning process including that it must be culturally competent, comprehensive and representative, and include meaningful involvement of clients**,** family members and other stakeholders.

Technical Assistance Documents are available as an adjunct to the Community Services and Supports Program and Expenditure Plan Requirements. These are intended to aid Counties in their planning process. The Technical Assistance Documents include:

- County Readiness Self-Assessment for the Implementation of the MHSA Community Services and Support Component
- Performance Measurement
- Wellness/Recovery/Resiliency Services and Support System Planning Checklist for Children, Youth, Transition Age Youth and Families' Service Planning
- Wellness/Recovery/Resiliency Services and Support System Planning Checklist for Older Adults, Adults, Transition Age Service Planning
- Considerations for Embedding Cultural Competency
- Program and Expenditure Plan Examples

Essential Elements for All Three-Year Program and Expenditure Plans

There are five fundamental concepts inherent in the MHSA that must be embedded and continuously addressed throughout the Program and Expenditure Plans submitted by counties. These include:

- **Community collaboration**: Community collaboration refers to the process by which various stakeholders including groups of individuals or families, citizens, agencies, organizations, and businesses work together to share information and resources in order to accomplish a shared vision. Collaboration allows for shared leadership, decisions, ownership, vision, and responsibility. The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically solve existing and emerging problems that could not easily be solved by one group alone.

- **Cultural competence**: Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer providers, and family member providers to work effectively in cross-cultural situations. (Source: DMH Cultural Competence Plan Requirement adapted from Cross, Bazron, Dennis, and Isaac, *Towards a Culturally Competent System of Care*, Volume I, 1998.)

  Cultural competence includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities. There is a clear focus on improved quality and effectiveness of services. Service providers understand and utilize the strengths of culture in service delivery. Culturally competent programs and services are viewed as a way to enhance the ability of the whole system to incorporate the languages and cultures of its clients into the services that provide the most effective outcomes and create cost effective programs. Identification, development, promulgation, and adoption of culturally competent best practices for care must be an integral part of ongoing culturally competent planning and implementation of the MHSA.

- **Client/family driven mental health system for older adults, adults and transition age youth and family driven system of care for children and youth:** Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client-centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.

  Many adults with serious mental illness and parents of children with serious emotional disturbances[1] have limited influence over the services they or their children receive. Increasing opportunities for clients and families to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing choice protects individuals and encourages quality. (Source: The President's New Freedom Commission on Mental Health – *Achieving the Promise Transforming Mental Health Care in America*.)

- **Wellness focus, which includes the concepts of recovery and resilience:** Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to

[1] Throughout this document, the phrases "children who may have" and/or "who have been diagnosed with serious emotional disturbances" include children/youth who may have and/or who have been diagnosed with serious mental illness.

live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.

Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health treatments, which teach good problem solving skills, optimism, and hope can build and enhance resilience in children. (Source: California Family Partnership Association, March 2005.)

- **Integrated service experiences for clients and their families throughout their interactions with the mental health system:** This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have co-occurring disorders, including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state for years to come.

These five fundamental concepts combine to ensure that through MHSA-funded activities, counties work with their communities to create culturally competent, client/family driven mental health services and support plans which are wellness focused, which support recovery and resilience, and which offer integrated service experiences for clients and families.

Three Types of System Transformation Funding Available

DMH Letter No.: 05-02, released in June 2005, provides information on county Planning Estimates for funds available for the Community Services and Supports component of the MHSA. MHSA funds are to be used to fundamentally transform how mental health is conceptualized and delivered in California. The transformation of public mental health and the key goals have been articulated within the President's New Freedom Commission on Mental Health, the six aims of the Institute of Medicine's *Crossing the Quality Chasm* report, and the California Mental Health Planning Council's *Mental Health Master Plan*. These will serve as guiding documents for the implementation of the MHSA in California.

All of these documents are available in the DMH resource list for the MHSA found at www.dmh.ca.gov/MHSA/res_list.asp.

The Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act envision full implementation of an approach to services and supports through which clients and their families, when appropriate, participate in the development of individualized service and supports plans, consistent with the five fundamental concepts above, in which they choose and direct the kinds and intensity of services that will assist them in attaining their goals. Funding provided through the MHSA will be used to transform the current mental health system from one that focuses primarily on clinical services into one in which county mental health programs can enter into partnerships with clients, their families and their communities to provide, under client and family direction, whatever it takes to enable people to attain their goals.

Ideally, county mental health programs should be able to fully and adequately serve all clients in this way. This does not occur presently due to a long history of under funding. Although it varies from county to county, relatively small percentages of clients can be fully served. A larger percentage of clients and their families receive some level of services. There also continue to be many individuals who may have serious mental illnesses and children and youth who may have serious emotional disorders, and their families, who are currently not served. Many individuals who are homeless and incarcerated in jails or juvenile halls fall into this latter category. Individuals who are members of ethnic populations are also in this latter category and these ethnic disparities must be addressed. Since county mental health programs do not have the infrastructure or resources to provide full services to everyone in need immediately, DMH will make available three different types of system transformation funding under the Community Services and Supports Component of the MHSA. These funding types are approaches to service delivery and are not categorical funds that need to be tracked separately.

- *Full Service Partnership Funds – funds to provide "whatever it takes" for initial populations*

  With the initial implementation and funding of the MHSA, DMH will take the first step in funding counties to develop full service partnerships with identified initial populations. These partnerships shall be culturally competent and shall include individualized client/family-driven mental health services and supports plans which emphasize recovery and resilience, and which offer integrated service experiences for clients and families. In selecting initial populations, specific attention should be paid to populations and individuals that are currently unserved, and to reducing racial/ethnic disparities. The goal will be to eventually provide all needed cost-efficient and effective services and supports for all those in need of mental health services and their families, consistent with the individualized plans.

  Funding for the services and supports for Full Service Partnerships may include flexible funding to meet the goals of the individual services and supports plans. Access to generic community services should be obtained whenever feasible and appropriate. Mental Health Services Act funds are for community services and supports when

access to these services cannot be obtained from other sources and such expenditures are consistent with other MHSA requirements.

- *General System Development Funds – funds to improve programs, services and supports for the identified initial full service populations and for other clients consistent with the populations described in Part II.*

  General system development funds are needed to help counties improve programs, services and supports for all clients and families (including initial Full Service Partnership populations and others) to change their service delivery systems and build transformational programs and services. Strategies for reducing ethnic disparities should be considered. Examples for this kind of funding are client and family services such as peer support, education and advocacy services, mobile crisis teams, funds to promote interagency and community collaboration and services, and funds to develop the capacity to provide values-driven, evidence-based and promising clinical practices. This funding may only be used for mental health services and supports to address the mental illness or emotional disturbance. (Mental health services and supports include mental health treatment, rehabilitation services including supportive housing and supportive employment, and personal service coordination/case management. In collaborative programs, the cost of the mental health component only is allowable; for positions with blended functions, only the proportion of costs associated with the mental health activities are allowable. Costs for community supports such as rental subsidies, other treatment such as health care or substance abuse treatment, and respite care are not allowable under General System Development. These examples are allowable under Full Service Partnerships.)

- *Outreach and Engagement Funding – funds for outreach and engagement of those populations that are currently receiving little or no service.*

  This funding is established in recognition of the special activities needed to reach unserved populations. Outreach and engagement can be one component of an overall approach to reducing ethnic disparities. Examples of this type of funding would be funding for racial ethnic community-based organizations, mental health and primary care partnerships, faith-based agencies, tribal organizations and health clinics; organizations that help individuals who are homeless or incarcerated, and that link potential clients to services; funds for clients and families to reach out to those that may be reluctant to enter the system; funds for screening of children and youth; and school- and primary care-based outreach to children and youth who may have serious emotional disorders. This funding may only be used for those activities to reach unserved populations. Some individuals may have had extremely brief and/or only crisis oriented contact with and/or service from the mental health system and should be considered as unserved.

In this initial plan, counties may request ongoing funding for any or all of the three categories and may request one-time-only start-up funds in any of these funding areas. For the three-year planning period, DMH requires that counties request a majority of their total CSS funding for Full Service Partnerships, in order to begin to provide full service to as many individuals/families as possible. Services funded from General System

Development or Outreach and Engagement funds provided to individuals who have full service partnerships may be counted in achieving this requirement. **Exceptions for Small Counties:** Small Counties are required to request a majority of their total CSS funding for Full Service Partnerships by Year 3 (FY 2007-08).

Medi-Cal Reimbursement

Although counties are encouraged to maximize other funding sources whenever possible, for counties to be innovative and transformative, funds requested under the MHSA should not be driven by the goal of maximizing Medi-Cal reimbursement. A transformed mental health system will require new and innovative activities and services not currently funded through Medi-Cal and other public or private payors and will include individuals not currently eligible for Medi-Cal funding. However, MHSA funds can be used as match to Medi-Cal or Healthy Families Program federal financial participation for those services consistent with the MHSA requirements.

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

Section I: Planning Process

Direction:

Planning Process: Pursuant to DMH Letter No.: 05-01, counties submitted requests to DMH for funding to support the local community planning processes. Included in those requests counties provided information about how their planning process would include consumers and families, how it would be comprehensive and representative, how the planning process would be staffed, and how staff and stakeholders would be trained in advance to participate in the planning process. As part of their Community Services and Supports Plan, counties are required to complete the responses below to confirm that they did what they said they would do and that they met their identified goals in their "plan to plan." Different levels of responses are required for counties whose plans were approved without conditions and those who had approval with conditions (see below). **NOTE: Counties who received approvals with conditions may resubmit to DMH those sections with conditions to obtain full approval of their County Funding Request for Community Program Planning.**

Plan Review: Consistent with MHSA statutory requirements (Welfare and Institutions Code Sections 5848(a) and (b)), each county's three-year program and expenditure plan, including the approved County Funding Request for Community Program Planning, shall be developed with local stakeholders and made available in draft and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the plan. At the close of the 30-day comment period the local mental health board or commission shall conduct a public hearing on the draft plan or annual updates. The county shall include any substantive written recommendations for revisions and a summary of the analyzed recommendations in the plan that is submitted to the State.

