Application: 0000000119

Joy Beeler - beelerj@mendocinocounty.org
BHBH County Behavioral Health Agencies Request for Applications (RFA)

Summary

ID: 0000000119

Applicant Organization Information

Completed - Apr 28 2023

Form for "DHCS Behavioral Health Bridge Housing" (BHBH)

Application Questions

Welcome to the BHBH application portal. Note that applications will only be accepted from the County Behavioral Health agencies as described in Attachment A on page 15 of the RFA. If you have any questions on your eligibility, please email BHBHinfo@ahpnet.com.

Responses Selected:

By checking this box, I acknowledge that I am completing this BHBH application on behalf of my County Behavioral Health Agency.

A. Applicant Organization Information

Name of County

Responses Selected:

Mendocino County

County Agency Full Name for Contracting Purposes

Behavioral Health and Recovery Services

Name of County Agency

For use in public-facing materials and program description

Behavioral Health and Recovery Services

County Agency Mailing Address

1120 S. Dora Street

County Agency City

Ukiah

County Agency State

CA

County Agency ZIP Code

95482

County Agency website URL

Behavioral Health and Recovery Services | Mendocino County, CA

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B. Application Summary

Provide a 250- to 300-word executive summary (for public use) describing your county's planned use of BHBH Program funding, including the number of people to be served, key partners, and desired outcomes.

Mendocino County Behavioral Health and Recovery Services (BHRS) proposes using BHBH funding to provide bridge housing beds for up to 150 homeless individuals. BHRS will work with the Mendocino County Homeless Continuum of Care, our direct services specialty mental health and substance use treatment providers, and homeless outreach service providers to decrease the number of street-level homeless individuals, as evidenced by changes in our Point in Time Count. The proposed project is to hire and train housing navigators, creating a Homeless Outreach Prevention and Engagement (HOPE) Team that will work with participants, service partners, and landlords to support participants in obtaining housing and/or maintain housing so that these individuals can be successful in recovery. In addition, funding will be used to support participants with security deposits, rental arrears, first/last month rent, utility deposits, housing program stipends, hotel/motel stays to support stabilization and assisted living costs. Mendocino County has extremely low rental vacancy rates of 3.09% (www.deptofnumbers.com/rent/california/mendocino-county/); each new supported housing complex that is built is filled almost immediately upon opening. This use of funds will support individuals in obtaining and maintaining housing and recovery through motel vouchers for non-congregate interim shelter options for those that can't utilize congregate shelters; rental assistance for first, last, and deposit to overcome impediments to moving in, and Sober Living Environment and Board and Care Patch rates for treatment-oriented housing options. We will also extend the current staffing levels to support the program goals.

C. Experience

1. Describe your county behavioral health agency's (BHA's) specific programs and efforts to address the housing needs of individuals with serious behavioral health conditions, including serious mental illness (SMI) and substance use disorder (SUD) (e.g., interim housing, recovery housing, Permanent Supportive Housing [PSH], homeless outreach). (500-word limit)

Mendocino County is a largely rural county with a vast land mass, which is experiencing a housing shortage. The shortage of housing impacts all income levels, but those with lower income and rental subsidies experience more challenges when trying to acquire housing. Efforts to address the housing needs of individuals with SMI/SUD in Mendocino County have included contracting for services with specialty mental health providers to increase access to permanent housing through the use of the Mendocino County Homeless Services (MCHSCoC) Coordinated Entry System, providing meals for those experiencing homelessness, screenings for homelessness related services, hotel vouchers, and providing shelter services inland and in the coastal region.

BHRS has over thirty years of providing various housing for seriously mentally ill individuals and those with substance use disorders. The housing types include permanent independent housing, supported housing, congregate living, respite, interim housing, and funding for shelter housing. BHRS frequently partners with a local housing development company, Rural Communities Housing Development Corporation (RCHDC), to increase housing opportunities. We have partnered on multiple complexes, including 14 single-bedroom and 2 two-bedroom apartments for permanent supported living, a transitional housing apartment complex with 8 one-bedroom units, a 37 apartment complex with a mix of studio and one-bedroom units for permanent housing for the seriously mentally ill (SMI), and a 20 unit apartment complex for supported living for individuals with SMI. We have also partnered with landlords to create master leased rented room opportunities for individuals struggling with independent living and needing additional socialization and support. BHRS has worked with motels to develop vouchers for individuals that need interim, respite, and transitional housing. BHRS is currently developing a new congregate living opportunity with a community-based organization utilizing No Place Like Home funding.

In 2019 through a PHC Local Innovation grant award, we were able to provide rapid rehousing for families. Using funds from the PHC Local Innovation grant and with funding from a SAMHSA Finding Home grant, we partnered with Rural Community Housing Development (RCHDC) on a 40 unit apartment complex (Orr Creek Commons Phase I and II). Of the 40 units, 19 of them are for individuals with a severe mental illness that are chronically homeless, homeless, or at risk of chronic homelessness. The project follows the housing first model, and is structured as inclusionary/integrated housing. Orr Creek Commons Phase II is a mixed community of special needs residents and general low income.

BHRS has sought grant funding through California Health Facilities Financing Authority to develop a Crisis Residential Treatment facility. In addition, Mendocino County has a tax initiative established to develop Behavioral Health Infrastructure; one funded project is a respite program. BHRS has developed some of these programs utilizing No Place Like Home funding, Mental Health Services Act Funding, grant funding, and local tax initiative funding. BHRS has also partnered with local treatment providers for transitional housing, interim housing, and sober living environments for those with substance use disorders.

2. What is your county BHA's experience collaborating with the Continuum of Care (CoC) and other homeless/housing agencies in your community? Did you communicate or collaborate with the CoC in the development of the proposed BHBH Program? (250-word limit)

BHRS has had a member or designee on the MCHSCoC for the Homeless since its inception. BHRS contracts with community-based organizations for direct services in supported housing environments, most of whom also hold seats on the CoC Direct service providers have access to the Homeless Management Information System (HMIS). BHRS has communicated with the CoC about the intent to apply for BHBH funding.
BHRS and direct service providers have experience providing mental health supportive services to supported housing. Supports include on-site groups and social activities, routine check-ins with individual clients, house/project meeting facilitation for shared tenant responsibilities, and 24/7 crisis response for urgent and emergency behavioral health response. Along with our contracted specialty mental health providers, BHRS currently provides services to six different housing units ranging in size from six to almost 40 units with a wide variety of criteria for tenancy ranging from short-term respite to permanent supported housing. BHRS supported housing experience includes project-based supported housing, tenant-based housing support through Full Service Partnership, and small scale single site housing co-located with services. The variety of supported housing types includes transitional housing, crisis respite, several permanent supported housing, rented rooms in a congregate living setting, and supportive mental health services to homeless shelters. The requirements for tenancy include specialty mental health diagnoses and homeless or risk of homelessness as well as requiring meeting Full Service Partnership criteria. Several housing partnerships are with RCHDC; the oldest collaborations was established over 20 years ago.

D. Understanding Community Need

1. As part of the Homeless and Housing Assistance Program Round 3 (HHAP Round 3), the California Interagency Council on Homelessness required a comprehensive local homeless action plan.

Applications and plans can be found at https://bcsh.ca.gov/calich/hhap_rd3_apps.html. Review your action plan(s) and answer the following questions.

a. Were you involved in the development of the HHAP Round 3 plan?

Yes

Please describe that involvement. (250-word limit)

Behavioral Health and Recovery Services holds a governance seat on the Mendocino County Homeless Services Continuum of Care (MCHSCoC), a collaborative of over 31 agencies throughout Mendocino County. The purpose of the MCHSCoC is to plan and support a coordinated and strategic approach to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency, including action steps to end homelessness and to prevent a return to homelessness. The MCHSCoC brings together a broad spectrum of participants to address all aspects of homelessness and the needs of all the homeless subpopulations. In setting goals and action steps, the MCHSCoC works collaboratively to incorporate the perspective of direct service providers, advocates, and individuals currently or formerly experiencing homelessness. The MCHSCoC Governing Board adopted a Strategic Plan to Address Homelessness in Mendocino County on April 27, 2020.

Mendocino County and MCHSCoC applied jointly for HHAP-3 funding. The application and action plan's coordination occurred in many settings, including MCHSCoC Governing Board and Committee meetings, planning sessions held for developing and improving the Strategic Plan to Address Homelessness in Mendocino County, and other MCHSCoC issued policy documents. The majority of these meetings and sessions were publicly accessible, and invitations were sent to program staff from multiple disciplines, which provided additional representation and insight into our local community landscape.

b. To the best of your knowledge, are the data included in this action plan accurate for the BHBH Program?

Yes

Please explain. (200-word limit)

Yes, the data in the report outlines the need in Mendocino County in 2020. Although there has been progress since the report was released, the Mendocino County Homeless Services Continuum of Care (MCHSCoC) conducted its most recent annual unsheltered Point-In-Time (PIT) Count on January 26, 2023. The Point in Time (PIT) Count is mandated by the United States Department of Housing and Urban Development and is used by the State of California and multiple Federal Departments to calculate allocations of homeless services funding. The data received through the January 26, 2023, PIT Count will provide more updated data to identify current needs and develop our planning to engage and support those persons experiencing homelessness throughout Mendocino County.

2. Did people with lived experience of homelessness and/or a serious behavioral health condition contribute to this proposal?

No

Please explain. (200-word limit)

Not specifically, but the MCHSCoC has designated roles for individuals with lived experience. In addition, many specialty mental health providers and behavioral health staff have lived experiences that will contribute to the development of the HOPE program and individuals with lived experience contributed to the reports used in developing the proposal. Contributions include discussions of the proposal in MCHSCoC meetings, voting on the proposal, and other housing decisions in MCHSCoC.

3. Have you used additional reports or data to inform the design of your BHBH Program?

Yes

a. Provide citations and links and/or attach other reports or information that have informed your assessment of community need.

In 2017, Mendocino County contracted with Dr. Robert Marbut to formally assess and analyze Mendocino County Homelessness. The analysis included various interviews, site visits, a review of Point in Time Count, and other reports. The report concluded that Mendocino's basic demographics of the homeless were similar to other communities, with noted exceptions of a higher percentage of female homeless individuals, a slightly younger homeless population, and a more chronic homeless population living in street-level homelessness for 3-5 years. The report indicated that the majority of the homeless population are from Mendocino County, with only about 38% not being from Mendocino County, however, the report notes these individuals are more chronically homeless than "homegrown" populations. The report noted a high percentage of individuals experiencing homelessness for 1-3 years. Mendocino County does not have much movement of homeless individuals between cities and the level of joblessness prior to homelessness is extremely high among the homeless population.
The report made twenty-eight recommendations for Action Steps, many of which the author noted were in progress —including focuses on governance, clinical, shelter & transitional housing, public space, and long-term recommendations. Several of the recommendations have been implemented, including re-establishing a shelter in Ukiah, robust use of HMIS, increased collaboration and reduction of agency silos, creation of a Homeless Outreach Team for street-level outreach, open and optimized placement at Willow Terrace (37 unit permanent supported housing for individuals with SMI), source new housing opportunities.
This proposal for BHBH spending provides an opportunity to address one of the identified concerns: a shortage of substance abuse and mental health dedicated beds in all levels of housing. Mental Health has been able to increase permanent supported and crisis housing resources using mental health funds, but this resource will expand the opportunity to those that don't meet the criteria under other housing resources for transitional, shelter, short-term, or move-in expenses.
(Partnership, 2022) With the addition of Homekey, the interim and permanent housing supply available in Mendocino County in 2021 for persons experiencing homelessness was 435 beds." "WHO CAN AFFORD TO RENT Renters need to earn 1.5 times the minimum wage to afford the average asking rent in Mendocino County. https://chpc.net/resources/mendocino-county-housing-need-report-2022/

(Consulting, 2018) According to the Homeless Assessment, on average, in 2018, 78% of people interviewed had been homeless for one or more years. Of those, just over half (51%) had been homeless for 1.5 years, which is strikingly high and worthy of notice because the rate of successful recovery from homelessness starts dropping after one year, and then precipitously drops after two to three years (Marbut, p. 19). When the length of time one is living on the streets is shortened, people are safer and more people can use limited resources. https://www.healthymendocino.org/content/sites/mendocino/MendocinoHomelessStrategicActionStepsFINAL.pdf

BHRS, in partnership with NAMI Mendocino, conducted a community feedback facility needs/prioritization survey in

22/23. There were 385 total respondents. 37.14% responded that dual diagnosis residential treatment – substance use and mental health were selected among the greatest need in Mendocino County.

1. Kemper Consulting Group Report 2018.pdf

Filename: 1. Kemper Consulting Group Report 2018.pdf **Size:** 978.3 kB

MendocinoHomelessStrategicActionStepsFINAL Marbut.pdf

Filename: MendocinoHomelessStrategicActionStepsFINAL Marbut.pdf **Size:** 194.0 kB

Community Feedback Survey. MC Facility Need 02-10-23 Survey Data Summary.pdf

Filename: Community Feedback Survey. MC Facility Need 02-10-23 Survey Data Summary.pdf **Size:** 437.8 kB

b. What do those reports say about reaching and serving people experiencing both homelessness and serious behavioral health conditions in your community? (350-word limit)

The reports say we should promote expanding meaningful mental health and substance abuse treatment options to address housing barriers, support a continuum of Dual Diagnosis (Behavioral Health/SUDT) services & treatment programs, and promote & prioritize successful support services that prevent homelessness due to relapse & recidivism risks for clients with behavioral health and/or Substance Use issues. In addition, promote & support effective Anti-Stigma, Trauma-informed community information, training & educational programs, and finally, establish behavioral health/SUDT treatment efficacy measures.

4. What are the gaps in the current system for people with behavioral health conditions that would be addressed by the BHBH Program? Are there specific subpopulations of the target population in your county that would be prioritized for support through the BHBH Program? (400-word limit)

According to a report by the Mendocino County Housing Authority, the county has a shortage of affordable housing, which affects low and moderate-income residents, seniors, disabled people, and families. The report also states that the supply of available housing units does not meet the demands of the population, resulting in high rental and purchase prices, further exacerbating the housing crisis. Additionally, the increasing number of homeless individuals is another indication of the housing need in the county.

In addition, there are gaps in the Mendocino County system for people with behavioral health conditions due to inadequate funding or resources. Some of the specific gaps that exist include:

Lack of coordinated care: There is a lack of coordination between different organizations and agencies that provide behavioral health services in Mendocino County, making it difficult for people with behavioral health conditions to get the care they need.

The Strategic Plan to Address Homelessness in Mendocino County seeks to address the fragmentation that currently exists in the system, which diminishes the effectiveness of homelessness-related funding, service delivery, and system performance. The Plan recognizes that transforming our county's homeless service system will also require close collaboration with community members and key stakeholders, elected officials, agency staff, service and housing providers, and people with lived experience of homelessness. Thus, our Plan continues the work to address the goals related to strengthening collaboration both between the MCHSCoC and the broader community.

Stigma and discrimination: There is a lack of public awareness and understanding of behavioral health conditions in Mendocino County, leading to stigma and discrimination against people with these conditions. Our BRIDGE HOPE program will include the creation of a welcoming and accessible environment for clients. Strategies such as culturally sensitive care, telehealth services, and peer support programs to help improve access to care. As well as promote & support effective Anti-Stigma, Trauma-informed community information, training & educational programs. HOPE team members will do street-level outreach to engage unhoused individuals in precontemplation around treatment and housing. HOPE Team members will be trained in using the VISPDAT and HMIS systems for prioritizing individuals in need of housing.

E. Proposed Program Design

1. What housing types do you propose to develop through the BHBH Program, how many beds will be available in each, and how did you estimate the need by housing type? (350-word limit)

Mendocino County intends to provide interim housing options. Homeless individuals and families have a range of special housing needs described in Mendocino County's Continuum of Care Plan, including emergency shelter, transitional housing, and permanent supportive housing. Emergency shelters provide immediate short-term housing, typically limited to less than six months. Transitional housing provides housing for between six months and two years, often coupled with intensive case management, alcohol and drug abuse assessment following the American Society of Addiction Medicine (ASAM), and proper level of care for treatment, mental health treatment, life skills, employment training, and assistance with creditworthiness. Permanent supportive housing offers a stable residential environment, often with mental health counseling, job training, and case management, among other services, to reinforce the advancement of formerly homeless persons up the ladder of the continuum of care. Each type of housing is distinct and meets a specific need. According to the County's 2022 Point-in-Time Homeless Population count, there were approximately 830 homeless people in Mendocino County. Of these, 223 were in emergency shelters, 47 were in transitional shelters, and 560 were without shelter. Most homeless locate in the urban areas of the county, particularly Ukiah and Fort Bragg, which have the majority of emergency shelters and transitional housing.

Mendocino County does not have property readily available to implement new permanent supportive housing within the time frame of this grant, so we plan to use funds to provide temporary shelter and interim housing for those waiting for permanent housing. One of the biggest challenges to obtaining and maintaining permanent supportive housing is substance use relapse. Providing sober living environments will help strengthen an individual's successful transition to permanent supportive housing. Our hope is to add seven to eight interim shelter and five to six Sober Living Environment beds per year, which will increase the total bed days by approximately 4800 on average.

2. How will you identify potential bridge housing options described above and how will you secure them for use by BHBH Program participants? (500-word limit)

Mendocino County has had partnerships with motels, Sober Living Environments, and other transitional housing resources for other projects in the past, including recent COVID emergency housing projects. We will leverage these relationships with BHBH funds to expand available temporary, interim, and transitional housing through motels, sober living environments, and other short-term housing. We will also use BHBH funding to support unhoused individuals in funding move-in costs, such as first and last month's rent and deposit costs, which are often an insurmountable barrier to someone living homeless. One of our strategies for identifying and securing additional bridge housing will be to continue developing strong relationships with our community partners. Relationship building will consist of meetings between behavioral health staff and housing providers to discuss financial and psychological needs. During these meetings, education and practical support towards the implementation of harm reduction and housing first principles will be routinely reviewed. The expectation is to lower barriers to entry.
Once a HOPE site is identified, official agreements will be secured through the County process.