Response:

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

   Counties whose plans were approved with conditions in this area or counties that did not follow their County Funding Request as approved, must also provide the following more detailed information:

   a) Describe the outreach and other activities used by the county to insure comprehensive participation from diverse consumers and families. Provide information about how consumers and family members were informed about methods of giving input in the public planning process. Briefly describe how this was accomplished for each age group, if different strategies were used.

   b) Describe how your organization reached out to consumers and families who do not belong to organized advocacy groups. Identify existing organized advocacy groups in your county and explain methods used to involve consumers and families outside these organizations. Include non-traditional groups such as American Indian tribes and tribal organizations.

   c) Describe how your organization reached out to consumers and families who have been traditionally unserved or underserved whether by reason of race, ethnicity, limited language access, culturally inappropriate care, geographic location or other factors. How did you identify consumers and family members who have been traditionally unserved or underserved? What methods were used to bring them into the public planning process? What was your level of success in including their participation? What was the impact on your plan as a result of the inclusion of these unserved and underserved communities?

   d) Provide a comprehensive list of activities designed to encourage consumers and family members to participate in the public planning process. (These could include but are not limited to: surveys, focus groups, interviews, conference calls, client advisory committees, consumer/family meetings, public meetings, public hearings, town hall meetings, meetings on American Indian rancherias or reservations, video conferences, and media announcements.)

   e) How well did consumer and family participation reflect the diversity of the county's unserved and underserved racial ethnic populations as reflected in the 200% poverty population?

   f) For those counties who previously did not have established consumer and family groups participating in county mental health program policy and planning, explain how you have initiated this type of resource and how you plan to sustain it.

   g) Describe in detail any financial or additional supports (such as stipends, childcare, supplemental meals, housing, transportation assistance, etc.) the county provided to encourage and assure client and family involvement in the public planning process. (Include the actual costs of providing all of the above.)

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

Counties whose plans were approved with conditions in this area, or counties that did not follow their County Funding Request as approved, must also provide the following more detailed information:

a) Identify in total the number of persons in addition to clients and family members who participated in your planning process and categorize them by organization represented. If some did not represent an organization – categorize as county constituent.

b) Describe what methods were used to insure that the stakeholder participation reflected the demographics of the county including geographic location, age, gender and age/ethnicity. Include information about how the process included stakeholders throughout the various regions of the county including American Indian rancherias or reservations, representatives of all ages, and race/ethnicities residing in the county.

c) Describe how meetings were organized for public planning and who facilitated those meetings. How were county mental health staff involved in these processes? Include information about the types and number of meetings held associated with public planning for MHSA implementation; identify the number of persons who attended and who they represented, and provide meeting minutes.

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.

Counties whose plans were approved with conditions in this area, or counties who did not follow their County Funding Request as approved, must also provide the following more detailed information:

a) Provide the name of the person with overall responsibility for the public planning process in your county and the percentage of their time devoted to the effort.

b) Provide the names and titles of other persons who supported the public planning process; identify their function and how much time they each devoted to the effort. Provide a summary of all staff functions performed and the amount of time devoted to the public planning process to-date. Include information about who handled the organizational work of the planning process, who was responsible for ensuring the participation of stakeholders from unserved and underserved populations, who was responsible for ensuring the participation of ethnically diverse populations, and whether or not consultants performed any of the functions identified. If other county staff were involved in public planning activities, please identify by function.

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

Counties whose plans were approved with conditions in this area or counties who did not follow their County Funding Request as approved, must provide the following more detailed information:

Complete and include the following matrix regarding training by function provided to date using MHSA community planning funds:

Functions:

a) Administration/management
b) Direct services: county staff
c) Direct services: contractors
d) Support services
e) Interpreters
f) General public
g) Mental Health Board/Agency Board of Directors
h) Community Event (number of attendees can be estimated)

Training Event	Presenter	Description of Training	Number of Attendees	Function (a-h)	Date

Section II: Plan Review

1) Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.
2) Provide documentation of the public hearing by the mental health board or commission.
3) Provide the summary and analysis of any substantive recommendations for revisions.
4) If there are any substantive changes to the plan circulated for public review and comment, please describe those changes.

A county's Program and Expenditure Plan will not be reviewed for funding until the county has successfully carried out a complete and adequate planning process as approved by the State Department of Mental Health, has completed the required local review and public hearing, and has met the above requirements.

PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Overview

Throughout the Community Services and Supports Program and Expenditure Plan Requirements document, references are made to the identification of specific populations to be served through the Mental Health Services Act.

Services for Children and Youth: The W&I Code, Section 5878.1(a) specifies that MHSA services will be provided to children and young adults with severe mental illness as defined in the W&I Code 5878.2: those minors under the age of 18 who meet the criteria set forth in subdivision (a) of 5600.3—seriously emotionally disturbed children or adolescents. Services will also be provided to children up through age 21 for those who meet the special education eligibility requirements under Government Code Chapter 26.5, Section 7570. Some transition age youth may also be served under W&I Code, Section 5865.1.

Services for Adults and Older Adults: The W&I Code, Section 5813.5 specifies that MHSA services will be available to adults and seniors with severe mental illnesses who meet the eligibility criteria in the W&I Code Section 5600.3(b)—adults and older adults who have serious mental disorder and (c)—adults and older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence. Some transition age youth may also be served under these provisions.

The MHSA Program and Expenditure Plan Requirements are based on a logic model that links: (1) community issues resulting from untreated mental illness and a lack of services and supports, (2) mental health needs within the community, (3) the identification of specific populations to be served based upon the issues and needs identified, (4) the programs and services/strategies to be implemented and (5) the desired outcomes to be achieved. In addition to a focus on community issues and outcomes, the MHSA also emphasizes the importance of measuring outcomes achieved by specific individuals and families, including but not limited to: hope, personal empowerment, respect, social connections, independent living for adults and safe living with families for children/youth, self-responsibility, self-determination and self esteem for clients and families. Along with other individual and system level outcomes, these individual value-driven outcomes will be incorporated within the outcome measurement system to be developed and implemented under the MHSA. DMH envisions an ongoing process of identifying community issues and unmet needs, focusing upon specific individuals and populations in need based upon these identified issues, developing and implementing state-of-the-art service and support strategies and assessing outcomes: all to ensure that counties are providing the highest level of quality care possible in the most efficient and effective ways. It is further envisioned that as a part of the ongoing quality improvement process, data and feedback on the individual, community and system levels are used to refine and improve services and supports. Plans for addressing individual quality of care issues are a part of this ongoing process.

Each county must plan for each age group in their populations to be served. If a county does not believe that providing expanded MHSA services for each age group in the initial years is feasible, an explanation must be provided regarding why this it is not feasible. The County must then indicate their plan to provide MHSA service to at least some populations in each age group by year three of this plan, and provide assurance that remaining age groups will be addressed in the subsequent plan.

Three-Year Program and Expenditure Plans submitted by counties must follow the format and structure included in the sections:

Section I: Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports
Section II: Analyzing Mental Health Needs in the Community
Section III: Identifying Initial Populations for Full Service Partnerships
Section IV: Identifying Program Strategies
Section V: Assessing Capacity
Section VI: Developing Work Plans with Timeframes and Budgets/Staffing

In this plan, counties must target reductions in racial ethnic disparities as they identify outreach and engagement efforts, initial full service populations and new and expanded programs and strategies.

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

Direction:

One of the major goals of the MHSA is to reduce the long-term adverse community impacts of untreated mental illness and serious emotional disorders. The MHSA identifies the following community issues related to mental illness which result from a lack of community services and supports:

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

Working with clients, families and other community stakeholders, counties should examine these issues and others in the context of their communities and identify which of these community issues and concerns they will focus on in their initial three-year program and expenditure plan. The selection of community issues to be addressed should inform a county's choices about which populations or groups of individuals will be identified for Full Service Partnership funding in this first three-year plan.

If, through the planning process, a county decides to focus on an issue or issues not specifically described in the MHSA, the Program and Expenditure Plan must describe why these issues are more significant for their community and how the issues are consistent with the purpose and intent of the MHSA.

Response:

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

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

County/Community Issues Identified in the Public Planning Process:

Children/Youth	Transition Age Youth	Adults	Older Adults
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.

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.)

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.

4) If you selected any community issues that are not identified in the "Direction" section above, please describe why these issues are more significant for your county/community and how the issues are consistent with the purpose and intent of the MHSA.

Section II: Analyzing Mental Health Needs in the Community

Direction:

Following identification of community issues, counties must provide an assessment of the mental health needs of county residents and residents of American Indian rancherias or reservations within county boundaries, including adults, older adults and transition age youth who may have or have been diagnosed with serious mental illness, and children, youth and transition age youth who may have or have been diagnosed with serious emotional disorders. The intent is to recognize all those who would qualify for MHSA services, including those who are currently unserved, underserved or fully served, and identify their age and situational characteristics (e.g., homelessness, institutionalization or out-of-home placement, involvement in the criminal or juvenile justice system, etc.). For purposes of this document the following definitions apply:

- Unserved – persons who may have a serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Examples of unserved populations described in the MHSA include older adults with frequent, avoidable emergency room and hospital admissions, adults who are homeless or incarcerated or at risk of homelessness or incarceration, transition age youth exiting the juvenile justice or child welfare systems or experiencing their first episode of major mental illness, children and youth in the juvenile justice system or who are uninsured, and

individuals with co-occurring substance use disorders. Frequently, unserved individuals/families are a part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian rancherias or reservations and lack of culturally competent services and programs within existing mental health programs. Some individuals, who should be considered in the priority populations identified in Section III of this document, may have had extremely brief and/or only crisis-oriented contact with and/or service from the mental health system and should be considered as unserved.

- Underserved/inappropriately served – individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences. Examples of people who are underserved or inappropriately served include older adults who are in institutions because they are not receiving services that would allow them to remain in their own homes, adults who are in Institutions of Mental Disease (IMDs) and Board and Care facilities but not receiving services that would allow them to move to more independent and permanent housing, transition-age youth who are not getting the vocational services they need to become successfully employed, and/or children and youth who may be receiving mental health services in out-of-county placements, but do not have the in-home supports needed to allow them to return home with their families. Frequently, underserved individuals/families are a part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian rancherias or reservations and lack of culturally competent services and programs within existing mental health programs.

- Fully served – People who have been diagnosed with serious mental illness and children/youth who have been diagnosed with serious emotional disorders and their families, who are receiving mental health services through an individual service plan where both the client and their service provider/coordinator agree that they are getting the services they want and need in order to achieve their wellness/recovery goals. Examples of people who may be fully served include individuals in AB 34 or 2034 programs and children and families receiving Wraparound services within a comprehensive Children's System of Care.

Although counties may also elect to provide some new or expanded services to underserved individuals already receiving some services in their system, DMH expects

counties to identify unserved individuals and their families in the priority populations for MHSA funding.

At this time counties are not being asked to provide detailed estimates of the numbers of individuals in their total population who may need mental health services but are currently unserved. DMH has begun planning for a statewide study on prevalence of adults and older adults who may have serious mental illness. DMH expects to provide more guidance for future plans regarding these data so that there will be consistency across the State. Counties are required, however, to include some descriptions and/or estimates of unserved populations. Using available local data, counties must assess in general terms the needs of unserved populations of individuals with the kinds of age and situational characteristics identified in the MHSA and described above. Particular attention should be paid to identifying and analyzing ethnic disparities. Some populations such as Native Americans may be underrepresented in the data. Other sources may be needed to present more complete information.

Counties shall also provide estimates of their underserved and fully served populations. For this first three-year plan, counties must identify and analyze in detail their current utilization data in terms of the numbers of clients and family members who need MHSA programs and services and are already being served. Counties must identify persons who are currently fully served and those who are underserved or inappropriately served. Assessments should consider the current service needs of gay, lesbian, bisexual and transgender individuals. In addition, counties should also consider the needs of individuals with co-occurring substance use disorders and other individuals with special needs, such as those with hearing or visual impairments, other physical disabilities and acute and chronic medical conditions such as HIV/AIDS.

The DMH's expectation is that counties will identify the number of persons, by age group, race ethnicity, gender and primary language, that may be underserved, including individuals that some might define as inappropriately served such as:

- An older adult with frequent emergency room visits who has not had a comprehensive medical, mental health and social assessment
- An adult living in an IMD or a Board and Care facility because of the lack of supported housing services
- A transitional age youth who does not have a comprehensive plan for transitioning out of foster care, or
- A child/youth living in an out-of-home placement or involved in the juvenile justice system due to lack of access to appropriate community-based services

Response:

Please address each of the following questions pertaining to the mental health needs assessment completed as part of the MHSA public planning process.

1. 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.

   Counties will have to use multiple informing factors to address this section. DMH will provide some data for counties based on the 2000 U.S. Census, updated Department of Finance population data, uninsured rates, and poverty rates by race ethnicity. Counties will also need information from other county offices, including social services, education, criminal and juvenile justice and other data sources such as recent county homeless surveys to estimate some of the populations. Ethnic-specific community-based organizations and tribal organizations often have detailed population data to contribute to this analysis.

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

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										
African American										
Asian Pacific Islander										
Latino										
Native American										
White										
Other										

TRANSITION AGE YOUTH	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL										
African American										
Asian Pacific Islander										
Latino										
Native American										
White										
Other										

ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL										
African American										
Asian Pacific Islander										
Latino										
Native American										
White										
Other										

OLDER ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL										
African American										
Asian Pacific Islander										
Latino										
Native American										
White										
Other										

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.

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.

Section III: Identifying Initial Populations for Full Service Partnerships

Direction:

In the previous section of these Program and Expenditure Plan Requirements counties were asked to discuss populations and persons that were unserved, underserved/ inappropriately served or fully served who meet the criteria for MHSA services in their county. In this section counties are asked to specify the estimated number of persons to be provided Full Service Partnerships within the first three years. As noted previously, it is the intent of DMH that counties will move toward identifying and providing full service to all persons covered in the MHSA. This will need to be accomplished in phases, as not everyone who will eventually be included under the MHSA can be fully served in the first three years.

As part of the community collaborative process, counties are encouraged to start "small and smart" when identifying initial full service populations so that they can be successful in helping clients and families achieve their goals and in establishing the effectiveness of MHSA services and supports.

General requirements for all populations:

- Each county must specifically identify their initial full service populations including the number of persons to be served in the first three-year Program and Expenditure Plan.
- Counties must specifically identify disparities in access for ethnic populations and discuss how their selection of initial full service populations will reduce disparities. Large and/or populous counties should review their ethnicity, gender and primary language data by regional and geographic sub-areas of the county.

Counties must determine, through their planning process, which populations are the most appropriate to focus on during the first three years. These decisions should be made in the context of the community issues and mental health needs identified in the two previous sections. Priority should be given to unserved populations. What follows are recommended initial populations within each age group that are consistent with issues of public concern and the MHSA. Counties who choose not to select from the

initial populations in each age group as described below must specify their reasons for not doing so, provide clear information as to why the initial populations they identify are more appropriate for this Program and Expenditure Plan, and describe how they are consistent with the purpose and intent of the MHSA.

Specific Populations by Age Consistent with MHSA and DMH Priorities:

- **Children and youth between the ages of 0 and 18, or Special Education Pupils up to age 21, who have serious emotional disorders and their families, who are not currently being served**. This will generally be youth and their families who are uninsured, under-insured and/or youth who are not eligible for Medi-Cal because they are detained in the juvenile justice system. It could also include homeless youth, youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements. Children and youth who are so underserved that they are at risk of homelessness or out-of-home placement are also included.
- **Transition age youth** between the ages of 16 and 25, who are currently unserved or underserved who have serious emotional disorders and who are homeless or at imminent risk of being homeless, youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems and youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization. Transition age youth who have experienced a first episode of major mental illness are also included.
- **Adults with serious mental illness** – including adults with a co-occurring substance abuse disorder and/or health condition who are either:

  Not currently served and meet one or more of the following criteria:

  - Homeless
  - At risk of homelessness – such as youth aging out of foster care or persons coming out of jail
  - Involved in the criminal justice system (including adults with child protection issues)
  - Frequent users of hospital and emergency room services

  Or are **so underserved** that they are **at risk of**:

  - Homelessness – such as persons living in institutions or nursing homes
  - Criminal justice involvement
  - Institutionalization

  Transition age older adults (often between the ages of 55 and 59) who are aging out of the adult mental health system and at risk of any of the above conditions or situational characteristics are also included.

- **Older adults 60 years and older with serious mental illness** – including older adults with co-occurring substance abuse disorders and/or other health

conditions – who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services. Older adults who are so underserved that they are at risk of any of the above are also included. Transition age older adults (as described above) may be included under the older adult population when appropriate.

Each individual identified as part of the initial full service population must be offered a partnership with the county mental health program to develop an individualized services and supports plan. The services and supports plans must operationalize the five fundamental concepts identified at the beginning of this document. They must reflect community collaboration, they must be culturally competent, they must be client/family driven with a wellness/recovery/resiliency focus and they must provide an integrated service experience for the client/family. Under Full Service Partnerships:

- The county agrees to work with the individual and his/her family, as appropriate, to provide all necessary and desired appropriate services and supports in order to assist that person/family in achieving the goals identified in their plan
- Individuals will have an individualized service plan that is person/child-centered, and individuals and their families will be given sufficient information to allow them to make informed choices about the services in which they participate
- All fully served individuals will have a single point of responsibility – Personal Service Coordinators (PSCs) for adults – case managers for children and youth – with a caseload that is low enough so that: (1) their availability to the individual and family is appropriate to their service needs, (2) they are able to provide intensive services and supports when needed, and (3) they can give the individual served and/or family member considerable personal attention. Services must include the ability of PSCs, children's case managers or team members known to the client or family member to respond to clients and family members 24 hours a day, 7 days a week. This 'best practice' service strategy is intended to provide immediate 'after-hours' interventions that will reduce negative outcomes for individuals including but not limited to unnecessary hospitalizations, incarcerations and evictions. For transition age youth, adults and older adults this service must include the ability to respond to landlords and or law enforcement. For children and youth it must include the ability to respond to persons in the community identified by a child's family. **Exceptions for small counties:** Small counties may meet the 24/7 requirement through peers or community partners who are known to the client/family rather than exclusively through the PSCs, case managers or team members.
- PSCs/case managers must be culturally competent, and know the community resources of the client's racial ethnic community.
- Services should also include linkage to, or provision of, all needed services or benefits as defined by the client and or family in consultation with the PSC/case manager. This includes the capability of increasing or decreasing service intensity as needed. Community Support Services, consistent with the

individual service plan may only be funded by MHSA funds when funding under any other public or private payor source or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services pursuant to Medi-Cal and Special Education Programs.

DMH will develop standardized outcome/performance measurement requirements and counties will be required to submit service, assessment and indicator/outcome information for each person/family who is fully served. Outcomes will address individual wellness/recovery and resiliency issues in addition to other outcomes. (A brief description of performance measurement strategies is included with the adjunct Technical Assistance Documents (Document 2 – Performance Measurement) and DMH will be providing further requirements in the future.) Counties should consider the workload associated with collecting service and outcome information when estimating and budgeting for MHSA clinical and support staff. A data collection model similar to that of the AB 2034 program will be used to track services/supports and individual client outcomes for the MHSA. For more information on the data requirements for the AB 2034 program, please see the AB 34 website at http://www.ab34.org/support_formsstate.asp.

The Program and Expenditure Plan must identify the number of individuals within the initial populations for each age group that counties expect to fully serve in each program for which MHSA funds are requested in the initial three-year period. Number of clients to be fully served and projected dates for entering into full partnerships with clients/families must be reflected in the work plan required in Section V.

Response:

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.

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

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

Section IV: Identifying Program Strategies

Direction:

It is recognized that counties will be proposing work plans to implement community services and supports through new or expanded programs. Strategies listed in this section will be used in those organized programs as approaches to address defined community issues and population needs. Multiple strategies in a single program will often be appropriate.

Counties that request funding for strategies other than those listed in the following pages must describe how the alternative strategies are transformational; how they will promote wellness, recovery and resiliency; how they will eliminate barriers to racial/ethnic communities including those for clients with limited English-speaking abilities; and how they will be culturally and linguistically competent, consistent with the intent and purpose of the MHSA.

Section 3(c) of the MHSA speaks to the intent of "expanding the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations." Section 3(e) refers to services that "…are provided in accordance with recommended best practices."