3. How will the BHBH Program address the unique needs of individuals with diverse behavioral health conditions (e.g., opioid use disorder, psychotic disorder, post-traumatic stress disorder, stimulant use disorder)? (500-word limit)

Mendocino County has several permanent supported living environments for individuals with serious mental health conditions. These partnerships have filled up almost immediately upon being available, and vacancies do not last long. One learning lesson that we have found from these partnerships is that chronic substance use is a frequent factor in reasons for eviction (damage associated with use, not the use itself). We have recognized that additional funding resources for substance use treatment are needed to support individuals with mental health conditions, substance use conditions, and dually diagnosed individuals to build the skills to sustain housing. We want to use BHBH funding to pay for sober living environments not funded by other resources.

4. How do you plan to address the needs of diverse cultural groups, families, and other unique populations? What steps are you taking to advance racial equity in the design of the BHBH Program? (500-word limit)

BHRS meets regularly with advisory bodies that consist of representatives from Mendocino County's Tribal communities and Latino/a/x communities. In addition, we partner with community-based organizations and Tribal Health Clinics, which have the trust of the populations most impacted by equity and historical trauma, and governmental distrust. We intend to utilize these relationships in initiating our HOPE team outreach efforts and to receive feedback from the advisory groups on the prioritization of activities.

BHRS values cultural humility and collects feedback from community stakeholders on an ongoing basis. We review the diversity of our programs and we strive to improve cultural responsiveness through required annual cultural responsiveness training, policies, and procedures. Program staff are trained in the impacts of historical trauma and institutional distrust. The BHRS Culturally and Linguistically Responsive Services Policy 1.A-3B will be referred to in developing the HOPE Program.

5. How does your county BHA plan to use the BHBH Program to support Community Assistance, Recovery & Empowerment (CARE) Program participants? (350-word limit)

BHRS has several programs that work with court-involved or criminal justice-involved individuals. We also have several therapeutic court programs, including Adult Drug Court, Family Dependency Drug Court, Assisted Outpatient Treatment, Intensive Outpatient Treatment, treatment services inside the Mendocino County jail, and Behavioral Health Court. We anticipate the CARE Program participants will be part of this continuum of care with court-involved individuals. The HOPE Team staff will engage CARE Participants in identifying factors contributing to homelessness, will build rapport and engagement and trust in resource providers, and will offer transitional/interim housing resources funded by BHBH.

BHRS' Assisted Outpatient Treatment (AOT) Program provides housing for qualified AOT clients that are unhoused. We have found that the majority of qualified individuals are unhoused, and that having housing greatly supports engagement in services. The housing offered is short-term supported housing, and often part of the transition off of AOT level court-monitored services, which involve application and engagement in permanent supported housing.

6. How will you ensure housing navigation is provided to all BHBH Program participants?

Describe your housing navigation program, including the following (500-word limit):

a. How will you identify and prioritize participants for housing navigation? What will be provided?

b. Will you offer Landlord Outreach and Mitigation Funds?

c. How will housing navigation be provided?

d. Do you plan to provide Participant Assistance Funds to help people meet their housing needs? If yes, how will these funds be managed?

HOPE Team members will do street-level outreach to engage unhoused individuals in precontemplation around treatment and housing. HOPE Team members will be trained in the use of the VISPDAT and HMIS systems for prioritizing individuals in need of housing. The program will prioritize interim housing and incentive funding based on those with the highest vulnerabilities through personalized outreach and use of the Coordinated Entry System to identify individuals engaged in services but still unhoused. The program will prioritize interim housing and engagement & incentive funding based on those with the highest vulnerabilities.
We don't plan to offer Landlord Outreach and Mitigation Funds at this time.
HOPE Team members will be County Employees, prioritizing those with lived or family member experience, who will do street-level outreach to unhoused individuals and network with provider and treatment agencies that support housing.
The HOPE team will work in pairs and provide outreach through face-to-face interaction with people experiencing homelessness. The outreach will occur on the streets, in camps, under bridges, in shelters, meal sites, libraries, public facilities, and wherever else people might be located. The HOPE Team will serve as a bridge to agency services, establishing contact in the field and facilitating referrals. If possible, the team will make a "warm hand-off," in which they personally introduce clients.
The HOPE team will help people staying in an emergency shelter or living unsheltered with the following process as they work on a plan to get into stable and permanent housing:
• Referral
• Intake
• Goal planning
• Barrier busting
• Housing identification and move in
• Stabilization and referral to long-term support
BHRS plans to provide Participation Assistance funds to help people meet their housing needs. The program funds will be managed through a policy and procedure, review and approval process. Evaluation will include

monthly data review and quarterly budget review.

7. Which of the following activities do you plan to fund using the BHBH Program? Address the estimates of people served that are included in your budget template as you answer questions 8-13.

Responses Selected:

County BHA BHBH Program Implementation Requirements
Bridge Housing – Shelter/Interim Housing
Bridge Housing - Rental Assistance
Bridge Housing - Auxiliary Funding in Assisted Living Settings (commonly referred to as board and care patches)

8. Describe how you will use funds for County BHA BHBH Program implementation requirements as described in Attachment C in the RFA.

In your response, include an explanation of how you will collaborate with the CoC and other homeless service providers. (350-word limit)

Upon notice of award, BHRS will work with our existing Mental Health Advisory Board to solicit input into program planning, implementation, and quality improvement from people with lived experience of homelessness and serious behavioral health conditions. The program lead will be identified to direct the program's efforts and coordinate with our Mendocino County Continuum of Care for the Homeless. BHRS holds a County seat on the MCHSCoC, and partner agencies hold several of the Mental Health and Substance Use Treatment provider seats within our service continuum. Several recipients of MCHSCoC funding opportunities are partner agencies. BHRS and contracted providers utilize the Coordinated Entry System and HMIS to prioritize vacancies in housing projects. The Program Lead will engage early in the program development stage to identify how referrals are to be provided and which additional HMIS data elements are needed to aid in determining an individual's eligibility, such as chronic homelessness status and having a serious or emotional disturbance. In addition, the program lead, along with fiscal and admin staff, will be responsible for submitting required reports and documentation to AHP/DHCS.

10. How will you use funds for bridge housing – shelter/interim housing options? (500-word limit)

a. Please describe the types of bridge housing settings you intend to create (e.g., shelter, motel vouchers, recuperative care—see Attachment C for a more detailed, though not exhaustive, list) and the number of beds of each. If you already have identified potential sites, please list them. If you have not, please identify the types of units you intend to explore (e.g., single-family homes, tiny homes, office conversion—see Attachment C).

b. Describe the supportive services that will be provided. How many people are you proposing to serve?

c. How will you identify and prioritize participants?

d. How will you accommodate pets?

e. Are you working with, or do you intend to work with, partners to deliver this program? If so, briefly describe the relationship(s) and how you are working with your partners or how you will identify or contract with partners.

BHRS shelter/interim housing options will include the use of motel vouchers and Sober Living Environments. This will provide a bridge for individuals unable to utilize shelter options existing in the community to provide short-term to mid-term interim housing while waiting for acceptance at longer-term permanent supported housing or assisted living. Mendocino County utilizes a voucher system with existing motels for other departments; BHRS will utilize existing relationships with local motels through a voucher system to house individuals that are high risk in HMIS, but cannot utilize existing resources through Full Service Partnership, congregate shelter options, or other resources. There are several motels in Ukiah and Fort Bragg and limited options in Willits. This will allow individuals to remain close to their home community. BHRS will utilize Sober Living Environments to extend the recovery time of those addressing substance use disorders. Congregate shelters and the isolation of motels can often be a trigger for those new to their sobriety. SLEs will provide a supported and sober place to extend recovery skills beyond treatment and before longer-term housing is available. Currently, there is one Sober Living Environment in Mendocino County operated by Ford Street Project, and we intend to explore other private options as well. Based on available beds and anticipated need, we are dedicating funding equivalent to 7-8 beds per year in motels and 5-6 beds per year in the SLE. We anticipate the length of stay in SLE to be six months on average, so between 10-13 people will be served per year on average. Motel utilization will likely be similar but may be shorter term, so we anticipated between three and six-month stays, serving roughly 14-24 people per year in motels.

BHRS will use existing specialty mental health and substance use treatment resources to provide support for individuals placed in shelter/interim housing placements, with additional peer supports through the housing navigators to connect with housing resources, and to prioritize appropriate bridge resources.

Some of the BHRS shelter/interim housing options through motels are able to accommodate pets. Unwillingness to leave or abandon a pet can be a reason individuals remain unhoused when sheltering with their pet is not allowed. Housing navigators will support clients to get certification for health support animals to ensure accommodations at

long-term housing.

BHRS will use HMIS prioritization of the most vulnerable individuals with mental health and substance use needs in prioritizing BHRS recipients. In addition, we will follow the recommendations of the MCHCoC established guidance on non-congregate shelter. In prioritizing those without other eligible funding, we anticipate a predominant need in individuals in CARE court or those with substance use disorders only, as there will be other funding resources through Full Service Partnership for individuals with serious mental health disorders. Housing navigators will work with existing providers of these services and the SLEs and motels to deliver these housing options, but we do not intend to contract the HOPE services to a subcontractor. We only intend to contract for use of the Sober Living beds.

11. How will you use funds for bridge housing through short- and/or mid-term rental assistance? (500-word limit)

a Describe your rental assistance program, including whether you plan to use scattered-site or project-based units, and how it will address the requirements described in Attachment C.

b. How many rental subsidies are you budgeting for, and at what cost? What are your assumptions for length of rental subsidy?

c. How will you identify and prioritize participants?

d. How will you provide supportive services to individuals accessing rental assistance?

e. Given that BHBH Program funding ends June 30, 2027, what are your plans to move people from BHBH Program rental assistance to longer-term subsidies and/or employment?

BHRS provides rental assistance in the form of help with first, last, and deposits using Full Service Partnerships when FSP clients are eligible for permanent supported housing, but do not have the savings for the move-in costs. Bridge housing funds will be used for individuals not qualifying for Full Service Partnership or other move-in and rental assistance resources. The supported housing projects that currently exist in Mendocino County are project based units in various locations in Mendocino County, predominantly Ukiah. BHRS is budgeting for the equivalent of between 15-16 clients being provided rental assistance/move-in rental support for permanent supported housing. We had considered funding this area much more, as it is the most desired, allowing for the longest-term housing to be possible. However, housing capacity is currently full, and turnover is slow in existing units, so we scaled this to a more reasonable expectation of between 1-2 a month per year. The estimate is based on first, last, and deposit at a low-income housing unit, $1124 per person. If individuals needed rental support for more standard housing units, we would serve fewer per year. Rental assistance will only be for move-in costs or overcoming a setback in rent that is a one-time expenditure, with the expectation that the individual's income will sustain the long-term permanent housing costs. Due to this, we will not need a transition for longer-term subsidies in 2027.

Participants will be prioritized using HMIS, with additional prioritization for individuals not eligible for other funding. We anticipate that since specialty mental health clients that are homeless and at risk of higher institutionalization are eligible for Full Service Partnership funding, Bridge funding will be predominantly used for those that have substance conditions without qualifying mental health co-occurring disorders.

Clients moving into supported housing will receive supports from existing mental health and substance use treatment providers, and will also receive peer-based support from housing navigators to connect with housing resources and to support the transition from homelessness or interim housing to permanent supported housing.

12. Describe any plans to provide auxiliary funding in assisted living facilities (commonly referred to as board and care patches).

BHRS plans to provide auxiliary funding in assisted living settings for bridge candidates that are at risk of or returning from conservatorship. Currently, in Mendocino County, Board and Care/Room and Board patch costs are only funded for individuals actively on conservatorship or Assisted Outpatient Treatment. Bridge housing will expand the resources available to those returning from higher levels of care that have not secured permanent housing and those at risk of conservatorship to prevent the long-term necessity of higher levels of care. Mendocino County have mental health treatment specific board and care and care homes in Mendocino County and several less treatment specific care homes. We have existing relationships with the mental health treatment specific care home, and plan to expand to other supportive environments to increase resources for individuals for whom housing is a contributing factor in their inability to care for their basic needs. We have budgeted for a little over four beds at the higher board and care patch rate, and anticipate we will serve approximately 4-5 clients per year in this setting. We anticipate stays to be closer to a year in these settings. Supported services are provided by the care home, but in addition housing navigators will offer peer-based support to ensure connection to housing resources and determine potential for less intensive care. We will prioritize those at risk for institutionalization and those ineligible for other housing supports for this type of funding.

F. Management Plan

Describe your agency's capacity to implement this project:

1. Describe your overall management and staffing plan for implementation of the BHBH Program.

a. How will you involve people with lived experience of homelessness and serious behavioral health conditions—both SMI and SUD—as part of the planning, implementation, and quality improvement?

BHRS will work with the MCHSCoC committee, who has designated governance roles for individuals with lived experience. In addition, many specialty mental health providers and behavioral health staff have lived experiences that will contribute to the development, implementation and review of the HOPE program. Contributions will include discussions of the proposal in MCHSCoC meetings, surveys, voting on the proposal, and other housing decisions.

BHRS intends for the housing navigator role to be filled by individuals with lived experience with mental health conditions, substance use conditions, and/or homelessness. In addition, BHRS has positions intended for those with lived experience in both mental health treatment and substance use disorder treatment that will collaborate with both the housing navigators and the unhoused individuals in coordinating and supporting care and treatment.

b. Provide a brief description of the role of the BHBH program director or lead, including FTE dedicated to this project.

The project lead, 0.10 FTE, will be identified from BHRS Substance Use Disorder Treatment Services. The HOPE Project estimates the program will require about 3-4 FTE staff doing direct housing navigation. The proposed classification for these staff is Community Health Services Specialist, with emphasis on those with lived experience. The HOPE Lead will commence a comprehensive recruitment effort immediately upon announcement of the award. If we are unable to successfully recruit a full complement of staff, existing and qualified staff from the BHRS pool of employees will be temporarily assigned to the project to ensure the targeted start date. The project lead will oversee the project to include supervision of staff, development of policies and procedures, navigating relationships with partner agencies, preparing contracts, attending and participating in grant meetings, overseeing the submission of grant reports, and ensuring integration with people with lived experience.

c. Do you plan to subcontract with provider organizations? If yes, provide a brief description of the role of subcontractors/providers, including how they will be selected and a timeline to initiate operations.

Mendocino County will establish subcontracts with Sober Living Environment providers and possibly with interim housing providers. We have established relationships with contractors and community-based agencies, which will be able to coordinate with the HOPE team that is established by this program to provide outreach to existing systems and identify unhoused individuals in existing service provision needing resources from BHBH to overcome housing barriers. We do not plan to subcontract the housing navigation.

d. Provide an organizational chart that shows how the BHBH Program will be housed in relation to your county's/agency's other behavioral health and homeless/housing programs.

BRIDGE Org chart.pdf

Filename: BRIDGE Org chart.pdf **Size:** 59.1 kB

2. Does your county BHA currently enter information into the HMIS data portal?

Yes

3. Provide a detailed timeline with significant milestones for the start-up and implementation of the BHBH Program.

You may optionally upload a file in place of filling out the following tables.

BHBH Program Implementation Start-Up Timeline.pdf

Filename: BHBH Program Implementation Start-Up Timeline.pdf **Size:** 89.6 kB

BHBH Project Start-Up Timeline.pdf

Filename: BHBH Project Start-Up Timeline.pdf **Size:** 89.3 kB

BHBH Program Quarterly Implementation Milestones Timeline.pdf

Filename: BHBH Program Quarterly Implementation Milestones Timeline.pdf **Size:** 79.1 kB

BHBH Program Implementation Start-Up (address each required area in Attachment C)

	Key Milestones	Responsible Party	Anticipated Completion Date
Row 1			
Row 2			
Row 3			
Row 4			
Row 5			
Row 6			
Row 7			
Row 8			
Row 9			
Row 10			
Row 11			
Row 12			

Do you need more rows to complete this table?

No

Bridge Housing Project(s) Start-Up (include bridge housing infrastructure, outreach and engagement, bridge housing-interim housing, bridge housing-rental assistance, bridge housing-auxiliary payments in assisted living settings, and housing navigation under bridge housing project(s) start-up)

	Key Milestones	Responsible Party	Anticipated Completion Date
Row 1			
Row 2			
Row 3			
Row 4			
Row 5			
Row 6			
Row 7			
Row 8			
Row 9			
Row 10			
Row 11			
Row 12			

Do you need more rows to complete this table?

No

BHBH Program Quarterly Implementation Milestones (provide detail for each specific program)

	Key Milestones	Responsible Party	Performance Measure
Row 1			
Row 2			
Row 3			
Row 4			
Row 5			
Row 6			
Row 7			
Row 8			
Row 9			
Row 10			
Row 11			
Row 12			

Do you need more rows to complete this table?

No

Summarize the key accomplishments to be completed in the first 90 days, first six months, and first year of the program.

By the end of the first 90 days, BHRS will have finalized agreements, established a HOPE Program Lead, trained the lead in HMIS, and begun the process of drafting policies and procedures, made contact and solicited input from local stakeholders, coordinated with our local CoC, and posted recruitment for HOPE team members.

Within the first six months, we hope to complete recruiting and hiring at least one HOPE team member. We will begin drafting procedures for motel/hotel vouchers, immerse the housing navigator in the community, and begin street-level outreach.

BHRS anticipates hiring and training four HOPE team members, establish agreements with local SLEs, and increase housing navigation capabilities and services within the first year.