Selected strategies must be consistent with the five elements identified earlier in this document: community collaboration, cultural competence, client- and family-driven, wellness/recovery/resiliency focus, and integrated service experiences for clients and families.

In this initial three-year Program and Expenditure Plan, each county, working collaboratively with community stakeholders, must identify the strategies to be used to build the necessary infrastructure and capacity to serve a diverse population of clients and their families. DMH expects that these strategies, selected by the counties through the stakeholder process, will serve designated initial full service populations and/or other individuals needing services from the public mental health system who may be currently unserved or who may not yet be fully served. Selected strategies may be funded by any of the three types of funding as appropriate – funding for Full Service Partnerships, funding for System Development and funding for Outreach and Engagement. Some of these strategies are also appropriate for funding through other state and community sources. Counties are encouraged to pursue collaborative funding and to use and leverage other funding sources in addition to MHSA funds for these strategies wherever possible.

AB 34 and AB 2034 programs for adults and Children's System of Care (CSOC) and Wraparound, and the philosophies, values and service standards they incorporate, are the foundations upon which the MHSA was built. The strategies described in this document are designed to operationalize system transformation and the principles of W&I Code Sections 5801, 5802 and 5806, relating to AB 34 and AB 2034 programs,

and W&I Code Section 5850 et seq. that define the core values and infrastructure requirements for Children's System of Care programs and services.

All strategies identified under each age group must be culturally competent and address elimination of cultural and linguistic barriers to care for clients and families from different race/ethnicities, gender and primary language needs. Services should be sensitive to the differing perspectives and concerns resulting from different cultural values, life experiences and context. Services should also be sensitive to sexual orientation and gender-sensitive, reflecting the differing psychologies and needs of women and men, boys and girls. Although the strategies below are listed by age group, counties are also encouraged to develop intergenerational strategies, which could include such strategies as programs for children and families in which a parent has a serious mental illness, programs for transition age youth and their families when the youth continues to live in her/his parental home, programs for adult children who are caregivers for their aging parents or aging parents caring for their adult children diagnosed with serious mental illness. Many of the strategies listed in this section could be used for any age group; they are listed here where they seem most appropriate to emphasize and with language most familiar to stakeholders in the particular age group.

In creating a plan and selecting strategies that will transform a local mental health system into a comprehensive community system that is client- and family-directed, culturally competent and recovery/resiliency oriented, it is important to think about the current culture of the county system and how it is perceived by a variety of stakeholders. Planning Checklists are included in the Technical Assistance Document 3 and 4 and are intended to be learning tools, to help stakeholders think about the concepts and principles underlying a transformed system, and review the current functioning of their local systems of care in relation to these concepts.

County requests for funding must be consistent with the purpose and intent of the MHSA and the three types of funding outlined on pages 7 and 8, Purpose and Summary. To insure this consistency, DMH has identified strategies that relate to the Vision and Guiding Principles for the MHSA. DMH believes these kinds of strategies will help move systems toward transformation and would be appropriate strategies for funding under the MHSA. In developing new programs and services, and/or expanding existing ones, counties, working together with clients, family members, communities, and other collaborative partners, should select from the strategies described below.

All counties must develop and/or expand peer support and family education support services within their three-year plan.

Children, Youth and their Families

The MHSA requires mental health services provided to children and youth to be part of the CSOC and adhere to the core values and guiding principles of CSOC. The infrastructure requirements for CSOC are stated in W&I Code Section 5850 et seq. The MHSA also requires implementation of Wraparound services unless a county can provide substantial evidence that it is not feasible to establish a Wraparound program in

their county. Wraparound programs must be consistent with program requirements found in W&I Code Section 18250-18252. If Wraparound services already exist in a county, it is not necessary to expand these services. If Wraparound services are under development, the county must complete the implementation within the three-year plan period.

The infrastructure requirements of the Children's System of Care program as found in W&I Code Section 5856 are designed to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children and their families. They include:

- A county interagency policy and planning committee
- A countywide interagency case management council
- Written interagency agreements or MOUs

The Wraparound Program includes services and supports which:

- Provide strength-based, family-driven services to children/youth and their families with multiple, complex mental health and behavioral needs
- Are based on a single individualized services and supports plan across systems
- Allows for organization, implementation and oversight of an interagency plan as well as taking on the critical tasks needed to support and serve the child/youth and family

Strategies

- Family Partnership Programs which are operated by family members and include strategies to engage racially and ethnically diverse families, and include services and activities such as training, information and referral, newsletter or information dissemination, support groups, individual advocacy and support, web-based information, outreach, administrative activities and program oversight, and direct services self-help support and empowerment through family partnership and peer consultation, such as the successful Family Resource Centers models promoted by CDSS
- Child/youth peer mentoring
- Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements
- Cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities, which proactively reach children who may have emotional and/or behavioral disorders and which can provide easy and immediate access to mental health services when needed
- Services and supports provided at school, in the community and in the

child/youth's home

- Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families
- Family preservation services
- Specialized services to address gay, lesbian, bisexual and transgender youth diagnosed with serious emotional disorders
- Crisis services including:
  - 24-hour phone line for crisis
  - Mobile crisis services
  - Respite services for both children/youth and families
  - Crisis and transitional residential treatment alternatives
- Education for children/youth and family or other caregivers regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities, and other information related to children/youth's mental health services and needs
- On-site services in juvenile halls and other detention facilities
- On-site services in child welfare emergency shelters
- Integrated physical and mental health services, which includes co-location and/or collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage must be provided for children and families served in these settings to the full range of mental health services when needed. These services are particularly needed to serve ethnic populations and others who may be more responsive to services in health care settings
- Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services
- Services in collaboration with faith-based communities; linkage for these families to the full range of community services and supports
- Services located in racial ethnic communities to reach children, youth and families who may be more responsive to services in these settings; linkage for these families to the full range of community services and supports, intergenerational strategies for children/youth and their families in which parents may have their own mental health problems. Services are delivered within the context of a single child/family services and supports plan.
- Integrated services and supports for children/youth and their families with co-occurring mental health and substance use disorders within the context of a single child/family services and supports plan
- Parental mental health education, with language access and culturally

appropriate approaches

- Permanent supportive housing for homeless families and families re-unifying after a child or parent has been in an institution (e.g. jail, juvenile hall, or hospital) or other out-of-home placement
- Values-driven evidence-based and promising clinical services that are integrated with overall service planning and which support youth/family selected goals
- Childcare
- Transportation
- Supportive family partnership educational opportunities
- Grief-loss family partnership support groups
- Ethnic- or tribal-specific social or community groups or other culture-based activities for children/youth and their families, which may be in collaboration with Native American rancherias or reservations

Transition Age Youth and Their Families

The strategies listed below are particularly appropriate for transition age youth and their families. In addition to these, many of the strategies for adults and for children, youth and their families may also be appropriate for transition age youth.

Strategies

- Development of self-help, peer support and youth/family-run programs, to add youth/families as providers in clinical settings and to develop youth training programs, including youth and family member leadership training programs
- Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate. A single PSC/case manager should follow transition age youth as they move from children and youth services into adult services and/or into the community as independent adults. Transfer out of a transition age program should be negotiated with the youth and not occur until s/he feels connected with the necessary services and supports for successful community independence and/or connection with the adult mental health system as appropriate.
- Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and in operationalizing a wellness philosophy including the concepts of both recovery and resiliency. Transition age youth, themselves, should be part of the pool of hired and trained staff.
- Integrated substance abuse and mental health services where youth receive substance abuse and mental health services simultaneously rather than sequentially, through an integrated team with a single individualized service plan. When appropriate, specialized housing for individuals with dual disorders should

be available.

- Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families.
- Supportive housing – permanent affordable housing with combined supports for independent living, including projects that meet the following criteria: (1) housing is permanent, meaning that each tenant may stay as long as he or she pays his or her share of rent and complies with the terms of a lease or rental agreement, (2) housing is affordable, meaning that each tenant pays no more than 30% to 50% of household income, and (3) tenants have access to an array of support services that are intended to support housing stability, recovery and resiliency, but participation in support services is not a requirement for tenancy. Supportive housing may be site-based (all or a portion of the units in a building are designated for people with special needs, and supportive services are available on-site) or scattered site (tenants have or rent houses at various locations in the community). Housing options are available for transition age youth who are single and those who choose to share housing, as well as families with children.
- Integrated service teams that provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma (including intergenerational trauma) assessments which are strength-based and focused on engagement of the transition age youth and which can provide gender and cultural specific assessments as in the DSM-IV-R cultural formulation
- Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding options
- Integrated "one stop" centers wherein essential health, substance abuse, employment, and mental health services can be accessed
- Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs
- Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements
- Values-driven evidence-based and promising clinical services that are culturally and linguistically appropriate and integrated with overall service planning and support housing, employment, and/or education goals and are consistent with the values of the youth and his/her community
- Classes regarding what youth need to know for successful living in the community
- Supportive employment including development of job options for young people, such as social enterprises, agency supported positions, and competitive employment options with equal pay and benefits
- Supportive education services

- Education for youth and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects
- Trauma-informed services and trauma-specific services (including intergenerational trauma services), particularly for young women with co-occurring disorders
- Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services
- Services to assist families in supporting youth during this period
- Crisis services including:
  - 24-hour crisis phone line
  - Mobile crisis services
  - Peer support in times of crisis
  - Crisis and transitional residential treatment alternatives
- Development of housing options including:
  - Temporary housing/shelter/vouchers
  - Transitional housing while youth are waiting for a more permanent housing opportunity
  - Safe havens
  - Permanent housing
- Partnerships with ethnic-specific community providers and programs
- Independent Living Programs
- Transportation (including acquisition of driver's licenses)
- Recreation and social activities. Transition age youth should be involved in the planning and development of activities
- Integrated physical and mental health services, which includes co-location and/or collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage must be provided for clients served in these settings to the full range of mental health services when needed. These services are particularly needed to serve ethnic youth and others who may be more responsive to services in health care settings and to reach youth with co-occurring chronic or life-threatening medical conditions and youth who are frequent users of hospital emergency rooms or inpatient care.
- Education for primary care providers and other health care providers to increase coordination and integration of mental health, primary care, and other health services.