G. Budget

Using the budget instructions in Attachment E, provide a detailed BHBH Program budget and a narrative budget justification. The budget must be submitted using the BHBH Program Excel budget template, available online. The budget template also contains information on the number of people to be served.

Once you have completed the budget template and the narrative budget justification, you will upload them with the application.

Budget Template

BHBH_budget_template_REV_508 -Final.xlsx

Filename: BHBH_budget_template_REV_508 -Final.xlsx **Size:** 148.1 kB

Budget Narrative

Bridge Budget Narrative.pdf

Filename: Bridge Budget Narrative.pdf **Size:** 77.2 kB

H. Attestation

Complete the attestation document (Attachment F) and upload it with the application.

Signed - Attachment F BHBH Program Applicant Attestation.pdf

Filename: Signed - Attachment F BHBH Program Applicant Attestation.pdf **Size:** 369.7 kB

Budget Narrative
Budget Year July 1/2023 – 06/30/2027

Personnel		**$1,299,062**
Title: Project Lead (0.10 FTE) **Total Salary**: $31,606 **Total Benefits**: $17,382 Under general supervision of BHRS Manager, plans, directs, evaluates, and supervises the work of the HOPE Team and ensures completion of BHBH Grant deliverables.	FTE: 0.10	$48,987
Title: Housing Navigator (4) (1.0 FTE) **Total Salary**: $725,249 **Total Benefits**: $398,887 Under general supervision of the Program Lead, Housing navigators will support individuals to navigate housing services, ensure enrollment in HMIS, and triage to shelter/interim housing options as appropriate.	FTE: 4.0	$1,124,137
Title: Grant Liaison (0.10FTE) **Total Benefits**: $ 19,375 **Total Salary**: 35,227 Under general supervision of BHRS Director, support grant activities, serve as point of contact for grants, ensuring all technical assistance opportunities, report submissions and other grant expectations are met.	FTE:0.10	$54,602
Title: Department Analyst 2 (0.15 FTE) **Total Salary**: $46,023 **Total Benefits**: $25,313 Under general supervision of BHRS Manager, supports grant activities including time tracking of BHBH staff, tracking deliverable costs, submitting invoices, tracking payments, and ensuring audit compliance with fiscal documents.	FTE: 0.15	$71,336

Subcontracts/Consultants	**$526,221**
Sub 1: Ford Street Project- Sober Living Environment contracts Will provide short term residential care for individuals following residential treatment to extend their sobriety in a supported environment.	$526,221

Other Direct Costs	**$2,753,890**
Motel Vouchers Shelter/Interim housing in the form of motel and hotel stays when other shelter options are not available.	$1,754,071
Assisted Living Payments Payments for Board & Care and Room and Board for individuals stepping down or at risk for LPS placement.	$929,656
Rental Assistance Rental deposits, first, last, and other rental support paid directly to landlords.	$70,163

Indirect Costs @ 10%	**$357,935**
Travel, mileage, supplies, staff supervision and time not allocated by FTE, building, vehicle and other equipment use, unforeseen expenses, client engagement and support expenses.	

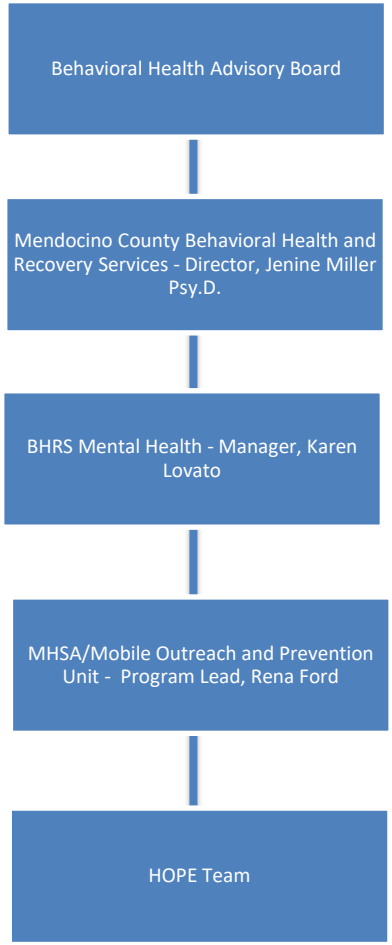
Total Budget	**$4,937,108**

Key Milestones	Responsible Party	Anticipated Completion Date
Convene an advisory board for soliciting input	Will Use Existing Mental Health Advisory Board	Completed Convening
Finalize BHBH Grant Agreement	DHCS, BHRS, AHP	Up to one month after receipt of award agreement
Establish the Program Lead	BHRS Director	Within two months of award announcement
Present HOPE Program to BHAB for input	Director/Project Lead	Within two months of award announcement
Coordinate with MCHSCoC	Project Lead	Ongoing through life of funding, and as needed
Post recruitment for (4) Bilingual/Bicultural Housing Navigators	Project Lead/BHRS Admin	Within two months of award announcement
Conduct interviews/hire Housing Navigators	Project Lead/BHRS Admin	Up to five months after award announcement
Notify other agencies and/or community organizations of the HOPE project	Project Lead	Within one month of award announcement
Program Lead trained in use of HMIS	Project Lead/BHRS Admin	within 3 months of award
Submit required reports and documentation to AHP/DHCS	Project Lead/Grant Liaison	As required

Key Milestones	Responsible Party	Anticipated Completion Date
Participate in community collaboration and networking with agencies and community organizations/groups serving the target population	Housing Navigators	Within 10 months of award
Establish Policies and Procedures to guide implementation of the HOPE Project	Project Lead/BHRS Admin	Within 6 months of award
Develop Voucher Procedure with local motel/hotels	Project Lead/BHRS Admin	Within 8 months of award
Develop per bed day agreement with local SLE	Project Lead/BHRS Admin	Within 8 months of award
HOPE Team Members are introduced to CoC and begin street level outreach	Project Lead/Housing N	Within 10 months of award and ongoing as needed
House first individuals with interim housing	Housing Navigators	within one year
House first individuals with rental assistance	Housing Navigators	within one year
House first individuals with SLE	Housing Navigators	within one year

Key Milestones	Responsible Party	Performance Measure
Housing Navigators Staffed	Program Lead/Grant Lia	% of Fully staffed
Interim/shelter Housing Provided	Program Lead/Grant Lia	Number of individuals in interim housing
Rental Assistance Provided	Program Lead/Grant Lia	Number of individuals received rental assistance and moved to permanent housing
SLE Resources Provided	Program Lead/Grant Lia	Number of individuals provided SLE Resources
Auxiliary/Assisted Living Services Provided	Program Lead/Grant Lia	Number of individuals provided Assisted Living

MENDOCINO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES BRIDGE HOPE TEAM ORGANIZATIONAL CHART



OTHER COMMUNITY BEHAVIORAL HEALTH HOMELESS/HOUSING PROGRAMS WE WILL COLLABORATE WITH

- Shelters
- Sober Living Environments
- Housing Resources
- Mendocino County Continuum of Care Governing Board
- Partner Treatment Agencies
- Tribal Governments & Other Cultural Entities

Mendocino County Behavioral Health System Program Gap Analysis & Recommendations for Allocation of Measure B Revenues

Kemper Consulting Group

Lee D. Kemper
Jim Featherstone

August 21, 2018

KEMPER
CONSULTING GROUP

Behavioral Health System Gap Analysis & Recommendations

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Behavioral Health System Gap Analysis & Recommendations

I. Executive Summary

Mendocino County's Measure B, the "Mental Health Treatment Act," was approved by County voters on November 7, 2017. Over the first five (5) years, Measure B will generate roughly $38 million for behavioral health facility construction and ongoing operations, services and treatment. Kemper Consulting Group was hired by Mendocino County to:

- Conduct an assessment of behavioral health facility and service needs in Mendocino County and identify current service needs in the County due to gaps in the continuums of care; and, identify projected service needs in five (5) years based upon current and anticipated needs; and,
- Present key policy and financing decisions that need to be made by the Board of Supervisors to effectuate effective and sustainable use of the Measure B revenues over time.

The *Mental Health Mission Statement* of the Mendocino County Behavioral Health Services Department (BHRS) speaks to delivering services "in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture" and maximizing independent living and improving quality of life through community-based treatment. The BHRS *Substance Use Disorders Treatment Mission Statement* speaks to promoting "healthy behaviors through prevention and treatment strategies that support our community's need to address alcohol and other drug abuse, addictions and related conditions." ***Our assessment finds that the current continuums of care in Mendocino County for mental health and substance use disorder treatment fall short of achieving the goals expressed in these mission statements in a number of key service areas.***

For the current mental health continuum of care, we find the continuum is missing key services that are essential to reducing the need for inpatient psychiatric care, including but not limited to Crisis Residential Treatment, day treatment, and a robust array of community-based wellness and support services. We also find the growing level of crisis mental health assessments is placing increasing strain on local hospital Emergency Departments that serve as the primary locations for patient assessment and hold pending a determination of their psychiatric needs. Further, we find that Mendocino County's use of out-of-county inpatient psychiatric care is growing at an accelerated pace, due in large part to a lack of alternative treatment options in the County. Between FY 2016-17 and FY 2017-18, the average daily number of persons in inpatient psychiatric care increased from 11.7 to 15.1 – an increase of 29%.

Over the next five years we believe the primary principle that should drive Measure B policy-making is a commitment to developing a comprehensive mental health services continuum in Mendocino County that provides a broad range of services and supports that remediate mental health conditions at the earliest possible time and reduce the need for inpatient psychiatric utilization. With this principle, we believe

Behavioral Health System Gap Analysis & Recommendations

Mendocino County can both set a goal of reducing the need for inpatient psychiatric care, while simultaneously assuring that inpatient psychiatric care is available in the County when needed. Further, we believe a goal of a 50% reduction in the use of inpatient psychiatric care within five years, by FY 2022-23, is a responsible goal. This would reduce daily hospital utilization from 15.1 persons per day to a more sustainable 7.6 persons per day.

To achieve this goal, among other things we recommend that Measure B funds be allocated to support facility construction of a Crisis Residential Treatment facility, which includes a Crisis Stabilization Unit (CSU), as currently planned but awaiting financing. We also recommend Measure B funds provide annual funding support to CSU operations. We recommend that Measure B funds be allocated to support facility construction for inpatient psychiatric care in Mendocino County, and offer alternative approaches for achieving this objective. We recommend that Measure B funds provide annual funding support for a substantial expansion of community-level support services that address mental health conditions of county residents, including those in more remote locations, at the earliest possible time and reduce the need for inpatient psychiatric care. Finally, we recommend Measure B funds be allocated to a Supportive Housing Pool for use in addressing the housing needs of persons with mental illness, including individuals that are under conservatorship with Mendocino County and placed out-of-county and persons that are homeless.

For the current SUDT continuum of care, we find the array of treatment services provides only the most basic components of a care continuum, and to a very small population. We find key services are missing, most notably community-based recovery and rehabilitation programs and a wide range of residential treatment options (low to high intensity). We note that planning for the development of SUDT services in the County is contextual to possible implementation of the Drug Medi-Cal Program's Organized Delivery System (ODS), and that discussions with Partnership Health Plan are underway regarding administration of the ODS for Mendocino County. We make no recommendations regarding implementation of the ODS, but we believe Measure B funds should be dedicated to expand access to SUDT services for county residents to expand upon the limited array of services that are currently available. Toward this end, we recommend 10% of Measure B funds be allocated to SUDT services over the first five years, subject to a proposed spending plan from the BHRS Director, and a continuation of this funding during the following five years.

More broadly, we offer the Board of Supervisors a proposed set of policies to guide the use of Measure B funds that include:

- Measure B funds are intended to ***supplement, not supplant,*** existing sources of funding for mental health and SUDT services;
- Measure B funds are intended to fund programs that address shortcomings in the service continuums for both Mental Health and Substance Use Disorder Treatment, as those continuums

evolve over time, with an emphasis on community-based services that reduce the need for higher level services;

- A Measure B Prudent Reserve should be established and funded to provide additional revenue for behavioral health programs in Years 6-10 of Measure B, when funding will be less due to the drop from 1/2-cent to 1/8-cent sales tax;
- A separate annual accounting of all Measure B revenues and expenditures should be undertaken that is distinct from standard accounting by BHRS; and,
- A 10-Year Strategic Spending Plan for Measure B revenues should be adopted that provides a framework for funding priorities over time. A proposed Spending Plan is offered for consideration.

II. Background

Kemper Consulting Group was hired by Mendocino County to conduct an assessment of behavioral health facility and service needs in Mendocino County to support program development and policy planning needed for implementation of Measure B, the "Mental Health Treatment Act," which was approved by Mendocino County voters on November 7, 2017. Measure B gives Mendocino County a unique opportunity to address mental health and substance use issues experienced by county residents today and into the future through its collection of sales tax revenue to support expanded behavioral health service delivery. As set forth in Measure B, over the first five (5) years the measure will generate roughly $38 million for facility construction and ongoing operations, services and treatment.[1] Of the revenue generated in the first five years, up to 75% of the revenue ***may be*** used for facilities and not less than 25% ***must be*** dedicated to services and treatment. Beginning with revenues collected in the sixth year and each year thereafter, 100% of new funding, estimated at nearly $2 million annually, ***must be*** used for ongoing operations, services and treatment. Among other stated purposes, Measure B is intended to achieve the following:

- Provide for assistance in the diagnosis, treatment and recovery from mental illness and addiction by developing:
  - A psychiatric facility and other behavioral health facilities;
  - A regional behavioral health training facility to be used by behavioral health professionals, public safety and other first responders; and,
- Provide for the necessary infrastructure to support and stabilize individuals with behavioral health conditions, including addiction and neurological disorders.

Kemper Consulting Group was hired by Mendocino County to conduct an assessment of behavioral health facility and service gaps in Mendocino County and produce a report that addresses all of the following:

a. Outline optimal continuums of care for mental health and substance use disorder treatment (SUDT) services in Mendocino County;
b. Identify planned additions to the existing mental health and SUDT continuums of care;
c. Identify service gaps in mental health and SUDT programming, taking planned additions into consideration;
d. Provide the following data summaries based on data provided by RQMC and BHRS:
   - Summary of current programs, services, target populations, funding sources, and expenditure amounts;
   - Summary data on numbers of persons receiving services by program component and cost of care; and, average daily census and cost of clients in inpatient care settings outside of Mendocino County;

e. Outline options for the treatment of persons with acute inpatient psychiatric needs in Mendocino County, including development of a Psychiatric Health Facility and alternatives to inpatient psychiatric care, and the projected costs of those options;
f. Present two snapshots of behavioral health service need in Mendocino County and include recommendations on both of the following:
    - Programs/services needed in the County right now due to gaps in the continuums of care;
    - Programs/services projected to be needed in five (5) years based upon current and anticipated needs; and,
g. Outline key policy decisions that need to be made by the Board of Supervisors to effectuate effective and sustainable use of the Measure B revenues over time and make recommendations on the use of Measure B funds.

Kemper Consulting Group's responsibility did not include review of a regional behavioral health training facility. Therefore, no work or recommendations regarding this matter are included in this report.

As a part of our work, KCG consultants reviewed a wide range of written documents and programmatic and fiscal data; conducted Internet research; interviewed a variety of public officials and private sector representatives outside of Mendocino County; and, conducted Key Informant interviews of Mendocino County officials, providers, and stakeholders. Sources for this work included:

- Programmatic and fiscal data supplied by RQMC and BHRS;
- California DHCS reports, budget documents, and letters;
- California EQRO reports;
- California Hospital Association reports;
- Phone interviews and email communications with Behavioral Health officials in various California counties; representatives of Psychiatric Health Facilities (PHF); and, California DHCS officials;
- Key Informant interviews with County leadership, including the CEO, Sheriff, and, HHSA and BHRS Directors; representatives of RQMC; leadership of local hospitals; community health center representatives; Behavioral Health Advisory Board members; and, Mendocino County residents that are consumers or family members of persons with mental illness (see **Appendix A** for a listing of Key Informants); and,
- Discussion with Measure B Advisory Committee at April 25, 2018 meeting; review of the Measure B Advisory Committee meeting videotape of May 23, 2018; and, review of Measure B Advisory Committee agenda and meeting materials.

III. Continuums of Care for Mental Health and Substance Use Disorder Treatment

The mission statements for Mendocino County's Health and Human Services Agency (HHSA) and Behavioral Health and Rehabilitative Services (BHRS) Department express broadly defined goals[2]. The ***HHSA Mission Statement*** speaks to supporting and empowering families and individuals to live healthy, safe, and sustainable lives in healthy environments.[3] The ***Mental Health Mission Statement*** speaks to delivering services "in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture" and maximizing independent living and improving quality of life through community-based treatment.[4] The ***Substance Use Disorders Treatment Mission Statement*** speaks to promoting "healthy behaviors through prevention and treatment strategies that support our community's need to address alcohol and other drug abuse, addictions and related conditions"[5] (see **Appendix B**). These three mission statements point to the importance of providing a comprehensive continuum of care for the prevention and treatment of mental health and substance use disorder conditions.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) outlines four overarching components[6] of an effective Continuum of Care:

- ***Promotion Strategies*** to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges and to reinforce the entire continuum of behavioral health services;
- ***Prevention Strategies*** and Interventions delivered prior to the onset of a disorder that are intended to prevent or reduce the risk of developing a behavioral health problem;
- ***Treatment Strategies*** for people diagnosed with a substance use or other behavioral health disorder;
- ***Recovery Strategies and Services*** that support individuals' abilities to live productive lives in the community and can often help with abstinence.

When considering the array of services currently available through the service delivery systems in Mendocino County for mental health and substance use disorder treatment (SUD) it is important to consider them within this federal framework.

1. Mental Health Services Continuum of Care

A. Existing Service Continuum

As described by SAMHSA, there are four segments of services in an effective continuum of care: promotion, prevention, treatment, and recovery. Within this context, the Specialty Mental Health Services required under Medi-Cal for children and adults includes a set of services that fall into the categories of treatment and recovery only. Under current Medi-Cal requirements, each county's Mental Health Plan is required to

include all of the services listed in **Table 1**.

Table 1 Medi-Cal Required Specialty Mental Health Services[7]		
Service	**Children**	**Adults**
Adult Crisis Residential Services*	x	x
Adult Residential Treatment Services*	x	x
Crisis Intervention	x	x
Crisis Stabilization	x	x
Day Rehabilitation	x	x
Day Treatment Intensive	x	x
Intensive Care Coordination	x	-
Intensive Home Based Services	x	-
Medication Support	x	x
Psychiatric Health Facility Services	x	x
Psychiatric Inpatient Hospital Services	x	x
Targeted Case Management	x	x
Therapeutic Behavioral Services	x	-
Therapy and Other Service Activities	x	x
*Include children ages 18-20		

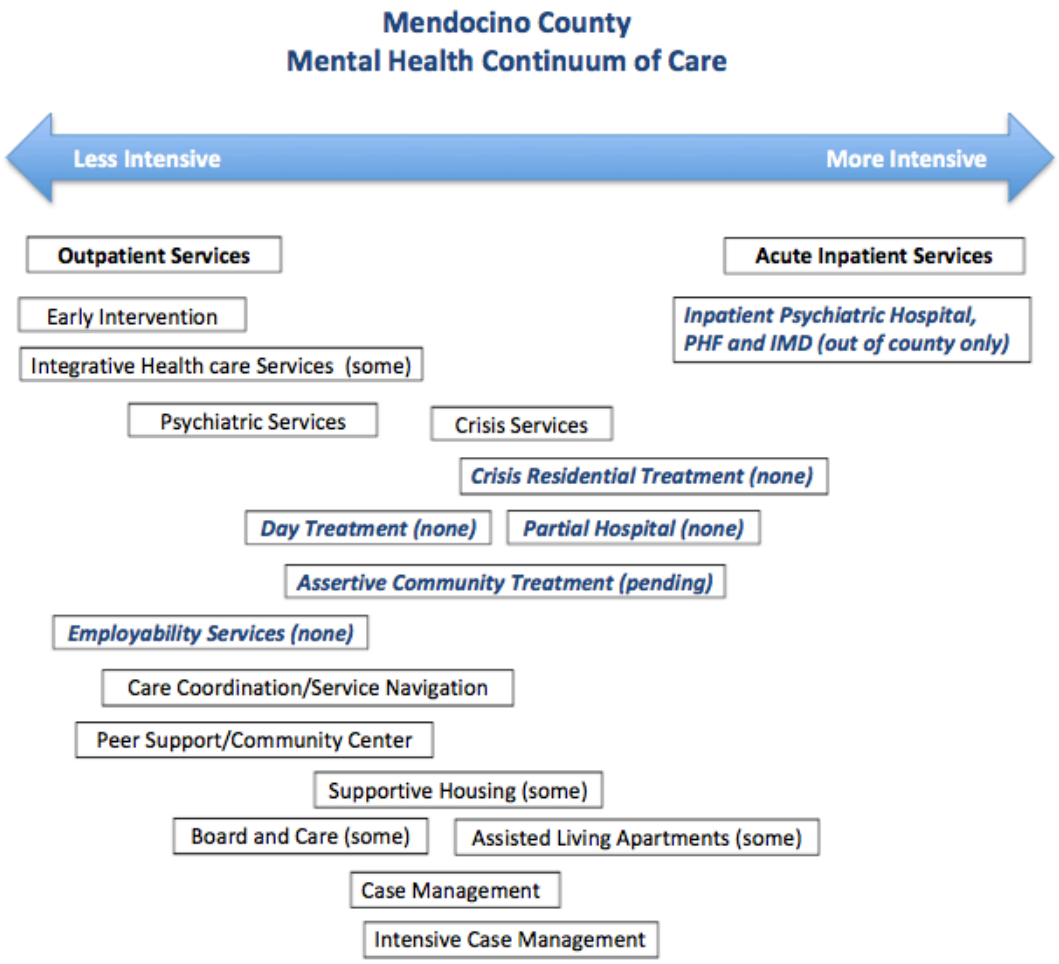
Counties utilize several sources of revenue to support the delivery of all required services, including Realignment, Medi-Cal reimbursements, Mental Health Services Act (MHSA), and county general funds. Redwood Quality Management Company (RQMC), Mendocino County's third party administrator, and its subcontractors deliver most of the mental health services provided to Medi-Cal eligible adults and children in Mendocino County. BHRS operates Mobile Outreach Team services in selected areas of the County.

As demonstrated on **Schematic 1** (following page), the current Mental Health continuum of care for both adults and children is missing a variety of key services in Mendocino County, including alternatives to inpatient psychiatric care (Day Treatment, Partial Hospital, Crisis Residential Treatment); inpatient psychiatric care (Psychiatric Health Facility, psychiatric inpatient services in an acute care hospital and IMD); and, Employability Services for adults.

B. Planned Additions to the Service Continuum

According to RQMC, there are two planned service additions partially underway. These include a Crisis Residential Treatment Center and a possible Crisis Stabilization Unit (CSU). Both components are included in a planned residential treatment campus to be located at 631 S. Orchard Street in Ukiah, California. Land at this location has been purchased, plans have been developed for both program components, and facility construction pends receipt of other funding.

SCHEMATIC 1



1. Substance Use Disorder Treatment Continuum of Care

A. Existing Service Continuum

Counties utilize several sources of revenue to support the delivery of all required Medi-Cal drug treatment services. These revenues include 2011 Realignment funding, Medi-Cal reimbursements, federal SAPT funding, and county general funds. California's Department of Health Care Services (DHCS) allocates funding for Drug Medi-Cal services to counties as a part of each county's Behavioral Health Subaccount allocation established by the 2011 Realignment law. Funds must be used exclusively for the Drug Medi-Cal Program, and to receive the funds, the county must contract with DHCS to arrange, provide, or subcontract

for the provision of services to all Medi-Cal eligible residents of the county. Mendocino County's BHRS Department is currently responsible for the provision of all Medi-Cal required services, which are:

- Outpatient drug-free treatment;
- Narcotic replacement therapy;
- Naltrexone treatment;
- Intensive Outpatient Treatment; and,
- Perinatal Residential Substance Abuse Services (excluding room and board).

The array of services currently required under Medi-Cal is limited and does not provide a comprehensive continuum of care for county residents; and, BHRS' SUDT treatment efforts focus primarily on the delivery of these five Medi-Cal services. As shown on **Table 2** (following page), there is some access to services beyond these in the County, including residential treatment, Medication Assisted Treatment, and treatment for dual diagnosis conditions, but these services are limited in availability. Furthermore, as of this writing, Mendocino County and DHCS are in discussions regarding the County's current level of compliance with Medi-Cal drug treatment requirements. Specifically, there is disagreement between DHCS and the County regarding the extent to which services are being provided and billing is taking place for Intensive Outpatient Treatment, the Narcotic Treatment Program, and Perinatal Residential Services.

B. Potential Additions to the Service Continuum

The Drug Medi-Cal program has developed an Organized Delivery System (ODS) model that is available to counties that opt-in to provide the expanded range of services. The ODS model is intended to provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment services. Under the ODS model, counties that contract with DHCS will have expanded and more direct responsibility for assuring client access to drug treatment services and movement through the treatment system. The continuum of required services under the ODS model include: Early Intervention; Outpatient Services; Intensive Outpatient Services; Short-Term Residential Services; Withdrawal Management; Opioid/Narcotic Treatment Program Services; Recovery Services; Case Management; and, Physician Consultation. Optional additional services include: Medication Assisted Treatment (MAT); Partial Hospitalization,; and Recovery Residences. For Mendocino County to contract with DHCS and assume responsibility for operation of the ODS for Drug Medi-Cal services, the BHRS would need to address two key challenges:

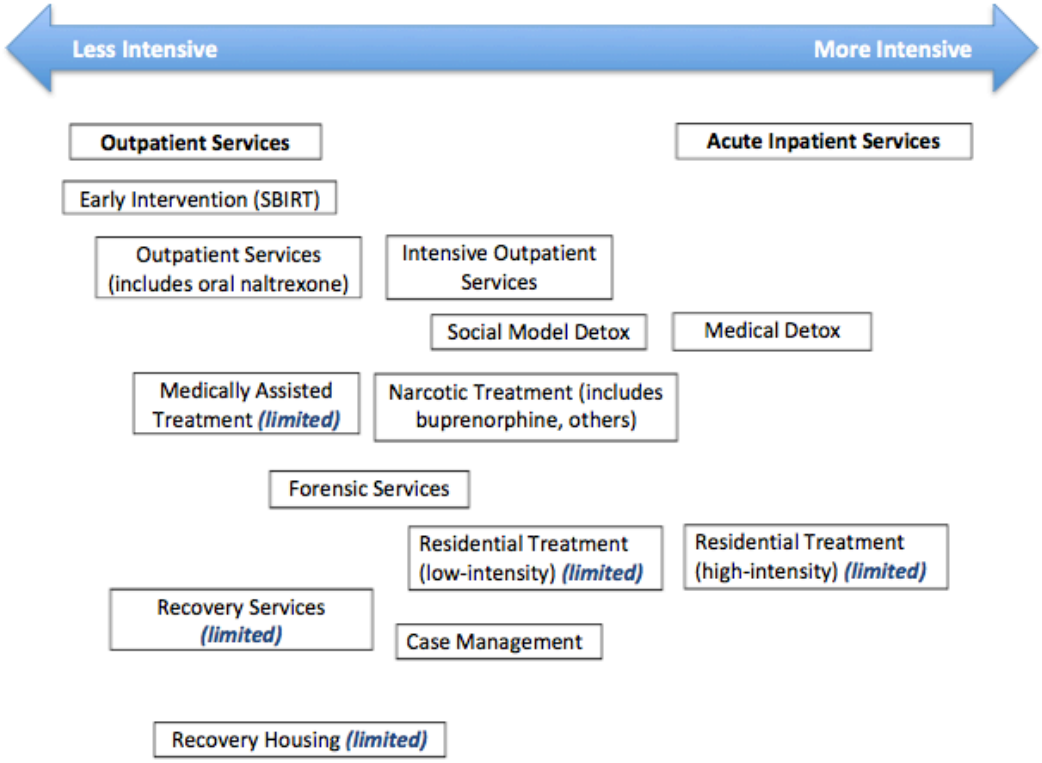
- Substantially expand administrative and program management operations to address all of the following: provider credentialing and contracting; quality assurance; compliance and service oversight; beneficiary outreach; claims processing; and policy direction; and,
- Identify and contract with an array of SUDT contractors for new service delivery.

Table 2[8] SUDT Services by Type of Service (FY 2016-17)				
Service Program	Name	Target Population	Served	Funding
Outpatient Services	BHRS	Medi-Cal	100	SAPT, Realignment, Medi-Cal
	Arbor Youth	Medi-Cal (ages 16-24)	NA*	Realignment, Medi-Cal
	Justice System/BHRS Collaboration	Dual Diagnosis	10	Realignment, Medi-Cal, MHSA
	Consolidated Tribal Health	Children, youth, adults, and seniors	NA*	MHSA, other
Perinatal Treatment	WINDO	Medi-Cal (pregnant women)	7	SAPT, Realignment, Medi-Cal
Prevention/Early Intervention	BHRS	Youth	395	SAPT, Realignment, Medi-Cal
Early Intervention	Justice System/BHRS	Adults with low-level crime	24	Fee-for-Service
Correctional Treatment	SUDT services in jail	Jail inmates	NA*	AB109
Adult Drug Court	Justice System/BHRS Collaboration	Adults with suspended state prison sentence	21	Realignment, Medi-Cal
Family Dependency Drug Court	Justice System/BHRS/CWS Collaboration	Families involved with Family/Children Services	78	Realignment, Medi-Cal, Family/Children Services
Residential Treatment	Athena House, Crossing the Jordan, Redwood Gospel Mission, Salvation Army	Individuals	32	Free (faith based)
	DAAC (Center Point), Humboldt Recovery Center	Individuals	6	Various
	Friendship House, Sierra Tribal Consortium	Individuals	5	Tribal funding
	New Life Community Services	Individuals	2	Private pay
	Ukiah Recovery Center	Individuals	1	Various
	Hilltop	Individuals	2	Various
	Progress House	Medi-Cal	23	Medi-Cal
	Health Right 360	Pregnant women/ mothers	1	Various
Medically Assisted Treatment	Santa Rosa Treatment Program, Drug Abuse Alternatives Center	Persons needing narcotic replacement therapy	NA*	Various
	Little Lakes Health Center, Long Valley Health Center, Mendocino Community Health Clinic, Mendocino Coast Medical Services	Persons needing naltrexone treatment	NA*	Various
TOTAL			707	
*Services with NA means data not provided				

Schematic 2 below presents a visual picture of the current continuum of SUDT services available to county residents.

SCHEMATIC 2

Mendocino County
Substance Use Disorder Treatment
Continuum of Care



In lieu of operating the ODS directly, Mendocino County may have the opportunity to participate in the ODS through a Regional Model for SUDT service delivery to be operated by Partnership Health Plan (PHC). Under the Regional Model, PHC is seeking to operate the ODS for eight counties participating in PHC. If PHC's plan is approved by DHCS, each of the counties would have the option to join. To participate, each county would pay PHC a single unique per-utilizer-per-month (PUPM) rate in exchange for PHC providing the required ODS services. As of this writing, the financing picture for PHC and the proposed rates for counties, including Mendocino County, are not yet finalized; and, BHRS has not made a determination regarding its approach for the ODS. ***Counties that do not operate the Drug Medi-Cal ODS directly or participate in the PHC Regional Model will not be eligible to receive Medi-Cal financing support for the expanded array of drug treatment services to Medi-Cal members.***

IV. Financing by Program

To place the revenues generated by Measure B into the broader financing context for mental health and SUDT services, we have prepared summary tables that show the array of existing programs and the amount budgeted for each program. The data provided for these tables was provided by RQMC and BHRS. Fund sources vary by program and may include Mental Health and SUDT Realignment, Medi-Cal, MHSA, and federal funds.

1. Mental Health Services

Overall funding dedicated to Mental Health Services provided through RQMC and its subcontractors in FY 2017-18 was $14,863,950. Of this amount, $8,983,950 was budgeted for services to children and $5,880,000 was budgeted for services to adults. See **Appendix C, Tables 1 and 2**, for a list of funding by program. Programs that do not exist are listed with none. Beyond the programs presented in this table, BHRS directly administers the Mobile Outreach and Prevention Services (MOPS) program, which was funded at $207,349 in FY 2017-18 (see **Appendix C, Table 3**).

2. Substance Use Disorder Treatment Services

Overall funding dedicated to Substance Use Disorder Services provided through BHRS and its contractors in FY 2017-18 was $2,096,335. Total persons served in FY 2016-17 were 707 persons. See **Appendix D** for a list of funding by program. With a population of just over 88,000 residents, current funding for SUDT services in Mendocino County is reaching only 707 people, less than 1% of the county population. The funding allocated to SUDT services is equal to roughly 14.1% of the funding allocated to mental health services.

V. Mental Health Service Utilization

1. Overall Mental Health Services Utilization

As shown in **Table 3**, a comparison of FY 2016-17 and FY 2017-18 mental health services utilization shows the following:

- More unduplicated (unique) persons received mental health services in FY 2017-18 ***– 18.4% more***
- More persons received Emergency Crisis Assessments ***– 22.8% more***
- More calls were made to the Crisis Line ***– 11.2% more***
- More unduplicated (unique) persons participated in Full Service Partnerships ***– 8.3% more***
- More inpatient psychiatric hospitalizations occurred ***– 17.3% more***

Based upon these data, three conclusions can be drawn. First, in FY 2017-18 Mendocino County's mental health system, under RQMC administration, responded to more crisis conditions, conducted more crisis assessments, and placed more people into inpatient psychiatric care than in FY 2016-17. Second, total hospitalizations reached 645, which represents a 17.3% increase in psychiatric hospitalizations over FY 2016-17. ***This is a significant increase.*** Finally, the number of Full Service Partnerships (FPP), designed to serve persons with serious mental illness, increased. However, they were provided to only a fraction of the persons that received inpatient psychiatric care. In FY 2016-17, roughly 24% received FPP support. For 2017-18, only 22.3% received FPP support.

Table 3[9]
Persons Served by Age and Type of Service
FY 2016-17 and FY 2017-18

Ages	Ages 0 to 24		Ages 25 to 65+		Total		
Fiscal Years	FY16-17	FY17-18	FY16-17	FY17-18	FY16-17	FY17-18	% Prior Year
Unique Persons Served	1280	1390	1044	1362	2324	2752	118.4%
Full Service Partnerships	43	42	90	102	133	144	108.3%
Emergency Crisis Assessments	593	661	1102	1420	1695	2081	122.8%
Inpatient Psychiatric Hospitalizations	163	225	387	420	550	645	117.3%
Crisis Line Contacts	1131	1001	4119	4837	5250	5838	111.2%

2. Persons Receiving Mental Health Services by Region

As shown in **Table 4** (following page) in both FY 2016-17 and FY 2017-18, slightly more than half of the persons that received mental health services in Mendocino County were residents of Ukiah and roughly 13% were residents of Willits. Residents of the North Coast, including Fort Bragg, composed between one-fifth and one-quarter of the service population. Residents in outlying areas, including North County,

Anderson Valley and South Coast, made up roughly 5% of the service population. Based on these data, it is evident that the primary locus for mental health services in Mendocino County is Ukiah, with a smaller emphasis on Fort Bragg and Willits, and that few services are reaching people in outlying areas.