Adults

In addition to the strategies for adults listed below, communities should also consider the transitional needs of adults (often between the ages of 55 and 59) who are aging out of the adult system and may have special needs to enable them to successfully transition out of the mental health system altogether or into needed, desired and appropriate older adult recovery-oriented and culturally appropriate services. Services for adults should include the family, as defined by the client, whenever appropriate.

Strategies

- Integrated service agencies which provide and/or broker all services that a client needs (see list under service strategies)
- Supportive housing – permanent affordable housing with combined supports for independent living, including projects that meet the following criteria: (1) housing is permanent, meaning that each tenant may stay as long as he or she pays his or her share of rent and complies with the terms of a lease or rental agreement, (2) housing is affordable, meaning that each tenant pays no more than 30% to 50% of household income, and (3) tenants have access to an array of support services that are intended to support housing stability, recovery and resiliency, but participation in support services is not a requirement for tenancy. Supportive housing may be site-based (all or a portion of the units in a building are designated for people with special needs, and supportive services are available on-site) or scattered site (tenants have or rent houses at various locations in the community). Housing options are available for adults, who are single and those who choose to share housing, as well as families with children.
- Client self-directed care plans (e.g., Wellness Recovery Action Plans or other similar models)
- For individuals with dual diagnosis, integrated substance abuse and mental health services where a client/member receives substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services as appropriate
- Integrated physical and mental health services, either co-located or in collaboration with primary care
- Integrated services with law enforcement, probation and courts for the purpose of crisis response, pre- and post-booking services, alternatives to jail for those with serious mental illness and/or collaboration to establish mental health courts for clients who have criminal justice charges. Integrated forensic programs include ones similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program.
- Intensive community services and supports teams capable of providing services to clients where they live, 24/7 including consumers or family members as team members

- On-site services in primary care clinics or other health care sites to provide individualized, inter-disciplinary services coordinated with other health care providers. These services are particularly needed to reach people with co-occurring chronic or life-threatening medical conditions, people who are frequent users of hospital emergency rooms or inpatient care and others who may be more responsive to services in this setting. Linkage must be provided for these clients to the full range of services.
- On-site services or services in collaboration with faith-based providers, churches, temples or similar settings where clients may feel more familiar and comfortable; linkage for these clients to the full range of services
- Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings
- Integrated services with ethnic-specific community-based organizations
- Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services
- Self-help and client-run programs such as drop-in centers, club houses, anti-stigma campaigns, job training classes, advocacy programs, and peer education
- Outreach services for persons who are homeless or at risk of homelessness that involve persistent, non-threatening, outreach and engagement strategies. These services should include the ability to provide for the immediate needs of an individual including physical health care, food, clothing and shelter. This may require that service teams have access to immediate cash and/or vouchers for client needs.
- Ethnic-specific outreach strategies to racial ethnic populations to eliminate disparities in care. Clients and families from the targeted communities are engaged to design the strategies and messages.
- Integrated assessment teams that provide comprehensive mental health, social, physical health and substance abuse and trauma assessments (including intergenerational assessments), which are strength-based, and focused on client/member engagement and which can provide gender-and cultural-specific assessments as in the DSM-IV-R cultural formulation
- Personal service attendants
- Self-directed services in which clients are given funds to pay for and choose their own services and supports with the help of a system service guide
- Education for clients and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects as well as alternatives to medications
- Classes and other instruction for clients regarding what clients need to know for successful living in the community
- Supportive employment and other productive activities and personal growth

opportunities including development of job options for clients such as social enterprises, agency-supported positions, and competitive employment options as well as volunteerism and other creative activities

- Vocational services
- Supportive education
- Family support, education, and consultation services, parenting support and consultation services, self-help groups and mentoring
- Values-driven culturally competent evidence-based or promising clinical services that are integrated with overall service planning and support housing, employment, and/or education goals
- Trauma-informed and trauma-specific services, particularly for women with co-occurring disorders
- Crisis services including:
  - 24-hour crisis phone line
  - Mobile crisis services, including crisis intervention team partnerships with law enforcement
  - In-home respite services for families who are housing and supporting a family member with mental illness
  - Peer-support services
  - Crisis and transitional residential treatment alternatives
- Client advocacy on criminal justice and child welfare issues
- Community-specific cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by the communities in place of or in addition to mainstream services
- Development of housing options including:
  - Temporary housing
  - Transitional housing if the clients are waiting for a more permanent housing opportunity including housing options for parents who are caring for their children
  - Safe havens
  - Permanent housing
  - Crisis residential facilities that are voluntary, including those that are client-run and/or that employ clients as staff
  - Respite housing for clients and families
- Child care
- Transportation services

- Integrated physical and mental health services, which includes co-location and/or collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage must be provided for clients served in these settings to the full range of mental health services when needed. These services are particularly needed to serve ethnic populations and others who may be more responsive to services in health care settings and to reach individuals with co-occurring chronic or life-threatening medical conditions and individuals who are frequent users of hospital emergency rooms or inpatient care.
- Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services

Older Adults

In addition to adults 60 years of age and over who can benefit from the structures and strategies below, there are a group of clients (often in the age-range of 55 through 59) with needs similar to older adults who may also best be served with the structures and services outlined below. DMH recognizes that older adult needs vary greatly by age, and counties may want to select different strategies based upon the age ranges of the populations identified in their Program and Expenditure Plan.

Strategies

- Transformative infrastructure and attitudinal change for the development of peer-support services and client-run services including peer counseling programs and programs that are inclusive of diverse ethnic providers to provide support and to increase client/member knowledge and ability to use needed mental health services and reduce disparities in care
- Supportive housing – permanent affordable housing with combined supports for independent living, including projects that meet the following criteria: (1) housing is permanent, meaning that each tenant may stay as long as he or she pays his or her share of rent and complies with the terms of a lease or rental agreement, 2) housing is affordable, meaning that each tenant pays no more than 30% to 50% of household income, and (3) tenants have access to an array of support services that are intended to support housing stability, recovery and resiliency, but participation in support services is not a requirement for tenancy. Supportive housing may be site-based (all or a portion of the units in a building are designated for people with special needs, and supportive services are available on-site) or scattered site (tenants have or rent houses at various locations in the community). Housing options are available for older adults who are single and those who choose to share housing, as well as with families.
- Integrated substance abuse and mental health services where clients/members receive substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized

housing to accompany these services

- Integrated assessment teams that provide comprehensive mental health, social, substance abuse, trauma and thorough physical health assessments which are strength-based and focused on engagement of older clients and which can provide gender- and culture-specific assessments as in the DSM-IV-TR cultural formulation
- Self-directed care plans, such as Wellness Recovery Action Plans and other models
- Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults
- On-site or collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services
- On-site services or services in collaboration with faith-based providers, churches, temples or similar settings where clients may feel more familiar and comfortable; linkage for these clients to the full range of services
- Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings
- Outreach to older adults who are homeless, or in their homes, through community service providers and through other community sites that are the natural gathering places for older adults
- Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities or other factors
- Education for the client and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects
- Education for and coordination or co-location with primary care providers to increase coordination and integration of mental health and primary care services
- Peer-supportive services and client-run services including peer counseling programs to provide support and to increase client/member knowledge and ability to use needed mental health services
- Values-driven evidence-based and promising clinical services that are integrated with overall service planning and which support housing and other client-selected goals
- Home care assistance, including training of caregivers and providers about enhancing the ‘therapeutic environment’ of the home
- Crisis services including:
  - 24-hour crisis phone line

- Mobile crisis services
- In-home respite services for families who are housing and supporting an older adult with mental illness
- Crisis and transitional residential treatment alternatives

- Trauma-informed and trauma-specific services
- Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by the communities in place of or in addition to mainstream services
- Residential care facilities with therapeutic environments for older adults who cannot live independently including a supplemental rate for mental health services
- Supportive employment and other productive activities and personal growth opportunities including development of job options for clients such as social enterprises, agency-supported positions, and competitive employment options as well as volunteerism and other creative activities
- Supportive and independent education opportunities
- Joint service planning with special services for seniors
  - Senior centers
  - Senior legal aid
  - Adult day health care
  - Adult day care
  - Geriatric assessment centers
  - Private caregiver resource centers
  - Multi-Service Senior Programs
  - Senior volunteer programs
  - Foster Grandparents
  - Senior nutrition centers
  - Ethnic- and gender-specific social or community groups or other culture-based partners
  - Grief/loss support groups
  - Community self-help groups (e.g., COPD, Overeaters Anonymous, Hospice, cancer, asthma, pain, Parkinson's, Alzheimer's, Alanon, AA, NA)
- Transportation
- Integrated physical and mental health services, which includes co-location and/or collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage must be

provided for clients served in these settings to the full range of mental health services when needed. These services are particularly needed to serve ethnic populations and others who may be more responsive to services in health care settings and to reach individuals with co-occurring chronic or life-threatening medical conditions and individuals who are frequent users of hospital emergency rooms or inpatient care.

- Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services

Other General Strategies

Additional general strategies for all age populations that might be particularly appropriate include telemedicine, mobile clinics that travel to a number of areas (a model used by public health), and training for primary health care providers who are providing many of the mental health services in small counties and to ethnically diverse populations.

Outreach and Engagement: Additional general strategies for outreach and engagement for all populations include hiring and training peers for peer-to-peer outreach, training and using volunteer or paid community health outreach workers in specific communities, visiting rancherias, reservations and community centers to reach Native Americans, visiting needle exchange sites, drop-in centers, outdoor areas with visible presence of illicit drug activities, and drug treatment facilities to reach dually diagnosed youth and adults, visiting homeless shelters, outdoor encampments and drop-in centers to reach homeless families, adults and youth.

Response

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

Note: Section VI requires completion of Exhibit 4 (Program Work Plan Summary), which specifies the strategies that will be used in each program.

Section V: Assessing Capacity

Direction:

Current Service Capacity

The MHSA requires that "the department shall evaluate each proposed expenditure plan and determine the extent to which each county has the capacity to serve the

proposed number of children, adults and seniors…" This will be accomplished through review of the Program and Expenditure plan which includes work plan and budget detail.

The required responses below are intended to provide enough information about your current mental health services system capacity and workforce for DMH to assess your ability to expand current programs and develop and implement new strategies. DMH recognizes that change is difficult, and counties will face many challenges as they move toward a transformed system. Understanding these challenges and developing the necessary strategic plan that will address and resolve them is important to the success of your programs and the success of the MHSA.