Table 4[10]
Persons Served by Region
FY 2016-17 and FY 2017-18

Region	FY16-17	Percent	FY17-18	Percent
Ukiah	1288	55.4%	1459	53%
Willits	307	13.2%	353	12.8%
North County	64	2.7%	83	3%
Anderson Valley	27	1.2%	31	1.1%
North Coast	493	21.2%	670	24.3%
South Coast	39	1.7%	38	1.4%
OOC/OOS	106	4.6%	118	4.3%
TOTAL	2324		2752	

3. Inpatient Psychiatric Hospitalizations

To undertake our analysis, we received mental health service utilization data from RQMC for the first three-quarters of FY 2017-18 (July 2017 to March 2018). From these data, we developed various projections for the full fiscal year. Among these, we projected that 641 persons would be placed into inpatient psychiatric care in FY 2017-18. In a recent update, RQMC reported that 645 persons received inpatient psychiatric services in FY 2017-18 (as shown in **Table 3** on the prior page), but they were not able to provide complete data on utilization. Based upon the validation of our projection of 641 persons, we believe the projections presented in **Table 5** (following page) can be relied upon to assess other important measures associated with inpatient psychiatric care.

Based upon the first three-quarters of FY 2017-18, our projections show there has been significant growth in the utilization of inpatient psychiatric services between FY 2016-17 and FY 2017-18:

- Number of persons that received inpatient psychiatric services increased from 550 to 645 – ***an increase of 17.3%.***
- Total inpatient hospital days are calculated to increase from 4,300 to 5,524 – ***an increase of 28.5 %;***
- Average length of psychiatric hospital stay is calculated to increase from 7.8 days to 8.6 days – ***an increase of 8%;*** and,
- Average number of persons hospitalized each day (daily census) is calculated to increase from 11.7 to 15.1 average beds/day – ***an increase of 29%.***

Table 5[11] Inpatient Psychiatric Hospitalizations FY 2016-17 and FY 2017-18				
Data Points	**FY16-17**	**FY17-18**	**Projected**	**% Prior Year**
Unduplicated Persons Serviced	424	380	507	119.5%
Hospitalizations	550	481	645*	117.3%
Total Hospital Days	4,300	4,143	5,524	128.5%
Hospital days/Unduplicated person	10.1	10.9	109	108%
Average Hospital Days/Episode	7.8	8.6	8.6	110.2%
Average Daily Hospital Beds (Daily Census)	11.7	15.1	15.1	129%
*Reported actual for full fiscal year. All other projections based on nine months of data for FY 2017-18				

Because Mendocino County does not have inpatient psychiatric beds at any general acute care hospital in the County, or at a Psychiatric Health Facility in the County, all inpatient psychiatric placements were made out-of-county, as shown in **Table 6**. A comparison of data on inpatient psychiatric hospitalizations for both

Table 6[12] Inpatient Psychiatric Hospitalizations – Placement Locations FY 2016-17 and FY 2017-18			
Facility	**FY16-17**	**FY17-18**	**% Prior Year**
Aurora (Santa Rosa)	148	107	72.3%
Respadd (Redding/Red Bluff)	128	179	140%
St. Helena/Deer Park	137	262	190%
St. Mary's (San Francisco)	14	21	150%
John Muir	11	5	45.5%
St. Francis	8	0	0%
Marin General	15	11	73.3%
San Jose Behavioral Health	0	5	new
Woodland Memorial Hospital	0	7	new
Sierra Vista	14	0	0%
VA Hospitals	14	9	64.3%
Heritage Oaks	22	5	22.7%
Freemont	9	6	66.7%
Other Locations	30	28	93.3%
TOTAL	550	645	117.3%

fiscal years (**Tables 7 and 8** on following page) shows that not only are more unique individuals being placed into inpatient psychiatric care and there are more placements, but that a smaller proportion of high-need patients is driving utilization. In FY 2016-17, 19% of patients (82) had two or more episodes of care and utilized 44% (1,878) of total hospital days. In FY 2017-18, 18% of patients (68) had two or more episodes of care and utilized 46% (1,906) of total hospital days.

Table 7[13] Inpatient Psychiatric Hospitalizations FY 2016-17								
Number of Hospitalizations	1	2	3	4	5	7	Total	Averages*
Unduplicated Persons Served	342	54	19	4	4	1	424	10.1 days
Hospitalization Episodes	342	108	57	16	20	7	550	7.8 days
Total Hospital Days	2422	1020	483	178	139	58	4300	11.7 beds
Average Hospital Days/Episode	7.1	9.4	8.5	11.1	7.0	8.3		7.8
Average daily hospital use: 4300 hospital days/365 days = 11.7 beds per day. Average hospitalizations per unduplicated person: 4300 hospital days/550 persons = 10.1 days/episode. Average hospital days per episode: 4300 hospital days/550 hospitalizations = 7.8 days/episode ***Patients with 2+ episodes of care (82) = 1,878 hospital days***								

Table 8[14] Inpatient Psychiatric Hospitalizations FY 2017-18 (July 2017 to March 2018)								
Number of Hospitalizations	1	2	3	4	5	9	Total	Averages*
Unduplicated Persons Served	312	47	15	4	1	1	380	10.9 days
Hospitalization Episodes	312	94	45	16	5	9	481	8.6 days
Total Hospital Days	2237	1113	410	218	57	108	4143	15.1 beds
Average Hospital Days/Episode	7.2	11.8	9.1	13.6	11.4	12.0		8.6
*Based upon 9 months of reported data. ***Average daily hospital use (nine months of data): 4143 hospital days/274 days = 15.1 beds per day.*** Average hospitalizations per unduplicated person: 4143 hospital days/380 persons = 10.9 days/person. Average hospital days per episode: 4143 hospital days/481 hospitalizations = 8.6 days/episode ***Patients with 2+ episodes of care (68) = 1,906 hospital days***								

Additional data on the reasons for inpatient psychiatric care (placement criteria) and the reasons for Crisis Line Contacts can be found in **Appendix E, Tables 1 and 2.**

4. Data on Interactions with Law Enforcement

As previously shown in **Table 3** (see page 16) there were 5,838 Crisis Line contacts in FY 2017-18, for an average monthly number of 486 monthly crisis contacts. Of total calls to the Crisis Line, 402 calls were from various law enforcement agencies, including the County Sheriff, city police departments, the California Highway Patrol and the Jail, as shown in **Table 9** (following page).

Recently, the County Sheriff's Office started collecting data on the number of jail inmates that have been prescribed mental health medications. Such prescribing provides evidence of the need for mental health services by jail inmates. As shown in **Table 10** (following page), on a monthly basis, between 39% and 76% by jail inmates were prescribed mental health medications, for an average monthly rate of 62%.

Table 9 Calls from Law Enforcement to Crisis Line (FY 2017-18)[15]		
Agency	**Number**	**Percent**
County Sheriff	165	41%
Fort Bragg Police	55	13.7%
Ukiah Police	118	29.4%
Willits Police	32	8%
California Highway Patrol	9	2.2%
Jail	23	5.7%
TOTAL	402	100%

Table 10[16] Mendocino County Jail Inmates & Mental Health Conditions (CY 2018)			
Month	**Average Daily Jail Population**	**Population Receiving Medication**	**Percent Receiving Medication**
January	300	117	39%
February	301	157	52.2%
March	306	211	69%
April	299	216	72.2%
May	304	232	76.3%
Monthly Average	302	187	62%

Finally, as shown on **Table 13** (see page 27), only 18 of the 2,081 Emergency Crisis Assessments conducted in FY 2017-18 (less than 1%) were conducted at the County Jail. Most Emergency Crisis Assessments were conducted at the Crisis Center (38.4%); Ukiah Valley Medical Center (35.7%); Mendocino Coast District Hospital (13%); and, Howard Memorial Hospital (11.2%).[17] Notwithstanding where crisis assessments are conducted, many interventions leading to mental health crisis assessments involve law enforcement personnel with either the County Sheriff or one of the city policy departments.

VI. LPS Conservatorships[18]

A subset of persons that receive services from the Mental Health System is persons that are placed in conservatorships. ***For adults under conservatorship, the costs of these services are in addition to the amounts expended by RQMC for administration of the adult mental health system.*** A discussion of Conservatorships is presented in this section.

1. Background on LPS Decision Making Process

Individuals that meet Lanterman-Petris-Short (LPS) conservatorship criteria are persons that have been determined to meet criteria for grave disability; they are unable to meet basic care needs of food, clothing, and shelter to the detriment of life or limb due to a mental illness. This process is most commonly initiated through the Welfare & Institutions (W&I) Code 5150 process. An individual referred for inpatient psychiatric hospitalization under 5150 that continues to meet grave disability criteria to the point that they can't safely be returned to their home community is referred for a temporary conservatorship.

Once referred for temporary conservatorship, the County Public Guardian is notified and court hearings are held to determine whether the temporary guardianship will become permanent. On some occasions an individual is identified as gravely disabled who has not been hospitalized through the W&I 5150 process. In those cases the County Behavioral Health Director orders an evaluation/investigation of the person's grave disability, and if the result of the investigation determines the individual is gravely disabled, then a local petition for temporary conservatorship is initiated. These cases are most often initiated when the individual is in jail or cared for by family/others (basic care needs being attended to by others) and the care can't be sustained so conservatorship needs to be considered.

2. Roles and Responsibilities

Once the courts have approved and appointed guardian and conservatorship, the Public Guardian becomes responsible for the person and their estate unless indicated. The Public Guardian is responsible for psychiatric and financial decisions on the client's behalf. Psychiatric decisions, including placement, are made jointly between the Public Guardian and BHRS. The initial decision of where to place a client includes a review of the active symptoms and risk factors the client is experiencing. In situations where the client is in an inpatient psychiatric facility, the facility staff will often recommend a level of care. The Court standard is to order the least restrictive level of care necessary to meet the client's basic needs, and often an agreed upon level is determined at the hearing for permanent conservatorship. Once an individual is placed in a long-term residential care facility, the BHRS LPS Placement Coordinator and the Public Guardian jointly monitor the client's progress and needs, and the court is notified of all changes in the level of care.

LPS Conservatorships expire each year, and in order to be renewed an evaluation by two qualified clinicians

must independently determine the individual continues to remain gravely disabled. If one of the clinicians finds the individual does not meet conservatorship criteria, the conservatorship is dropped. If both find the individual continues to meet criteria, a court hearing is established. If the client contests the reappointment, a trial (judge or jury at the client's discretion) is heard to determine if the conservatorship will be reestablished. If an individual believes they are capable of caring for themselves they can also contest the conservatorship if it has been at least six months since the last court hearing. If the Public Guardian and BHRS do not feel the client continues to meet criteria the petition will not be renewed. Length of stay at facilities varies greatly depending on the severity of the individual's symptoms and individual responsiveness to treatment.

3. Types of Residential Placements

There are various types of long-term residential care placement options and there are many different scales of service within the types of care. Most placements that are targeted for long-term specialty mental health care fall in the category of Institutes for Mental Disease (IMD), and within this category of IMDs there State Hospitals, Mental Health Rehabilitation Centers (MHRC), Adult Residential Facilities (ARF), Residential Care Facilities for the Elderly (RCFE), and Skilled Nursing Facilities (SNF). Some other placement options are not targeted for specialty mental health care, but provide residential care for those with medical care needs or daily support related to aging or disability. For LPS conserved individuals that are almost ready to return to independent living and self care, there are supported living environments which are like independent homes but with staff regularly overseeing and providing support to assure the individual is eating, sleeping, taking medications, and otherwise meeting basic activities of daily living.

Residential Care Facilities that are specially designed for treating individuals with mental illness have two types of costs: board and care costs and patch rates. Payment for the board and care costs come out of the client's income (SSDI, etc.) and are paid by the Public Guardian's Office. The Public Guardian's Office facilitates obtaining income for clients that qualify when they are appointed guardian. These costs are relatively fixed across levels of placement. The patch rates are supplemental rates to cover the specialty mental health services provided in the facility. Patch rates vary considerably between placements and the type of services provided – between $60 and $1,000 per day – and are paid for by the BHRS.

County BHRS officials report there are a limited number of residential care facilities for specialty mental health issues in California, and that placements are frequently full and there is strong competition among counties for available placements. These officials also report that Mendocino County has limited in-county placements, and all of them are the lowest levels of care clients would utilize before returning to independent living from conservatorship. At this time, Mendocino County has only one specialty mental health board and care facility, and does not have any specialty Mental Health Rehabilitation Centers, Special Treatment Programs, acute psychiatric facilities, or state hospitals.

4. Data on LPS Conservatorships

As presented in **Table 11**, between FY 2015-16 and FY 2016-17, the average monthly number of clients in Conservatorship declined slightly, from 63.1 per month to 61.8 per month. While average monthly clients appear to have declined in FY 2017-18, total costs of care for FY 2017-18 are projected to equal or exceed those in FY 2016-17, at roughly $2.5 million. As shown on this table, ***roughly two-thirds of the conservatorship placements made in FY 2017-18 were made out-of-county because of the lack of suitable placement options in Mendocino County.***

Table 11
LPS Conservatorships
FY 2015-16, FY 2016-17 and FY 2017-18

Fiscal Year	Average Monthly Clients	Unduplicated Clients	Total Residential Days	Total Costs*	Placements in County	Placements out of County	Percent out of County
15-16	63.1	73	18,036	$2,640,962	24	60	71.4%
16-17	61.8	56	16,220	$2,516,904	36	41	53.2%
17-18	54.2	46	10,706	$1,909,176	17	34	66.57%

*Data provided by BHRS. Cost data reflects county costs and may not include costs that are absorbed by RQMC in serving the under 25 population.

VII. Selected Program Outcomes for Inpatient Psychiatric Care

Behavioral Health Concepts, Inc. ((BHC), a behavioral health consulting firm, serves as California's External Quality Review Organization (EQRO) for Medi-Cal Specialty Mental Health Services. We contacted BHC to obtain EQRO data on Mendocino County and comparison counties to compare overall performance on available measures. From BHC, we received selected performance data for FY 2016-17 pertaining to inpatient psychiatric care. Among other things, **Table 12** provides data on Mendocino County and comparison counties regarding:

- Percent Medi-Cal population;
- Percent of high cost clients;
- Re-hospitalization rates post hospital discharge (within 7 days and within 30 days); and,
- Provision of outpatient services post hospital discharge (within 7 days and within 30 days).

Based on these measures, in comparison with other California counties, in FY 2016-17 Mendocino County had one of the highest proportions of county residents eligible for Medi-Cal and one of the highest proportions of clients that are considered "high cost." Notwithstanding these dynamics, Mendocino County's re-hospitalization rates were less than or equal to most other counties; and, the County's provision of outpatient services was generally better than most other counties and the statewide average. ***However, based on 550 inpatient placements in FY 2016-17, these data show many clients did not receive outpatient services within 7 days (193, or 35% of clients) and many did not receive outpatient services within 30 days (143, or 26% of clients).***

Table 12[19]
EQRO Mental Health Service Outcomes (FY 2016-17)
Mendocino & Selected Comparison Counties

County	Population	Percent Medi-Cal	Percent High Cost	7-Day Re-hosp	30-Day Re-hosp	Outpatient within 7 Days	Outpatient within 30 days
Mendocino	**88,378**	**47.0%**	**4.38%**	**3%**	**9%**	**65%**	**74%**
Nevada	98,095	26.2%	5.56%	5%	10%	52%	68%
Lake	64,306	48.8%	3.08%	4%	9%	53%	71%
Sutter-Yuba	171,653	43.2%	1.79%	2%	8%	40%	72%
Napa	142,028	23.0%	2.93%	3%	3%	35%	55%
Humboldt	135,116	39.7%	2.63%	10%	22%	26%	61%
State Average	39,255,883	34.5%	2.86%	5%	15%	40%	58%

EQRO Definitions:
- High Cost: Clients with approved claims of more than $30,000 in a year
- Re-hospitalization: After discharge from an inpatient facility client goes back to an inpatient facility within 7 or 30 calendar days.
- Outpatient Follow-up: Documents whether or not a patient received an outpatient service within 7 or 30 days post discharge from an inpatient psychiatric facility (first hospitalization only, not prior or subsequent hospitalizations)

VIII. Addressing Gaps in the Mental Health Services Continuum

As discussed in Section III, there are a number of key gaps in the current continuum of mental health services in Mendocino County. This section considers alternative approaches for addressing these gaps, presents the experience of other counties, and places the approaches in the Mendocino County context.

1. Crisis Stabilization Unit (CSU)

As defined by California DHCS, "crisis stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a timelier response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy."[20] A Crisis Stabilization Unit (CSU) is licensed as an outpatient mental health program for up to 23 hours and 59 minutes of crisis stabilization and observation. Clients voluntarily admit for services or are brought in on a 5150 hold by law enforcement (or other LPS designated staff based on county policy). A CSU is utilized to provide a centralized location for conducting voluntary and involuntary mental health assessments and provides an alternative to a hospital ED. A CSU typically provides:

- Crisis stabilization, with a focus on individualized interventions directed toward resolution of the presenting, psychiatric episode;
- Evaluation of clients for whom inpatient psychiatric hospitalization may be indicated;
- Admission of clients for inpatient, psychiatric hospitalization;
- Referral for drug and/or alcohol use issues; and,
- Referrals to other county and community-based agencies and services.

As of October 2017, California's DHCS reported that sixteen counties were operating a CSU, including Alameda, Contra Costa, Fresno, Humboldt, Kern, Marin, Orange, Riverside, Sacramento, San Diego, San Francisco, San Joaquin, Santa Clara, Santa Crus, Sonoma, and Solano Counties. Most of these counties are counties with larger populations.[21] Three smaller counties not referenced in DHCS report – Napa, Nevada and San Luis Obispo Counties – have recently opened CSUs. Their programs are briefly described below:

- *Nevada County.* Since October 2016 Nevada County has operated a CSU that the County calls its "Mental Health Urgent Care Center." As described by the County, this 4-bed center is a 23-hour program that provides emergency psychiatric care in a warm, welcoming environment for individuals experiencing a mental health crisis. The center is located adjacent to the Sierra Nevada Memorial Hospital Emergency Department, where all evaluations occur after CSU business hours. The center is an LPS designated facility that can accept voluntary as well as 5150 clients. The program was funded by SB 82.[22] The Urgent Care Center is contracted to Sierra Mental Health Wellness group, a community based organization. Operational costs are between $1.2 and $1.3 million annually. According to the

Nevada County Health and Human Services, the CSU currently operates at a revenue loss estimated at roughly $400,000 due to fewer savings associated with reduced inpatient hospitalization than originally anticipated. At this time, Nevada County plans to continue the program because it is considered important to the overall wellbeing of the community.[23]

- *Napa County.* Napa County received $1.998 million in SB 82 funding for development of a 4-bed Crisis Stabilization Unit (CSU) to serve individuals experiencing a mental health crisis. Grant funds were used for the construction and renovation and for purchase of furnishings, equipment, and for information technology costs. The CSU is intended to fill gaps in the County's continuum of care and will serve approximately 2,190 clients on an annual basis. This estimate includes clients needing emergency psychiatric medication services and general crisis services that may not require staying at the CSU. The CSU is designed to serve individuals that are in psychiatric crisis, including those seeking services voluntarily as well as referrals from first responders such as police, sheriff, paramedics, ambulance and hospital Emergency Departments.[24] Based on the first year of operations, Napa County officials reported a revenue shortfall of roughly $475,000.[25]

- *San Luis Obispo County.* San Luis Obispo County recently opened a new 4-bed CSU on a shared campus near the county's existing Psychiatric Health Facility. San Luis Obispo County received $971,070 in SB 82 funding for development of the facility. The County contributed $300,000 to the project, for a total cost of roughly $1.2 to $1.3 million. The 4-bed CSU is designed to provide immediate response on a short-term basis (lasting less than 24 hours) to stabilize individuals experiencing mental health crises. County officials reported they expect the new facility to relieve strain on the county's 16-bed PHF. According to local officials, annual operating costs are projected to be between $1.4 million and $1.6 million.[26]

Research shows that a centralized Crisis Stabilization Unit that provides psychiatric emergency services can reduce boarding time in the hospital Emergency Department and ED clearance and placement time.[27] While a CSU can contribute to a reduction in the placement of persons into inpatient psychiatric care, such a reduction is not assured. For example, Napa County officials reported that their early experience with their CSU has not reduced inpatient utilization, but instead has contributed to a modest increase. Furthermore, to the extent there are limited service options available that provide an alternative to inpatient psychiatric care, a CSU by itself will not reduce inpatient admissions. It does, however, provide an alternative location to hospital EDs for the provision of psychiatric emergency services, and it provides law enforcement with a location to take patients that does not require officers to remain with patients to provide security while determinations are made concerning treatment and placement.

A. Mendocino County Context

As shown in **Table 13**, the number of Emergency Crisis Assessments increased from 1,695 in FY 2016-17 to 2,081 in FY 2017-18 – ***an increase of 22.8%.*** In FY 2017-18, most assessments took place at the Crisis Center (38.3%), Ukiah Valley Medical Center (26%), Mendocino Coast District Hospital (13%), and Howard Memorial Hospital (11.2%). As presented in **Table 5** (see page 18) 550 persons were placed into inpatient psychiatric care in FY 2016-17 and 645 persons were placed in FY 2017-18. The increased volume of persons needing mental health assessment, and the increased need for placement in inpatient psychiatric care, is putting increasing strain on hospital Emergency Departments in the County and is imposing costs on these hospitals as they hold patients awaiting placement in out-of-county psychiatric facilities.

Table 13[28]
Emergency Crisis Assessments
FY 2016-17 and FY 2017-18

Location	FY16-17	%	FY17-18	%
Ukiah Valley Medical Center	708	42%	742	35.7%
Crisis Center-Walk Ins	491	29%	798	38.4%
Mendocino Coast District Hospital	235	14%	270	13%
Howard Memorial Hospital	209	12%	233	11.2%
Jail	12	<1%	18	<1%
Juvenile Hall	13	<1%	6	<1%
Schools	10	<1%	3	<1%
Community	15	<1%	11	<1%
FQHCs	2	0%	0	0%
TOTAL	1695	100%	2081	100%

At an annual rate of 2,081 mental health assessments, the average daily rate is 5.7 assessments per day. Based on the experience of other counties, it may be challenging for a CSU to be financially self-sustaining with available Medi-Cal and other third party reimbursements. However, the value of investing resources in this approach may be derived more from having a centralized assessment operation with centralized clinical operations that relieves local hospitals from the responsibility and cost of providing a secure and safe Emergency Department location for these assessments, and where local law enforcement can reliably take persons needing assessment and hand-off responsibility to responsible officials.

As referenced earlier, both Nevada County and Napa County operate CSUs and both have had difficulty making their CSU operations fully reimbursable and self-sustaining. Nevada County reported that its operating revenue (funding from various billable sources, including Med-Cal, other insurance) is roughly $400,000 below break-even. Similarly, Napa County reported that its operating revenue shortfall in FY 2017-18 is roughly $475,000. Based on this experience, we anticipate additional funding support beyond Medi-Cal and other reimbursements would be needed to support CSU operations.

It is important to note that Mendocino County's geography and the locus of most service delivery makes the utility of a CSU on the 101-corridor more impactful for the hospitals in Ukiah and Willits than for Mendocino Coast District Hospital in Fort Bragg. In our interviews with representatives of Ukiah Valley Medical Center and Howard Memorial Hospital, we learned that both hospitals hold ED beds for individuals pending 5150 determinations and placement of patients in care. Howard Memorial Hospital reported that an average of 2 beds is held each day. If a CSU were established as a part of the new Crisis Residential Treatment facility campus (already supported by SB 82 funding) there would be a relief of this responsibility for both hospitals, along with cost-savings due to these beds becoming available for other ED purposes. A separate strategy would need to be developed for the Mendocino Coast that makes the assessment processes at Mendocino Coast Hospital complementary with the CSU in Ukiah.

Based on our review of the data and current service dynamics, we believe a CSU makes sense for Mendocino County. However, prior to finalizing terms for operation of a CSU, we believe a fiscal analysis needs to be completed by RQMC, in consultation with BHRS and local hospitals, that considers all of the following:

- Projected daily and annual CSU utilization, and underlying assumptions;
- Projected CSU operational costs, and underlying assumptions;
- Identification of key revenue sources, including Medi-Cal, and projection of revenues by revenue source, and estimate of funding needed to support CSU operations; and,
- Identification and quantification of offsetting savings to local hospital EDs resulting from reduced use of hospital facilities for emergency psychiatric conditions.

It is important to state that a CSU is a crisis response strategy. It is not a strategy to prevent crises from occurring in the first place. However, as a part of post crisis follow-up, a CSU that is co-located with a Crisis Residential Treatment (CRT) program would be a practical option, because some persons in crisis could be placed into residential treatment instead of inpatient psychiatric treatment. This is the approach being taken by Bay Area Community Services (BACS), which is working to open a facility that provides an LPS designated CSU on the first floor and a second floor that will serve as a 12-16 bed CRT. It is also similar in approach to that taken in San Francisco County by the Progress Foundation, which is providing a walk-in voluntary (non-LPS designated) Urgent Care Center with a CRT program.

RECOMMENDATION: It is recommended that a CSU should be established in Mendocino County and annual operating revenue should be allocated to support the CSU from Measure B funds. This CSU should be placed in the context of a planned Crisis Residential Treatment Program, discussed later in this report.

2. Embedded Crisis Clinicians in Hospital Emergency Departments

The embedding of crisis clinicians in a hospital Emergency Department is an alternative to establishing a

CSU. With this approach, embedded clinicians provide assessment and treatment of mental health conditions in the hospital ED 24/hours per day, 7 days/week. Local law enforcement responding to persons with mental health conditions takes these persons to the hospital ED for mental health assessment and treatment. Depending on local needs and priorities, the crisis clinicians embedded at the hospital can be county employees, contracted employees, or hospital employees.

Two studies of embedding crisis clinicians in EDs showed comparable findings. One study involved embedded crisis worked from the University of Pittsburgh Medical Center-Mercy and Western Psychiatric Institute and Clinic of UPMC, who provided interventions aimed at quickly linking patients with the care and resources. With this intervention, the percentage of patients admitted to the hospital for MH or addiction matters declined.[29] A second study involved the placement of four mental health professionals that provided crisis assessments for patients in the ED in an Access Center that was added to the ED. The Access Center was staffed 24 hours a day, 7 days a week and was available to meet the mental health needs of ED patients quickly.[30]

Sutter County operates a joint county mental health plan for Sutter and Yuba Counties. Sutter County utilizes an "embedded crisis clinician" model in the Rideout Memorial Hospital ED, as described below.

- *Sutter-Yuba Counties.* The Sutter-Yuba program operates two psychiatric emergency services units. One unit embeds crisis clinicians in the Rideout Memorial Hospital ED. The second unit is a walk-in (non-LPS) crisis clinic that is on a shared campus with the county's psychiatric health facility. Clinicians with these two units conduct assessment, placement, referral to outpatient services, and some scheduling into county behavioral health services. Staffing for the two units includes a 15 crisis counselors and 4 therapists. The two units operate 24 hours/day, seven days/week.[31]

A. Mendocino County Context

In addition to staffing a Crisis Center, RQMC dispatches crisis clinicians to the three hospitals in Mendocino County: Ukiah Valley Medical Center, Howard Memorial Hospital, and Mendocino Coast District Hospital. These crisis clinicians are not embedded clinicians that stay at each facility on a 24-hour, 7-day per week basis. Rather, these clinicians are called and go to the hospital EDs as needed. Current Memoranda of Understanding between the hospitals and RQMC provide specified response times. In general, county law enforcement and hospital representatives reported that RQMC's response is reliable and timely.

In light of the current role RQMC crisis clinicians play in responding to mental health crises at Mendocino County hospitals, it is not clear how embedding crisis workers on a full-time basis in each hospital would substantially improve current dynamics. On the one hand, if the crisis clinician is "at the ready" in the local hospital, the worker is immediately ready to receive the client. On the other hand, if the time standards set in the MOUs are workable, it isn't clear what the improved outcomes would be of having embedded

workers, as the primary issue would remain placement in a locked setting. Furthermore, for the embedded crisis worker concept to succeed, local hospitals would need to allocate designated space on a full-time basis for these crisis workers. Second, the locus of crisis mental health care would continue to be local hospital EDs, and current dynamics of psychiatric patients sitting in the ED awaiting placement would likely continue, and current cost impacts to hospitals would remain.

RECOMMENDATION: The embedding of crisis mental health clinicians in local hospitals would not substantively improve local service dynamics and is not recommended for Mendocino County.

3. Crisis Residential Treatment Services

As defined by the California DHCS, adult Crisis Residential Services (CRS) "provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work."[32] Crisis residential services are designed to provide a positive, temporary alternative for people experiencing an acute psychiatric episode or intense emotional distress who might otherwise face voluntary or involuntary commitment. Programs provide crisis stabilization, medication monitoring, and evaluation to determine the need for the type and intensity of additional services within a framework of peer support and trauma-informed approaches to recovery. The programs emphasize mastery of daily living skills and social development using a strength-based approach that supports recovery and wellness in homelike settings.

According to the California Mental Health Planning Council, crisis residential treatment programs "reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same, or superior outcomes to those of institutionalized care."[33] Our research found that a handful of Northern California counties have Crisis Residential Treatment programs (**Table 14**), and only Shasta County operates the program directly.

Table 14[34]
Counties with Crisis Residential Treatment Programs

County	Operated by County	Beds
Shasta	Yes	15
Butte	No	10
Placer-Sierra	No	14
Sonoma	No	20
Marin	No	10
Napa	No	8
Yolo	No	14

In our research, we also found California counties that developed hybrid models that incorporated a Crisis Residential Treatment (CRT) program. These models include the following:

- *Placer County.* Placer County combines mental health assessment of clients in the hospital ED with a CRT program. Clients that do not need inpatient placement may go to the CRT program or alternative service. Placer County employs three (3) clinicians per day, 1 of who is stationed at their busiest hospital in Roseville. The other 2 clinicians are available to respond to the other hospital ED and to the two jails for crisis evaluations. A contractor (Sierra Wellness Group) manages the afterhours and weekends portion, during which they employ 2 clinicians from 5pm to midnight, and 1 for the overnight with 1 backup/on-call. The county does have the back-up option of a PHF for inpatient placements when needed. According to county officials, this approach has provided a cost-effective alternative to inpatient hospitalization.[35]

- *San Francisco County.* San Francisco County's Progress Foundation combines a walk-in voluntary Urgent Care Center with a CRT. While the Urgent Care Center is non-LPS designated, it serves as an alternative to a CSU, and to inpatient hospitalization and it provides immediate care with the option of up to 14 days of crisis residential services.[36]

- *Bay Area Community Services (BACS).* BACS is working to open a combined CSU with a CRT to allow easy access to on-going services in Oakland. The BACS program will be done with a home they are remodeling to have the first floor provide an LPS designated CSU with a second floor that serves as a 12-16 bed CRT.[37]

A. Mendocino County Context

Mendocino County's MHSA Three Year Program and Expenditure Plan states that the County is partnering with mental health contract providers to develop a Crisis Residential Treatment (CRT) facility for adults (18 and older) to be funded, in part, by a Mental Health Wellness Grant. Operational funding for the program is expected from MHSA/CSS and Medi-Cal, and the Plan states that the program is in the development phase with intentions to open doors in FY 2018-19.

According to the MHSA Plan, "the CRT facility will be a therapeutic milieu for consumers in crisis who have a serious mental health diagnosis and may also have co-occurring substance use and/or physical health challenges to be monitored and supported through their crisis at a sub-acute level." The CRT will put an emphasis on "reducing inpatient hospitalizations when possible, reducing unnecessary emergency room visits for mental health emergencies, reducing the amount of time in the emergency room, and reducing trauma and stigma associated with out-of-county hospitalization."[38]

Mendocino County received an SB 82 grant for $500,000 that was approved for the purpose of building a 10-bed Crisis Residential Treatment (CRT) Program. As stated in the terms of the grant, the program "will provide a clinically effective and cost-efficient alternative to psychiatric hospitalization for individuals ages 18 and over experiencing a mental health crisis." Redwood Community Services (RCS), an affiliated agency of RQMC, was awarded a contract by Mendocino County to provide CRT services, as well as locate and secure a property as the County's designated grantee. RCS projects it will serve up to 800 individuals annually at the facility. SB 82 grant funds were provided to purchase real property, renovate real property, purchase furnishings, equipment, and information technology and to finance 3 months of start-up costs.[39] Land at 631 S. Orchard Street, Ukiah, was purchased with the SB 82 funding and construction of a facility, which would include a CSU on the same grounds, pends receipt of other financing. The projected cost of construction for the combined Crisis Residential Treatment facility and CSU is approximately $4.66 million, not including the land that has already been purchased.[40]

RECOMMENDATION: A Crisis Residential Treatment Program should be established in Mendocino County and capital construction of the facility (including a CSU) at 631 S. Orchard Street, Ukiah, should be funded by Measure B funds, if funding is not readily available from other sources.

4. Psychiatric Inpatient Services

As defined by the California DHCS, psychiatric inpatient hospital services "include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary."[41]

Psychiatric inpatient hospital services are provided by Short-Doyle/Medi-Cal (SD/MC) hospitals and Fee-for-Service/Medi-Cal (FFS/MC) hospitals. County Mental Health Plans (MHP) are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system and for payment of the non-federal share of cost for Medi-Cal beneficiaries.

As defined by DHCS, a Psychiatric Health Facility (PHF) "is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. Psychiatric Health Facility Services are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings."[42] A PHF is an alternative category of acute psychiatric care provided in a Psychiatric Inpatient Hospital. Under federal Medicaid law, a PHF with

16 beds or less may qualify for federal Medicaid reimbursement, subject to other state licensing requirements. County MHPs are responsible for authorization of psychiatric inpatient hospital services provided in a PHF and for payment of the non-federal share of cost for Medi-Cal beneficiaries.

The California Hospital Association (CHA) has developed data on the availability of psychiatric inpatient services in California. Using a standard of 50 beds needed for each 100,000 county residents, CHA estimates that the 13-county region presented in **Table 15** needs 776 inpatient psychiatric beds. As shown on this table, current inpatient psychiatric bed capacity in the 13-county region is 234 beds. CHA estimates that Mendocino County needs 44 inpatient psychiatric beds.

Table 15[43]
Acute Care Psychiatric Bed Distribution – Northern California

County	Population	Adult Hospital Beds	Child/Adol Hospital Beds	Gero-Psych Hospital Beds	Psych Intensive Care Beds	PHF Beds	Chem/Dep Beds
Mendocino	87,649	0	0	0	0	0	0
Colusa	21,482	0	0	0	0	0	0
Del Norte	27,254	0	0	0	0	0	0
Glenn	28,017	0	0	0	0	0	0
Humboldt	135,727	16	0	0	0	16	0
Lake	64,591	0	0	0	0	0	0
Marin	261,221	17	0	0	0	0	0
Napa	142,456	37	0	0	0	0	0
Shasta	179,533	37	0	0	0	16	0
Siskiyou	43,554	0	0	0	0	0	0
Sonoma	502,146	75	20	0	0	0	0
Tehama	63,308	0	0	0	0	0	0
Trinity	13,069	0	0	0	0	0	0
TOTALS	1,570,007	182	20	0	0	32	0

The CHA standard of 50 psychiatric beds for every 100,000 in population aligns with the standard recommended by the Treatment Advocacy Center in 2008. The Center solicited estimates of bed need from 15 experts on psychiatric care in the United States, including professionals that have run private and state psychiatric hospitals, county mental health programs, and experts on serious psychiatric disorders. A range of 40 to 60 beds per 100,000 in population was identified through this process, and a consensus of 50 beds per 100,000 in population was approved.[44]

A. Mendocino County Context

Mendocino County does not have any inpatient psychiatric beds in a general acute care hospital or a PHF in the County. Based on current inpatient psychiatric hospital utilization data, there is clear evidence of high

need for inpatient psychiatric beds. As presented in **Table 5** (see page 18), between FY 2016-17 and FY 2018 there was a 17.3% increase in inpatient psychiatric placements, and the average number of persons receiving inpatient psychiatric care increased from 11.7 to 15.1 per day, an increase of 29%.