Response:

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.

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.

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.

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

Direction:

A detailed work plan is required describing how you intend to implement proposed uses of MHSA funds for each program. A program is made up of one or more services used in an organized manner to provide strategies for services and supports as listed in Section IV to an individual to achieve positive outcomes. Strategies are the approaches to providing a program/service. Some services may not be part of a comprehensive program and may be presented as a stand-alone service and program. The service level is consistent with service function reporting, the level at which claims must be documented to the State for the cost report and service activities documented through the Client and Services Information System (CSI). New service function codes

may be added as a result of new reporting requirements under CSS.

- Examples of Programs:
  - Integrated service agency which provides a broad array of services to a targeted group of clients
  - Home visiting services for the elderly that provide or broker a range of services needed to support those individuals in living in the least restrictive setting
  - Wraparound services for children and youth
- Examples of Services:
  - Crisis Intervention
  - Service Coordination (Case Management)

The level of detail required throughout the Program and Expenditure Plan and in these work plans is essential to analyzing each county's capacity to implement MHSA services, supports and outreach strategies consistent with local planning decisions and the intent and purpose of the MHSA. This detail will also be incorporated into some of the measures for the performance contract and provide the foundation for periodic progress reports that will be required by DMH. Work plans must include the requested information in the format as indicated below.

Response:

I. Summary Information on Programs to be Developed or Expanded

1) Please complete **Exhibits 1, 2, and 3,** providing summary information related to the detailed work plans contained in the Program and Expenditure Plan.
2) The majority of a county's total three-year CSS funding must be for Full Service Partnerships. If individuals proposed for Full Service Partnerships also receive funds under System Development or Outreach and Engagement Funding, please estimate the portion of those funds that apply toward the requirement for the majority of funds during the three-year period. (Small counties are exempt from this requirement until Year 3 of the three-year plan.) Please provide information demonstrating that this requirement has been met.
3) Please provide the estimated number of individuals expected to receive services through System Development Funds for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.
4) Please provide the estimated unduplicated count of individuals expected to be reached through Outreach and Engagement strategies for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.

5) For children, youth and families, the MHSA requires all counties to implement Wraparound services, pursuant to W&I Code Section18250, or provide substantial evidence that it is not feasible in the county in which case counties should explore collaborative projects with other counties and/or appropriate alternative strategies. Wraparound programs must be consistent with program requirements found in W&I Code Sections 18250-18252. If Wraparound services already exist in a county, it is not necessary to expand these services. If Wraparound services are under development, the county must complete the implementation within the three-year plan period.

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 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:
   a) A brief description of the program
   b) Identification of the age and situational characteristics of the priority population to be served in this program
   c) Identification of strategies for which you will be requesting MHSA funds for this program
   d) Identification of the funding types that will be used and the age group of the priority populations to be served for each strategy. Many strategies may be used in a 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.

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

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.

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.

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

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.

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.

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.

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.

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

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.

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

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

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

    b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements. Strategies are approaches to provide a program/service. Multiple strategies may be used as an approach for a single service. No budget detail is required at the strategy level. Examples of strategies include self-directed care plans, integrated assessments for co-occurring disorders, on-site services in child welfare shelters, and self-help support.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is

required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

PART III: REQUIRED EXHIBITS

1. Required Exhibits—Overview

- ❑ **Exhibit 1** – Plan Face Sheet
  The Plan Face Sheet is the coversheet to be used in the transmission of the Program and Expenditure Plan. The Face Sheet must be printed in ink or typewritten. **A single Exhibit 1 is required**.

- ❑ **Exhibit 2** – County Program Work Plan Listing
  This is a listing of all work plans submitted by the County for which MHSA funding is being requested. This form provides a Program Work Plan number and Program Work Plan name that will be used consistently on all related work plan documents. It identifies the type of funding being requested for each work plan and the age group to be served. **A single Exhibit 2 is required for each fiscal year**.

- ❑ **Exhibit 3** – Full Service Partnership Population
  This Exhibit is to be used to provide the estimated number of individuals to be fully served by age group and the percent of those individuals who are currently unserved or underserved by race/ethnicity by fiscal year. This exhibit should reflect <u>all</u> Full Service Partnerships in <u>all</u> MHSA-funded programs. **A single Exhibit 2 is required.**

2. Required Exhibits—Individual Program Work Plans

- ❑ **Exhibit 4** – Program Work Plan Summary
  This Exhibit provides summary information and **is required for each detailed work plan.** This Summary will include the Work Plan number and name as shown on Exhibit 1. Provide a brief description of the program and how it is intended to advance the goals of the MHSA, a brief description of the priority population being served and the age and situational characteristics of that population, a listing of strategies to be used in this program to meet the need of the individuals to be served, the type of funding being requested and the age group being targeted.

- ❑ **Exhibit 5** – Budget and Staffing Detail Worksheets
  This Exhibit contains all budget and staffing detail instructions and forms and is **required for each detailed work plan**. For counties that have chosen to implement intergenerational programs or strategies and are providing separate staffing for an age group, that staffing detail must be included in the Staffing Detail Worksheet contained in this Exhibit. If separate age-specific staffing is not planned for intergenerational strategies, the county must describe how the staffing is appropriate for the age group being served.

3. Required Exhibits—Progress Reports

- **Exhibit 6** – Quarterly Progress Reports
  This Exhibit provides the format for the Quarterly Progress Report. For each quarter of each fiscal year, please complete the **targeted** number of individuals to be fully served, a description of the age and situational characteristics. For each quarter of each fiscal year, please provide the total estimated number of individuals to be served through System Development and Outreach and Engagement programs and services. The Quarterly Progress Report is due one month after the end of each quarter (i.e., January – March report is due April 30**). A single Exhibit 4 is required with the Program and Expenditure Plan and will be required to be updated with quarterly actuals after plan approval**.

- **Exhibit 7** – Quarterly Cash Balance Report
  This Exhibit is required for quarterly reporting of MHSA cash on hand. The Quarterly Cash Balance Report is due one month after the end of each quarter (i.e., January – March report is due April 30). **A single Exhibit 5 is required each Quarter after plan approval.**

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: _____ Date: _____

County Mental Health Director:

_____
Printed Name

_____
Signature

Date: _____

Mailing Address: _____

_____

_____

Phone Number: _____ Fax: _____

E-mail: _____

Contact Person: _____

Phone: _____

Fax: _____

E-mail: _____

EXHIBIT 2: COMMUNITY SERVICES AND SUPPORTS – PROGRAM WORK PLAN LISTING

County:
Fiscal Year: *(please complete one per fiscal year)*

		TOTAL FUNDS REQUESTED				FUNDS REQUESTED BY AGE GROUP			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
		$	**$**	**$**	**$**	**$**	**$**	**$**	**$**
	Total Funds Requested:	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**

EXHIBIT 3: FULL SERVICE PARTNERSHIP POPULATION – OVERVIEW

Number of individuals to be fully served:
FY 2005-06: Children and Youth:_____ Transition Age Youth:_____ Adult:_____ Older Adult:_____ TOTAL:_____
FY 2006-07: Children and Youth:_____ Transition Age Youth:_____ Adult:_____ Older Adult:_____ TOTAL:_____
FY 2007-08: Children and Youth:_____ Transition Age Youth:_____ Adult:_____ Older Adult:_____ TOTAL:_____

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									
% Native American									
% White									
% Other									
Total Population									
				2007/08					
% African American									
% Asian Pacific Islander									
% Latino									
% Native American									
% White									
% Other									
Total Population									

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County:	Program Work Plan Name:
Program Work Plan #:	Estimated Start Date:

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	
Priority Population: *Describe the situational characteristics of the priority population*	

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
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
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	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑

EXHIBIT 5: BUDGET INSTRUCTIONS/WORKSHEETS

Instructions for Preparing the Mental Health Services Act Community Services and Supports Budget

Counties are required to complete the Mental Health Services Act (MHSA) Community Services and Supports Budget worksheet and Detailed Staffing worksheet in order to obtain funding for services under the MHSA. Counties must also prepare a budget narrative that describes line items in the budget, the approach used by the county to estimate budget amounts, source documents for the budget, and the specific other one-time CSS funding costs identified on line C. The proposed budget and budget narrative must correlate to the narrative Program Work Plans contained in the Community Services and Supports Program and Expenditure Plan prepared by each county.

A separate budget worksheet and budget narrative must be prepared for each work plan and for each fiscal year from 2005-06 through 2007-08 the county proposes to operate the program or provide the service. Below are the specific instructions for preparing the attached MHSA Community Services and Supports budget worksheet.

General Instructions:

- Round all expenditures to the nearest whole dollar.
- Enter proposed budget amounts separately for the County Mental Health Department, Other Governmental Agencies and Community Mental Health Contract Providers in separate columns.
- Counties should enter detailed budget information for Community Mental Health Contract Providers only when a contractor has been selected. If provider has not yet been determined, whether County or Contract, complete the Detailed Staffing worksheet with the estimated number of FTEs by classification and function (but do not enter salaries, wages and benefits), enter the total proposed program/service budget on line A.5., the total revenues on line B.3., and the total funding requirements on line D. Describe in the budget narrative the basis for developing the estimated funding requirements.
- For expansion of existing programs or services, enter funding and revenues currently incurred as well as the proposed expansion of expenditures and revenues under the MHSA so that total program or service expenditures and revenues are included in the budget.

Counties will not be held to individual budget line items nor to the program totals but to the overall CSS budget. The individual line items will be used by the State Department of Mental Health to evaluate each county's proposed budget.

Heading Instructions:

- Enter the county name or county names if multiple counties are proposing to operate the program or provide the service jointly.
- Enter the Program Work Plan Number that correlates with Exhibit 2 in the Community Services and Supports Plan.
- Enter the Program Work Plan Name that correlates with Exhibit 2 in the Community Services and Supports Plan.
- Select from the menu the type of funding.
- Select from the menu the initial population to be served by the program/service.
- Enter the total proposed client capacity of the program/service once the program/service is fully operational.
- Enter the existing client capacity of the program/service as currently staffed.
- The client capacity of the program/service expanded through the MHSA is automatically calculated as the difference between total client capacity and existing client capacity.
- Select from the menu the fiscal year for the budget.
- Enter the individual page number and total number of pages for all programs/services submitted by the county.
- Select from the menu the number of months the program/service will be operational during the fiscal year.
- Select from the menu whether the program/service is a new program to be established with MHSA funds or an existing program/service to be expanded with MHSA funds.
- Enter the name of the individual who prepared the budget.
- Enter the telephone number of the individual who prepared the budget.