The rate of growth in Mendocino County's utilization of inpatient psychiatric care between FY 2016-17 and FY 2017-18 should alarm public officials and the public. This high level of utilization and its associated costs are not in line with the BHRS Mental Health Department's mission to deliver services "in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture." Further, the costs associated with this level of care are not sustainable over time. ***These data reveal a serious weakness in the overall composition of the County's mental health services continuum – there are no meaningful alternatives to inpatient psychiatric care, and there are insufficient front-end services that support persons with mental illness and reduce the incidence of crisis conditions.***

Further, as shown in **Table 8** (see page 19), based upon the first nine months of FY 2017-18, sixty-eight (68) unduplicated persons with two or more inpatient episodes (18% of clients) utilized 1,906 total hospital days (46% of hospital days) and 312 unduplicated persons with one inpatient episode (82% of clients) utilized 2,237 total hospital days (54%). The small multiple episode group, the so-called "frequently utilizers," followed a trajectory of placement, return to the community, and return to placement. This dynamic reveals a lack of sufficient community-based treatment support and ongoing follow up services for people that return from inpatient care. These data, along with the data referenced above, demonstrate the need for a much more robust front-end continuum of services that reduces the need for inpatient psychiatric care, including but not limited to Crisis Residential Treatment, day treatment, supported housing, and other supports.

At the same time, these data demonstrate that Mendocino County has an immediate need for inpatient psychiatric beds at either a general acute care hospital or PHF, and that unless a facility is constructed in Mendocino County to address this demand, the County will continue to compete with other California counties for limited inpatient placement opportunities out-of-county.

There are two options for Mendocino County to expand inpatient psychiatric bed capacity in the County. One option is for one of the local hospitals along the Interstate 101-corridor to build a new wing for psychiatric beds. We identify hospitals along this corridor because this is locus of most demand for services and care provided in the County. In our discussions with Ukiah Valley Medical Center and Howard Memorial Hospital officials, we found genuine interest in the concept. At the same time, we understand that in order for either hospital to make a commitment to expand hospital facilities and operations to take on this responsibility, the owner of those facilities, Adventist Health, would need to make a determination that it is in the organization's strategic business interest to take on the responsibility. Further, we understand that final decisions for such an undertaking would be made at the organization's corporate

level, not at the local hospital level. Accordingly, we cannot assess the viability or likelihood that one or both of these hospitals would want to take on this responsibility.

Alternatively, a second option is that Mendocino County could proceed to develop a 16-bed Psychiatric Health Facility that meets Medi-Cal standards for reimbursement at a suitable site in Mendocino County. For this avenue to be pursued, the Board of Supervisors would need to identify a suitable location for the facility and establish a process for determining ownership of the facility, build responsibility, and operational responsibility. Additional discussion about development of a PHF is provided in **Section IX**.

RECOMMENDATION: Expanded psychiatric inpatient hospital capacity is needed in Mendocino County. Facility construction costs for the development of this capacity should be funded by Measure B funds.

IX. Considerations for Development of a Psychiatric Health Facility

There are three options for development of a Psychiatric Health Facility (PHF) in Mendocino County:

- County owned and County operated facility;
- County owned facility and private provider operates facility under contract with the County; and,
- Privately owned and operated facility and provider contracts with the County.

For all three options a variety of decisions will need to be made by county officials, including determination of the location and ownership of the land for the PHF; build management responsibility; and, operational responsibility, including the determination of the agency or agencies that make patient admission decisions and prioritize bed availability. In the following discussion, we outline features that are common to all three options and identify features that are unique to each option.

1. Features Common to Three PHF Options

A. Construction and Clinical Licensing Requirements

The construction requirements, facility licensure requirements, and clinical staffing requirements are common to all three options. Generally, California health facility laws and regulations define the requirements for construction of a Psychiatric Health Facility (PHF). California regulations for clinical staffing for a 16-bed PHF[45] are briefly summarized below:

- Clinical Director (who may also serve as the administrator);
- On-call psychiatrist 24/7;
- 17 total staff over a 24-hour period, off which there shall be 2 licensed mental health professionals, 5 nursing staff, and 5 mental health workers;
- LCSW to oversee social services;
- RN 40 hours per week; and,
- Registered nurse, a licensed vocational nurse, or a psychiatric technician awake and on duty in the facility at all times.

B. Populations Served

Typically, Medi-Cal reimbursable clients are the primary target population for a PHF, although most PHFs take clients that have other insurance coverage when the admission is approved by the county. According to data provided by RQMC, 78% of persons receiving Emergency Crisis Assessments in FY 2017-18 were enrolled in Medi-Cal, either with Partnership Health Plan or dual Medicare/Medi-Cal enrollees.[46] Based on this statistic, it is reasonable to assume that most patients treated at the PHF will be covered by Medi-Cal.

When a local mental health system has a full continuum of services that provide support to persons with mental illness and prevent hospitalization, the reliance on inpatient psychiatric care provided by a PHF or other facility can be reduced. Assuming that Mendocino County is committed to reducing inpatient utilization and maximizing the treatment of persons with mental illness in less restrictive settings as described in the BHRS Mental Health Mission Statement, the PHF should be viewed as a resource for the provision of needed inpatient psychiatric care with the intention that committed efforts will concurrently be made to reduce utilization of that type of care. When that type of care is reduced, the PFH can continue to play an important role in the County by providing that care when it is needed; and, it can remain financially viable by accepting patients needing inpatient psychiatric care from other counties in the region. As shown on **Table 15** (see page 33), there is a dearth of available inpatient psychiatric beds in the Northern California region. This means there will be a ready supply of patients needing care that can be served by a facility in Mendocino County.

As a part of establishing a PHF, Mendocino County will need to define the terms for how priority will be given to Mendocino County patients and the conditions for placement of non-county residents. It should be possible for Mendocino County, or the PHF under contract with Mendocino County, to structure agreements with other counties that make beds available when Mendocino County needs are met and excess capacity at the facility exists. This model is currently used for Nevada County, Mariposa County, and Trinity County, all of which do not have their own facilities but instead contract with El Dorado County (as well as other facilities) to purchase beds at the PHF in El Dorado County.[47]

C. Projected Build Costs

Not including the cost of the land, the estimate for the cost of construction a new PHF facility is between $5 and $6 million. This estimated cost range is based upon interviews with representatives of Heritage Oaks Hospital and Telecare, two PHF providers in the State of California and in the Northern California region.[48] We also contacted Butte County, which owns and operates its own PHF, but county officials were unable to provide build costs because the county's building is over 20 years old.[49]

The cost of remodeling a county-owned or other building is estimated at a minimum of $300 per square foot. This estimate is based upon an interview with Restpadd, which operates PHFs in Shasta County and Tehama County.[50] It is important to note that this cost estimate of $300 per square foot is subject to volatility because it is strongly influenced by the specific conditions of a potential site, the site's compliance with current building codes and its readiness for construction, including environmental conditions. In our research, we found current PHFs range in size from 7,500 and 14,000 square feet.[51] With a square foot cost of $300, we project a cost range of $2.25 million to $4.2 million for a remodeled building.

We note that this cost projection for remodeling is considerably less than that provided by Heller & Sons,

Inc., contained in its proposal to the Howard R. Hospital Foundation to remodel the old Howard Hospital building for a psychiatric health facility on that property. That proposal contained a cost range of between $11.2 million and $14.9 million.[52] To test the relative competitiveness of these various cost estimates, a formal PHF Request for Proposals process would need to be undertaken by Mendocino County.

Taking all of the available information into consideration, for the purposes of developing a new PHF facility construction cost estimate, we have set a cost of $7.5 million as reasonable. This assumes a base cost of $6 million (top-end of $5 to $6 million range identified by PHF builder-operators) plus 25% for contingency.

D. Medi-Cal Payment Rates

According to the California DHCS, Medi-Cal Adult PHF daily rates have increased from $651.20 in FY 2012-13 to $847.90 in FY 2017-18, which reflects a 30.2% increase in the daily rate in six years. Available DHCS data also shows a 7.3% increase in FY 2018-19 for an average PHF claim of $909.58.[53] For all Medi-Cal eligible persons, 50% of the cost (non-federal share) is a county cost.

2. Features Unique to Each PHF Option

A. County Owned and County Operated PHF

With this option, the PHF would be designed, built, owned, staffed and operated entirely by the Mendocino County. Under this approach, the County would need to delegate management of construction to a designated county agency. For development and operation of the clinical program, the County would need to delegate management to a designated county department. The County would also need to authorize hiring through the usual processes and creation of new county positions that meet the licensing requirements for PHF staffing. This approach would require the most direct and ongoing County commitment to management of construction and operation of the facility.

1. Projected Annual Operating Costs

Butte County operates its own PHF. According to Butte County officials, annual operating costs include salary costs of $2.9 million per year for 23 staff, including nurses, clinicians, psychiatrists and mental health technicians who work the 24-hour schedule. In addition, there is roughly $900,000 in other administrative costs, for a total of approximately $3.8 million annually.[54] Operating costs for Sutter-Yuba County's PHF are estimated at $4.3 million dollars annually.[55] It is important to note that a county operated PHF with county employees is generally the most expensive option due to higher staff costs associated with county employees. Based upon this reported information, the range of annual operating costs for a county owned and operated PFH is between $3.8 and $4.3 million.

2. Other Considerations

For the county to build a PHF, the county will need construction management and oversight expertise. For the county to operate a PHF, the county will need clinical and operations expertise, including the ability to:

- Hire and manage numerous clinical staff, including nurses, clinicians, psychiatrists and mental health technicians that work a 24-hour schedule;
- Establish, administer and maintain a claiming process for PHF reimbursement that is reliable and secure and ensures reimbursement from all payer sources, including Medi-Cal, Medicare and private insurance;
- Assure financial viability of the PHF by maximizing bed usage and minimizing empty bed days; and,
- Contract with other counties or private insurance providers for excess bed supply and establish associated claims processes.

B. County Owned and Privately Operated PHF

With this option, the PHF facility would be designed and built to Mendocino County specifications, and the County would own the facility. For PHF operations, the County would solicit bids and select a provider to be responsible for PHF programming and provision of direct services under contract. The County could ask PHF providers to separately bid out both the construction and the operations, with the understanding that the facility would be County owned. With this approach, the County would maintain ownership control of the building and contract out PHF operations. The County could periodically place the PHF program through a competitive bid process to ensure the most competitive provider continues to provide PHF services under Mendocino County's preferred terms.

1. Projected Annual Operating Costs

Based upon our interview with Restpadd, which operates PHFs in Shasta County and Tehama County, the estimated annual cost of PHF operations at its facilities is roughly $3 million per year for staffing plus an additional 12% for administrative costs, for a total estimated cost of $3.4 million.[56] This estimated cost is roughly $400,000 to $900,000 less than the estimated cost for operation by county employees.

2. Other Considerations

For the County to build a PHF, the County will need construction management and oversight expertise. For the County to contract out operation of the PHF, the County will need appropriate clinical and management expertise to oversee the contract.

C. Privately Owned and Privately Operated PHF

With this option, the County would solicit and select a private provider to build and operate the PHF on behalf of Mendocino County, subject to specific conditions set by the County. The approved provider would then be responsible for building a suitable facility as well as the hiring and managing all staff that are required to provide PHF services.

This approach could limit the County's direct, up-front financial investment because the costs for building and operation could be negotiated over a longer period of time. Thus, this approach could make it possible for Measure B dollars to be used for other programming. However, this approach would also limit the county's control over the project as the program would be owned by a third party contractor, and the Board's contract with the provider would need to do both of the following: 1) Prioritize bed availability for Mendocino County to ensure County residents have appropriate access to placement, when needed; and, 2) Define the timeline and terms of payoff for building construction and how County building ownership rights will be handled at payoff. The County's contract with the provider would be especially important because the County would be a customer of the provider, but not the only customer.

1. Projected Build Costs

With this approach, the provider would be solely responsible for constructing a suitable facility and establishing an appropriate PHF program based on current licensing requirements. While there could be some negotiation with the County, the responsibility would remain primarily with the contracted provider. The County would be required to certify the site for Medi-Cal reimbursement. Further, the provider would be required to secure financing on its own, unless negotiation with the County provided some amount of Measure B revenue. As referenced earlier, the project facility build cost is up to $7.5 million (base estimate plus contingency).

2. Projected Annual Operating Costs

With this approach the PHF contractor would operate and provide staffing for the PHF. As referenced earlier, the estimated cost of PHF operations at similar facilities in Shasta County and Tehama County is roughly $3 million per year for staffing plus an additional 12% for administrative costs, for a total of $3.4 million.[57] We use this figure as the estimated cost for contracted out PHF operations. We contacted other PHF programs to get additional operating cost estimates, including Heritage Oaks Hospital and Telecare, but no information was available because these firms considered this information to be proprietary.

X. Current and Future Behavioral Health Service Needs

Our assessment of Mendocino County's current Mental Health service continuum is that it does not offer a robust set of alternative services that prevent crisis conditions and provide alternatives to inpatient psychiatric care. The system is heavily tilted toward responding to crisis conditions, with the primary service strategy of inpatient psychiatric care in out-of-county facilities.

Based upon our research and analysis and our discussions with Key Informants, we recommend the following program services are all needed in Mendocino County:

- PHF or other inpatient psychiatric care;
- Crisis Residential Treatment;
- Crisis Stabilization Unit (CSU);
- Expanded outreach, such as the Mobile Outreach Teams;
- Addressing service needs of outlying and remote areas of the county;
- Expansion of support programs and wellness efforts, with special attention to making these services more robust by including medication management, employment services, and other services to support families;
- Day Treatment;
- Supportive Housing;
- Partial hospital care/rehabilitative care/board and care; and,
- Expansion of substance use disorder treatment.

Among these, the need for an expanded support programs and wellness efforts – with direct services provided to individual consumers and their families – was most emphasized by consumers and family members. In our interviews, these informants shared their struggles in managing their needs, or in assisting with the care of their loved ones, and their feelings of isolation and lack of connection and support. Collectively, they pointed to a need for one-on-one coaching support for consumers to help them reach their goals for recovery and healing; more support for family members assisting their loved ones in recovery; broad based wellness efforts across the county, not just in populated areas; employment services; and, support with transportation to get to needed services.

Over the next five years we believe the primary principle that should drive Measure B policy-making is a commitment to developing a comprehensive mental health services continuum in Mendocino County that provides a broad range of services and supports that remediate mental health conditions at the earliest possible time and reduce inpatient psychiatric utilization. As a part of this, we believe policy makers should establish a policy goal of Measure B funding is to reduce the need for inpatient psychiatric care, while simultaneously assuring that inpatient psychiatric care is available in the County when needed. We believe

a goal of a 50% reduction in the use of inpatient psychiatric care within five years, by FY 2022-23, is a responsible goal. This would reduce daily hospital utilization from 15.1 persons per day to a more sustainable 7.6 persons per day.

With respect to the SUDT services continuum, as we discussed in this report, Mendocino County's current array of SUDT services is limited to a small set of services. The near-term expansion of these services hinges primarily on the County's determination of how it will proceed with the Drug Medi-Cal Organized Delivery System (ODS). If the County does not implement the new ODS, either through county administration or through Partnership Health Plan (PHC), then the expanded continuum of services will not be available to residents of the County. As of this writing, we do not know what the real viability of the PHC plan is, so we are not in the position to make a recommendation about this approach. However, we do know that county administration of the ODS would set a very high bar for the County because the County would be required to directly administer services under a managed care model that is similar in approach to that required for the County's Mental Health Plan, which the County has contracted out to a third party administrator.

In the near term, we believe it makes sense for policy makers to assess where Measure B funds can be allocated to expand access to SUDT services in the County, either through current service contracts or through new contracts with providers, so that more people can be served. As reported by BHRS, only 707 persons received SUDT services in FY 2016-17 from all funding sources. We believe this small number is far out-paced by the level of need, and an allocation of Measure B funds for an expansion of SUDT services is not only appropriate, but also essential. In addition, we believe some of these resources should be dedicated to dual treatment of SUDT and mental health conditions.

XI. Key Policy Decisions and Recommended Actions

It is recommended the Mendocino County Board of Supervisors approve the following policy approach pertaining to the use of Measure B revenues:

GUIDING PRINCIPLE: The guiding principle for the use of Measure B revenues is the development of a comprehensive mental health services continuum in Mendocino County that provides a broad range of services and supports that remediate mental health conditions at the earliest possible time and reduce the need for inpatient psychiatric utilization.