Line Item Instructions:

A. EXPENDITURES

1. *Client, Family Member and Caregiver Support Expenditures*
    a. Clothing, Food and Hygiene – Enter budgeted amounts to be incurred on clothing, food and hygiene for clients, family members and caregivers.
    b. Travel and Transportation – Enter budgeted amounts to be incurred in providing travel and transportation to clients, their family members and their caregivers. This includes budgeted amounts for mileage, bus tickets, meals and other transportation and travel expenses.
    c. Housing – Enter the amounts budgeted for the different types of housing supports provided to clients, family members and caregivers on lines i through iv.
    d. Employment and Education Supports – Enter budgeted amounts to be incurred in providing employment and education supports.
    e. Other Support Expenditures – Enter other budgeted amounts to be incurred on behalf of clients, family members and caregivers not identified above. Provide a description of the type and amount of each expenditure in the budget narrative.
    f. Total Support Expenditures is automatically calculated and is the sum of lines 1a through 1e.
2. *Personnel Expenditures* – Personnel Expenditures should equal the personnel costs shown on the Staffing Detail worksheet.
    a. Current Existing Personnel Expenditures – Enter the current existing personnel expenditures from the Staffing Detail worksheet for the County Mental Health

Department, Other Governmental Agencies and Community Mental Health Contract Providers. The total column should equal the total current existing personnel expenditures on the Staffing Detail worksheet.

b. New Additional Personnel Expenditures – Enter the new additional personnel expenditures from the Staffing Detail worksheet for the County Mental Health Department, Other Governmental Agencies and Community Mental Health Contract Providers. The total column should equal the total new additional personnel expenditures on the Staffing Detail worksheet.
c. Employee Benefits – Enter budgeted County Mental Health Department, Other Governmental Agencies and Community Mental Health Contract Provider employee benefits. This includes FICA, medical and dental insurance, disability insurance, workers compensation insurance, retirement plan contributions, and other employee benefits. An average of current employee benefits may be used to estimate these amounts.
d. Total Personnel Expenditures is automatically calculated and is the sum of lines 2a through 2c.

3. *Operating Expenditures*
   a. Professional Services – Enter budgeted amounts to be incurred for consulting, facilitation and other professional services.
   b. Translation and Interpreter Services – Enter budgeted amounts to be incurred on translation and interpreter services.
   c. Travel and Transportation – Enter budgeted amounts to be incurred for staff travel and transportation. This includes hotels, mileage, meals, car rental, motor pool charges and other travel and transportation expenses.
   d. General Office Expenditures – Enter budgeted amounts to be incurred for general office expenditures including postage, photocopy expenses, office supplies and other supplies.
   e. Rent, Utilities and Equipment – Enter budgeted amounts to be incurred for rent, equipment and utilities including room rental for meetings, equipment rentals, telecommunication costs and utilities.
   f. Medication and Medical Supports – Enter budgeted amounts to be incurred in providing medications or necessary medical supports to clients under this program/service.
   g. Other Operating Expenses – Enter any other budgeted operating expenditures not identified above. Provide a description of the type and amount of each expenditure in the budget narrative.
   h. Total Operating Expenditures is automatically calculated and is the sum of lines 3a through 3g.
4. *Program Management (Other Governmental Agencies and Community Mental Health Contract Providers only).* The County Mental Health Department should enter budgeted amounts to be incurred in managing services under the MHSA on the County MHSA Administration Budget.
   a. Existing Program Management – For expansion of an existing program/service, enter the budgeted amount of existing program management costs to be incurred in support of this program/service. Program Management includes such costs as the Executive Director, accounting and other support costs incurred by a Community Mental Health Contractor that have typically been included in the unit rates.

b. New Program Management – Enter the budgeted amount of new program management costs to be incurred in support of this program/service. Program Management includes such costs as the Executive Director, accounting and other support costs incurred by a Community Mental Health Contractor that have typically been included in the unit rates.
c. Total Program Management is automatically calculated and is the sum of lines 4a and 4b.

5. *Estimated Total Expenditures when service provider is not known.* The County Mental Health Department should enter the total budgeted amount for the program (rather than detailed budget line items) when the type of provider is not known or the contract provider has not been selected.
6. ***Total Proposed Budget is automatically calculated and is the sum of lines 1f, 2d, 3h, 4c and 5.***

B. REVENUES

1. *Existing Revenues* – For expansion of an existing program/service, enter current estimated revenues by type of revenue. It is recommended that the fiscal year 2003-04 cost report inflated by the home health agency market basket index (3.4%) be used as a basis for estimating revenues. Increases in programs/services (e.g., EPSDT) should also be considered as well as the fiscal year (i.e., budgets for fiscal year 2005-06 should include two years of inflation). Counties should maintain documentation on how revenues are estimated.
   a. Medi-Cal – Enter the estimated Federal Financial Participation (FFP) for the program/service, including FFP generated for Medi-Cal Administrative Activities (MAA).
   b. Medicare/Patient Fees/Patient Insurance – Enter the revenues anticipated to be collected from Medicare, patient fees and patient insurance.
   c. Realignment – Enter the amount of realignment revenues estimated to be used in providing existing services under this program/service.
   d. State General Funds – Enter the amount of State General Funds estimated to be used to fund this program/service, including EPSDT and AB 2034.
   e. County Funds – Enter the amount of county funds estimated to be used to fund existing services under this program/service.
   f. Grants – Enter estimated grant revenues to be received in providing services under this existing program/service.
   g. Other Revenue – Enter any other revenue estimated to be received to cover the costs of providing existing services under this program/service.
   h. Total Existing Revenues is automatically calculated and is the sum of lines 1a through 1g.
2. *New Revenues* – Enter the amount of revenues expected to be generated in providing new or expanded services under this program/service. Many of the services and costs under the MHSA are eligible for Medi-Cal, Medicare and other reimbursement. Counties should attempt to estimate revenues that would off-set MHSA program/service expenditures using the proposed budget amounts from Section A.
   a. Medi-Cal – Enter the estimated Federal Financial Participation (FFP) to be generated by the program/service, including FFP generated for Medi-Cal Administrative Activities (MAA).

b. Medicare/Patient Fees/Patient Insurance – Enter the revenues anticipated to be collected from Medicare, patient fees and patient insurance.
c. State General Funds – Enter the amount of EPSDT State General Funds estimated to be generated by this program/service.
d. Other Revenue – Enter any other revenue estimated to be received to cover the costs of providing new or expanded services under this program/service.
e. Total New Revenues is automatically calculated and is the sum of lines 2a through 2d.

3. The Total Revenues is automatically calculated and is the sum of lines 1h and 2e.

C. ONE-TIME CSS FUNDING EXPENDITURES – Enter one-time start-up and implementation expenditures for the program/service. Provide a detailed description of these expenditures in the budget narrative. Requirements for one-time funding will be issued in a separate DMH Letter.

D. TOTAL FUNDING REQUIREMENTS – This amount is automatically calculated and equals the total proposed budget (line A6) less total estimated revenues (line B3) plus one-time expenditures (line C). This reflects the amount of funding requested for this program/service under the MHSA and should match the funding shown in Exhibit 2 of the Community Services and Supports Plan. Counties submitting a joint program budget should describe in the budget narrative the amount of funding required for each individual county. It is suggested that counties use the estimated percent of clients from each county to estimate the funding required for each individual county.

E. PERCENT OF TOTAL FUNDING REQUIREMENTS FOR FULL SERVICE PARTNERSHIPS (System Development and Outreach and Engagement funding only) – The majority of a county's total CSS funding must be for Full Service Partnership services. In some programs/services, part of the System Development and/or Outreach and Engagement expenditures will be incurred in providing services to Full Service Partnership clients. In order to give a county credit towards the majority requirement, counties should indicate in this cell the percent of total funding requirements that will be used to serve Full Service Partnership clients. Counties should not enter anything in this cell for Full Service Partnership programs.

Mental Health Services Act Community Services and Supports Budget Worksheet

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

Program Work Plan # _____ Date: _____

Program Work Plan Name _____ Page ____ of ____

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

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

Existing Client Capacity of Program/Service: _____ Prepared by: _____

Client Capacity of Program/Service Expanded through MHSA: 0 Telephone Number: _____

	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 Partnersh				

Instructions for Preparing the Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

Counties are required to complete the Mental Health Services Act (MHSA) Community Services and Supports Staffing Detail worksheet in order to obtain funding for services and supports under the MHSA.

General Instructions:

- Round all expenditures to the nearest whole dollar. Round all FTE counts to two decimals.
- The heading information is linked to the heading information on the budget worksheet. No additional heading information is required.
- Counties should enter detailed budget information for Community Mental Health Contract Providers only when a contractor has been selected. If a contractor has not been selected and the county anticipates contracting for the program or service, provide an estimate of the number of FTEs by classification and function (but do not enter salaries, wages and benefits).
- Counties that have chosen to implement intergenerational programs with staffing specific to each age group should identify the age group for each classification (for example, type "Adults" in the classification column and then all the staff for the adult component of the intergenerational program directly below). If separate age-specific staffing is not planned for an intergenerational program, the county must describe in the Work Plan how the staffing is appropriate for the age group being served.

Column Instructions:

- *Classification* – Enter the position classification as used by the county or Contract Provider for the position.
- *Function* – Enter the function of the position, such as personal services coordinator, etc.
- *Client, FM & CG FTEs* – Enter the number of full-time equivalent positions to be staffed with clients, family members and/or caregivers that will have the position classification and function listed in the first two columns.
- *Total Number of FTEs* – Enter the total number of full-time equivalent positions (including clients, family members and caregivers) that will have the position classification and function listed in the first two columns.
- *Salary, Wages and Overtime per FTE* – Enter the salary, wages and overtime for the position classification and function listed in the first two columns. If a county is not sure of the exact salary, it may use the mid-point or other step to estimate the salary, wages and overtime per FTE. Include any bi-lingual pay supplements if applicable for the position.
- *Total Salaries, Wages and Overtime* – The amount is automatically calculated and is the total number of FTEs multiplied by the Salary, Wages and Overtime per FTE to determine the Total Salaries, Wages and Overtime for each position classification and function.

Row Instructions:

- *Current Existing Positions* – For expansion of an existing program/service, enter the existing authorized positions for the program/service. Note that this corresponds to authorized positions and not individual persons. The total FTEs and total salaries, wages and overtime is automatically calculated at the bottom of Section A. The total salaries, wages and overtime must be reported in one or more of the columns on line A.2.a. of the Budget worksheet. The total on line A.2.a. of the Budget worksheet should equal the total salaries, wages and overtime on this line.

- *New Additional Positions* – For expansion of an existing program or a new program/service, enter the new additional positions for the program/service that will be funded through the MHSA. Note that this corresponds to positions and not individual persons, so an existing county employee could fill a new additional position if the position is new. The total FTEs and total salaries, wages and overtime is automatically calculated at the bottom of Section B. The total salaries, wages and overtime must be reported in one or more of the columns on line A.2.b. of the Budget worksheet. The total on line A.2.b. of the Budget worksheet should equal the total salaries, wages and overtime on this line.

- *Total Program Positions* – Total Program Positions is automatically calculated and represents the sums of Sections A and B.

Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): 0 | Fiscal Year: 2005-06

Program Work Plan # 0 | Date: 1/0/00

Program Work Plan Name 0 | Page ____ of ____

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

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

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

lient Capacity of Program/Service Expanded through MHSA: 0 | Telephone Number: 0

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 Position					
					$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.

Instructions for Preparing the MHSA CSS Administration Budget

Counties are required to complete the Mental Health Services Act (MHSA) CSS Administration Budget worksheet. **Each County Mental Health Director is required to sign the certification at the bottom of the budget worksheet in order to obtain funding for any CSS expenditures under the MHSA.** Failure by a county to submit a signed certification is cause for rejection of a county's CSS Program Budget and Expenditure Plan. Counties should prepare a budget narrative that describes the line items in the budget, the approach used by the county to estimate the budget amounts and the source documents for the budget. Below are the specific instructions for preparing the attached MHSA CSS Administration budget worksheet.

General Instructions:

- Round all expenditures to the nearest whole dollar. Round FTE counts to two decimals.
- Only county administrative costs should be shown on the CSS Administration Budget worksheet. Contract providers and other county governmental organizations with management and support costs should show those budgeted expenditures in the relevant CSS program budget.

Counties will not be held to individual budget line items nor to program budgets but to the overall budget. The individual line items will be used by the State Department of Mental Health to evaluate each county's proposed budget.

Heading Instructions:

- Enter the county name or county names if multiple counties are proposing to administer MHSA services jointly.
- Select from the menu the fiscal year for the budget.
- Enter the date the budget worksheet is prepared. Revisions will be made to budget documents and maintaining the correct preparation date is critical for identifying the most recent budget submittal.

Line Item Instructions:

A. EXPENDITURES

1. Personnel Expenditures

a. MHSA Coordinator – Enter the number of FTEs and the salary expenditures for the county's MHSA coordinator. If this position is not full-time on MHSA administrative activities, enter the partial FTE and corresponding salary related to MHSA administration.

b. MHSA Support Staff – Enter the number of FTEs and the salary expenditures for the county's MHSA support staff.

c. Other Personnel – List the positions, the number of FTEs and the salary expenditures for other personnel performing MHSA administration activities. Such personnel can be grouped by function (i.e., one line for finance staff, one line for information technology staff, etc.). Insert additional lines if necessary.

d. Total Salaries – Enter the sum of lines 1a through 1c.

e. Employee Benefits – Enter budgeted employee benefits. This includes FICA, medical and dental insurance, disability insurance, workers compensation insurance, retirement plan contributions, and other employee benefits. An average of current employee benefits may be used to estimate these amounts.
f. Total Personnel Expenditures is the sum of lines 1d and 1e.

2. *Operating Expenditures*
   a. Professional Services – Enter budgeted amounts to be incurred for consulting, facilitation and other professional services.
   b. Travel and Transportation – Enter budgeted amounts to be incurred for staff travel and transportation. This includes hotels, mileage, meals, car rental, motor pool charges and other travel and transportation expenses.
   c. General Office Expenditures – Enter budgeted amounts to be incurred for general office expenditures including postage, photocopy expenses, office supplies and other supplies.
   d. Rent, Utilities and Equipment – Enter budgeted amounts to be incurred for rent, equipment and utilities including room rental for meetings, equipment rentals, telecommunication costs, utilities and computer hardware and software for new employees.
   e. Other Operating Expenses – Enter any other budgeted operating expenditures not identified above. Provide a description of the type and amount of each expenditure in the budget narrative.
   f. Total is the sum of lines 2a through 2e.
3. *County Allocated Overhead*
   a. Countywide Administration (A-87) – Enter budgeted A-87 costs attributable to MHSA programs.
   b. Other Administration – Enter budgeted other county allocated administrative costs attributable to MHSA programs. These costs could include centralized accounting or purchasing costs not included in the A-87 allocation or the other personnel expenditures. Provide a description of these budgeted costs in the budget narrative.
   c. Total County Allocated Administration – Enter the sum of lines 3a and 3b.
4. ***Total Proposed Budget is the sum of lines 1f, 2f and 3c.***

B. REVENUES
   1. *New Revenues* – Enter the amount of revenues expected to be generated from any of the administrative activities, if any. Counties should attempt to estimate revenues that would off-set MHSA administrative expenditures using the proposed budget amounts from Section A.
      a. Medi-Cal – Enter the estimated Federal Financial Participation (FFP) to be generated, including FFP generated for Medi-Cal Administrative Activities (MAA).
      b. Other Revenue – Enter any other revenue estimated to be received to cover the costs of administration under this program.
   2. ***Total Revenues is the sum of lines 1a and 1b.***

C. TOTAL FUNDING REQUIREMENTS – Equals the total proposed county administration budget (line A4) less total estimated revenues (line B2). This reflects the amount of funding requested for county administration under the MHSA.

Mental Health Services Act Community Services and Supports Administration Budget Worksheet

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

Date: _____

	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 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County:
Program Work Plan #:
Program Work Plan Name:
Fiscal Year: *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

EXHIBIT 7: INSTRUCTIONS FOR PREPARING THE MENTAL HEALTH SERVICES ACT CASH BALANCE QUARTERLY REPORT

Counties are required to complete the Mental Health Services Act (MHSA) Cash Balance Quarterly Report. The purpose of the report is to allow the State Department of Mental Health to monitor the amount of cash on hand for on-going operations in each county for each component of the MHSA. Counties that indicate excessive cash on hand will be contacted by the Department to explain the reason for such excessive balances and this may be a factor in subsequent distributions of MHSA funds.

A representative from each County Mental Health Department is required to sign the certification at the bottom of the Cash Balance Quarterly Report. Counties should prepare one Cash Balance Quarterly Report for each component of the MHSA (note that a report for the planning component only needs to be reported for fiscal year 2004-05). Below are the specific instructions for preparing the attached MHSA Cash Balance Quarterly Report.

General Instructions:

- Round all dollar amounts to the nearest whole dollar.
- Enter an increase to cash balance as a positive number and a decrease as a negative number.

Heading Instructions:

- Enter the county name.
- Select from the menu the Mental Health Services Act component represented in the Cash Balance Quarterly Report.
- Enter the date the Cash Balance Quarterly Report is prepared.
- Select from the menu the fiscal year represented in the Cash Balance Quarterly Report.
- Select from the menu the quarter represented in the Cash Balance Quarterly Report.

Line Item Instructions:

A. CASH FLOW ACTIVITY
   1. *Cash on hand at the beginning of quarter* – Enter the amount from line 6 of the prior quarter Cash Balance Quarterly Report. If this is the first quarter for which a report is prepared, enter $0.
   2. *Quarterly Advance from State DMH* – Enter the amount advanced from the State Department of Mental Health for this MHSA component since submission of the prior Cash Balance Quarterly Report.
   3. *Total cash available is automatically calculated and is the sum of lines 1 and 2.*
   4. *Actual expenditures* – Enter the actual expenditures incurred for this MHSA component and specific quarter as a negative number.

5. *Adjustments of prior quarters* – Enter any adjustments to prior reported actual expenditures on this line. Enter increases to expenditures as a negative number and reductions to expenditures as a positive number.
6. ***Cash on had at end of quarter is automatically calculated and is the sum of lines 1 and 5. This amount should be reported on line 1 of the next Cash Balance Quarterly Report.***

B. RESERVED CASH ON HAND AT END OF QUARTER

1. *Anticipated one-time expenditures to be incurred during quarter* – Enter the State DMH approved one-time expenditures that are anticipated to be funded during the next quarter with the cash on had at the end of the quarter. An estimate of expenditures is acceptable if actual amounts are not known.

C. CASH ON HAND FOR ON-GOING OPERATIONS is automatically calculated as the sum of lines A6 and B1. This represents the amount of available cash to fund normal, on-going operations of this MHSA component during the next quarter.

Mental Health Services Act Cash Balance Quarterly Report

County _____ Date _____

MHSA Component Comm. Services and Supports Fiscal Year 2005-06

Quarter 1st (July - Sept)

A. Cash Flow Activity	
1. Cash on hand at beginning of quarter (line 6 from prior Quarterly Report)	
2. Quarterly advance from State DMH (insert as positive number)	
3. Total cash available (sum of lines 1 and 2)	$0
4. Actual expenditures (insert as a negative number)	
5. Adjustments of prior quarters (insert as negative or positive number, as appropriate)	
6. Cash on hand at end of quarter (report on line 1 for next Quarterly Repor	$0
B. Reserved Cash on Hand at End of Quarter (enter as negative numbers)	
1. Anticipated one-time expenditures to be incurred during quarter	
C. Cash on Hand for On-Going Operations	$0

COUNTY CERTIFICATION

I HEREBY CERTIFY, to the best of my knowledge and belief, under penalty of perjury, that this report is correct and complete and that all expenditures have been made in accordance with the Mental Health Services Act requirements.

Signature _____

Name and Title _____

E-Mail Address _____

Telephone Number _____