KEY POLICIES: The following policies are recommended to assist Mendocino County in meeting its goal of a comprehensive mental health services continuum:

1. Measure B funds should ***supplement, not supplant,*** existing sources of funding for mental health and SUDT services, which include Realignment, MHSA and Medi-Cal funding.
    a. Prior to considering any proposed spending of Measure B funds that would supplant an existing source of funding for behavioral health services, a programmatic and fiscal analysis of such proposed spending should be prepared for consideration by the Board of Supervisors.
2. A biannual review process of Measure B spending and its impact on the mental health and SUDT continuums of care should be undertaken and presented to the Board of Supervisors.
3. A Measure B "Prudent Reserve" should be established and funded to provide additional revenue for behavioral health programs in Years 6-10 of Measure B, when funding will be less due to the drop from 1/2-cent to 1/8-cent sales tax.
4. In addition to standard accounting of behavioral health revenues and expenditures by BHRS, a separate annual accounting of all Measure B revenues and expenditures should be undertaken that is distinct from BHRS' accounting.
    a. The Board of Supervisors would determine the public or contracted entity that will responsible for carrying out a separate accounting of Measure B revenues and expenditures; and,
    b. A biannual accounting report on Measure B revenues and expenditures should be prepared for the Board of Supervisors by the responsible entity.
5. A 10-Year Strategic Spending Plan for Measure B revenues should be adopted that addresses top priority needs in Years 1-5 of Measure B funding, establishes a Prudent Measure B Reserve for use in future years, and provides a framework for continued funding of identified priorities in Year 6-10 that provides flexibility to refine and revise spending priorities over time.
6. BHRS, RQMC and its subcontractors should be directed to restructure the manner in which data is provided to the Board of Supervisors and the public on the populations served by current and newly funded behavioral health programs so that client-level data is collected and reported by program and by region, and quarterly monitoring of utilization and service trends can be more fully evaluated.

XII. Proposed Measure B Strategic Financing Plan

To effectuate program development, it is recommended the Mendocino County Board of Supervisors approve a 10-Year Measure B Strategic Financing Plan to guide current and future use of Measure B revenues. The Financing Plan proposed in this section is designed to address the key shortcomings of the current mental health and SUDT continuums of care that Kemper Consulting Group has identified through its assessment of service gaps and future needs. The proposed Measure B Strategic Financing Plan that follows would address the following priority areas of need for mental health and substance use disorder services:

1. Create an in-county residential treatment alternative to inpatient psychiatric care by funding construction of a Crisis Residential Treatment facility (land already purchased, plans approved, construction pending financing);
2. Create a centralized system for mental health crisis assessment and intervention through annual dedicated operational funding for a Crisis Stabilization Unit (construction included as part of Crisis Residential Treatment facility), along with Medi-Cal and other reimbursements;
3. Create in-county inpatient psychiatric treatment capacity by funding construction of Psychiatric Health Facility (pending RFP process); operations to be funded from existing revenue sources, including Realignment and Medi-Cal;
4. Reach more persons with mental illness through expansion of programs and supports in communities across Mendocino County, based on a plan to be developed by BHRS. Such plan would consider all of the following: expansion of mobile outreach; expansion of wellness programs to include more robust array of services (medication management, employment services, other supports); expanded monitoring of clients engaged with the mental health system through greater intensity support services; one-on-one consumer and family support programs; and, day treatment and/or partial hospital programs.
5. Reach more persons with substance use disorders through expansion of programs and supports in communities across Mendocino County, based on a plan to be developed by BHRS.
6. Expand the reach of Full Service Partnerships to more seriously mentally ill people by dedicated annual funding (pending proposal from BHRS);
7. Expand in-county Supportive Housing opportunities for mentally ill persons, including homeless mentally ill and individuals under conservatorship, by creating a Supportive Housing Pool for alternative housing support uses, such as construction, match for state/federal financing opportunities, rental subsidies and vouchers (pending proposal from BHRS and the county housing authority); and
8. Create a Prudent Reserve that is carried forward into Years 6-10 of the initiative, when the rate of sales tax collection drops from 1/2-cent to 1/8-cent and annual revenues drop from roughly $7.5 million to $2.0 million.

Proposed Measure B Strategic Financing Plan – Years 1-5							
	% Allocation	**TOTAL**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Measure B Revenue	**-**	**$37,500,000**	**$7,500,000**	**$7,500,000**	**$7,500,000**	**$7,500,000**	**$7,500,000**
Crisis Residential Treatment (CRT)	12.7%	$4,750,000	$4,7500,000	$0	$0	$0	$0
Psychiatric Health Facility (PHF)	20%	$7,500,000	$0	$4,000,000	$3,500,000	$0	$0
Crisis Stabilization Unit (CSU)	5.3%	$2,000,000	$0	$500,000	$500,000	$500,000	$500,000
Support Services Expansion	15.3%	$5,750,000	$1,000,000	$1,000,000	$1,250,000	$1,250,000	$1,250,000
FSP Expansion	6.7%	$2,500,000	$500,000	$500,000	$500,000	$500,000	$500,000
Supportive Housing Pool	9.3%	$3,500,000	$500,000	$750,000	$750,000	$750,000	$750,000
SUDT Services Expansion	10%	$3,750,000	$750,000	$750,000	$750,000	$750,000	$750,000
Measure B Prudent Reserve	20.7%	$7,750,000*	$0	$0	$250,000	$3,750,000	$3,750,000
TOTAL	100%	$37,500,000	$7,500,000	$7,500,000	$7,500,000	$7,500,000	$7,500,000

Proposed Measure B Strategic Financing Plan – Years 6-10							
	% Allocation	**TOTAL**	**Year 6**	**Year 7**	**Year 8**	**Year 9**	**Year 10**
Annual Measure B Revenue	**-**	**$10,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**
Measure B Reserve	**-**	**$5,000,000**	**$1,000,000**	**$1,000,000**	**$1,000,000**	**$1,000,000**	**$1,000,000**
Crisis Residential Treatment (CRT)	0%	$0	$0	$0	$0	$0	$0
Psychiatric Health Facility (PHF)	0%	$0	$0	$0	$0	$0	$0
Crisis Stabilization Unit (CSU)	16.7%	$2,500,000	$500,000	$500,000	$500,000	$500,000	$500,000
Supportive Services Expansion	41.6%	$6,250,000	$1,250,000	$1,250,000	$1,250,000	$1,250,000	$1,250,000
FSP Expansion	16.7%	$2,500,000	$500,000	$500,000	$500,000	$500,000	$500,000
Supportive Housing Pool	0%	$0	$0	$0	$0	$0	$0
SUDT Services Expansion	25%	$3,750,000	$750,000	$750,000	$750,000	$750,000	$750,000
TOTAL	100%	$15,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000
Net Measure B Prudent Reserve		$2,750,000*					

*Net Reserve potentially available for Regional Behavioral Health Training Facility

Taken together, the recommended policy actions and the Measure B Strategic Financing Plan would create a framework for building out the existing, limited continuums of care for both mental health and substance use disorder treatment over time. The proposed financing plan will not address all needs in all areas at the same time; and, it is assumed that service needs will be redefined over time as the services continuums are expanded. Thus, within certain categories of proposed spending, notably Support Services and Supportive Housing, it is intended that BHRS leadership, in consultation with RQMC, the Measure B Committee, the Behavioral Health Advisory Committee, and community stakeholders, further refine the areas where service expansion can be undertaken in a timely and cost-effective manner.

1. Program Development Action Steps

It is recommended the Board of Supervisors take the following steps toward implementation of the new mental health and SUDT programs recommended in the proposed Measure B Strategic Financing Plan:

1. Approve appropriation of funding of an amount up to $4.75 million from Year 1 Measure B revenues for construction of the Crisis Residential Facility/Crisis Stabilization Unit planned for the site at 631 S. Orchard Street in Ukiah, if no other funding is readily available.
2. Direct the BHRS Director, in consultation with RQMC and the Behavioral Health Advisory Board, to prepare a plan for utilization of Year 1 Measure B funds for the following service categories: expansion of specific services under the Supportive Services category; expansion of FSP services; and expansion of SUDT treatment services, including dual diagnosis treatment services.
3. Authorize the CEO to undertake a Request for Proposals (RFP) process to solicit proposals from qualified operators of Psychiatric Health Facilities (PHF) in California for construction and operation of a 16-bed PHF on land to be identified by Mendocino County. This RFP would be structured to require bids in two ways:
    a. Ownership and operation of the facility by the PHF operator under a long-term land lease agreement; and,
    b. Ownership of the facility by the County of Mendocino and operation of the PHF under a long-term Services Agreement with the PHF operator.
4. Authorize the CEO to undertake a Request for Proposals (RFP) process to solicit proposals from local hospitals in Mendocino County for construction of inpatient psychiatric beds that would be owned and operated by these hospitals, but would be committed with first priority to Mendocino County under a long-term agreement that is conditional for allocation of construction funding from Measure B.
5. Direct the BHRS Director, in consultation with the county housing authority, RQMC, the Measure B Committee, and Behavioral Health Advisory Board, to prepare a strategic plan for the development of expanded housing support programs for persons with mental illness and/or recovering from substance use. Such plan should address priorities for construction, services and vouchers or rental subsidies.

XIII. Appendix

APPENDIX A Key Informant Interview Participants		
Organization	**Informant**	**Title**
Behavioral Health Advisory Board	Jan McGourty	Chair
	Lois Lockart	Member
	Flinda Behringer	Member
	John Wetzler	Former Chair
County Behavioral Health & Rehabilitation Services Department	Jenine Miller	Director
County Executive Office	Carmel Angelo	County Executive
County Health & Human Services Agency	Anne Molgaard	Acting Director
	Tammy Moss Chandler	Director
County Sheriff	Thomas D. Allman	Sheriff
	Timothy Pearce	Captain, Jail Commander
Community Physician	Ace Barrish	MD
Community Physician	Marvin Trotter, MD	Hospital ED Physician
Community Resident	Tammy Lowe	
Community Resident	Edna McLean	
Community Resident	Stephanie O'Flaherty	
Community Resident	Josephine Silva	
Howard Memorial Hospital	Jason Wells	President
Measure B Committee*	Whole Committee	Chair and Members
Mendocino Coast Clinics	Lucrecia Renteria	Executive Director/ARCH Chair
Mendocino Community Health Centers	Carol Press	Executive Director
	Ben Anderson	Behavioral Health Manager
Redwood Quality Management Company	Camille Schraeder	Systems Officer
	Tim Schraeder	Chief Executive Officer
Therapist (Manchester, Pt. Arena)	Lorelei Hammond	LCSW
Ukiah Valley Medical Center	Gwen Matthews	CEO
*Consultants met with the Measure B Committee on April 25, 2018 and watched video of the Committee's May 23, 2018 meeting regarding Consultant's scope of work		

APPENDIX B County Agency and Department Mission Statements	
Organization	**Mission Statement**
Health and Human Services Agency	In partnership with the community, the Health and Human Services Agency will support and empower families and individuals to live healthy, safe, and sustainable lives in healthy environments, through advocacy, services and policy development.
Mental Health	Mental Health Services strives to: ▪ Deliver services in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture. ▪ Educate ourselves, individuals, families and the community about mental illness and the hopeful possibilities of treatment and recovery. ▪ Maximize independent living and improve quality of life through community-based treatment. ▪ Maximize the resources available and attend to concerns for the safety of individuals and the community. ▪ Manage our fiscal resources effectively and responsibly while insuring that productivity and efficiency are important organizational values which result in maximum benefits for all concerned.
Substance Use Disorders Treatment	The Substance Use Disorders Treatment program "is committed to providing services to residents of Mendocino County of diverse backgrounds. We offer a culturally competent, gender responsive, trauma informed system of care for adults and adolescents while striving to meet linguistic challenges. Utilizing holistic, person-centered recovery, we promote healthy behaviors through prevention and treatment strategies that support our community's need to address alcohol and other drug abuse, addictions and related conditions."

APPENDIX C Table 1 Mental Health Services for Adults (FY 2017-18)[58] Administered by Redwood Quality Management Company			
Program Service Type	**Program Name**	**Population**	**FY17-18 Budget**
Early Intervention	Redwood Community Crisis Center	All Ages	$160,000
	RVIHC Yuki Trails	All Ages	$20,000
	Consolidated Tribal Health Project	All Ages	$32,000
	RVIHC Family Resource Center	15-24	$20,000
	Nuestra Alianza	18+	$55,000
	Mendocino Coast Hospitality Center	18+	$162,000
	Manzanita Services Inc.	18+	$250,000
	MCAVHN	18+	$10,000
	Costal Senior	60+	$10,000
	Redwood Coast Senior Center	60+	$45,000
	Ukiah Senior Center	60+	$30,000
	FSP Flex Funds	All Ages	$300,000
Psychiatry	Dr. John Garratt & Olga Segal	25+	$211,000
Day Treatment	***None***	***None***	-
Crisis Residential Treatment	***None (pending development)***	***None***	-
Partial Hospital	***None***	***None***	-
PHF/Hospital	Aurora	All Ages	$40,000
	St. Helena	All Ages	$10,000
	Heritage Oaks	All Ages	$40,000
	Sierra Vista	All Ages	$15,000
	Physician Fee's	All Ages	$10,000
	Restpadd Redding/Red bluff	All Ages	$1,250,000
IMD	Crestwood	All Ages	$10,000
Employability Services	***None***	***None***	-
Outpatient Services	Redwood Community Services*	All Ages	$1,500,000
	Manzanita Services	Over 18	$1,015,000
	Mendocino Coast Hospitality Center	Over 18	$505,000
	MCAVHN	Over 18	$180,000
Assertive Community Treatment	***None (pending development)***	***None***	-
TOTAL			**$5,880,000**
*Includes Crisis Services			

APPENDIX C Table 2 Mental Health Services for Children (FY 2017-18)[59] Administered by Redwood Quality Management Company			
Program Service Type	**Program Name**	**Population**	**FY17-18 Budget**
Early Intervention	Redwood Community Crisis Center	All Ages	$130,000
	Tapestry Family Services	0-24	$65,000
	Action Network	All Ages	$49,250
	Arbor Youth Resource Center	15-24	$100,000
	RCS Stepping Stones Housing	16-24	$230,000
	Laytonville Healthy Start Family Resource	6-17	$35,000
	MCYP	6-24	$125,000
	Anderson Valley Unified School District	6-17	$54,700
	FSP Flex Funds	All Ages	$10,000
Psychiatric	Dr. Rebecca Timme & Larry Aguirre	0-24	$150,000
Day Treatment	***None***	***None***	-
Crisis Residential Treatment	***None***	***None***	-
Partial Hospital	***None***	***None***	-
PHF/Hospital	Aurora	All Ages	$20,000
	Heritage Oaks	All Ages	$20,000
	Physician Fee's	All Ages	$10,000
	Restpadd Redding/Red bluff	All Ages	$145,000
IMD	Crestwood	All Ages	$10,000
Employability Services	***None***	***None***	-
Outpatient Services	Redwood Community Services*	All Ages	$5,100,000
	Tapestry Family Services	Under 25	$1,800,000
	Mendocino County Youth Project	Under 25	$600,000
Assertive Community Treatment	***None (pending development)***	***None***	-
Out-of-County Placements	Milhous	Under 18	$50,000
	Remi Vista	Under 18	$40,000
	Summitview	Under 18	$40,000
	Victor Treatment Center	Under 18	$150,000
	St. Vincent's	Under 18	$40,000
	Charis	Under 18	$10,000
TOTAL			**$8,983,950**
*Includes Crisis Services			

APPENDIX C Table 3 Mobile Outreach and Prevention Services (FY 2016-17 and FY 2017-18)[60] Administered by Behavioral Health and Rehabilitative Services Department		
	FY 2016-17	FY 2017-18
Client Served	30	52
Male	12	25
Female	18	27
Number of Contacts	282	892
Total Funding	$147,167	$207,349
Summary: Mobile Outreach and Prevention Services (MOPS) funds three mental health workers that serve the North County, South Coast, and Anderson Valley and Surrounding Ukiah area with the support of a Sheriff Services Technician. Services are not provided in Ukiah, Fort Bragg, or Willits. Program funding is provided by CHFFA and Whole Person Care (Medi-Cal).		

APPENDIX D Substance Use Disorder Treatment Services (FY 2017-18)[61] Administered by Behavioral Health and Rehabilitative Services Department				
Service Program	Name	Target Population	Served in FY 2016-17	Budget FY 2017-18
Outpatient Services	BHRS	Medi-Cal	100	$768,885*
	BHRS/Justice System	Dual Diagnosis	10	
	Arbor Youth	Medi-Cal (ages 16-24)	NA	$70,000
	Consolidated Tribal Health	Children, youth, adults, seniors	NA	$16,000
Perinatal Treatment	WINDO	Medi-Cal (pregnant women)	7	$143,508
Prevention/ Early Intervention	BHRS	Youth	395	$295,721
Correctional Treatment	SUDT services in jail	Jail inmates	NA	$54,538
Adult Drug Court	Justice System/BHRS Collaboration	Adults with suspended state prison sentence	21	$233,231
Family Drug Court	Justice System/BHRS/ CWS Collaboration	Families involved with Family/Children Services	78	$354,152
	Ukiah Recovery Center	Individuals	1	$100,300
	Hilltop	Individuals	2	$22,500
	Health Right 360	Pregnant women/ mothers	1	$37,500
TOTAL			615	$2,096,335
*Funding for Dual Diagnosis program included in total				

APPENDIX E Table 1 Inpatient Psychiatric Hospitalizations - Placement Criteria[62] FY 2016-17 and FY 2017-18				
Criteria	**FY16-17**	**Percent to Total**	**FY17-18**	**Percent to Total**
Danger to Self	316	57.4%	344	53%
Gravely Disabled	122	22.2%	153	24%
Danger to Others	17	3.1%	12	2%
Combination	95	17.2%	136	21%
TOTAL	550		645	

As shown in Appendix E, Table 1, the number of placements for the first nine months of FY 2017-18 persons that were "Gravely Disabled" and those that were "Danger to Self/Others (combination)" were almost equal with those placements for all of FY 2016-17. Further, placements due to "Danger to Self" are running 8% higher than FY 2016-17.

APPENDIX E Table 2 Crisis Line Contacts – Reason for Call[63] FY 2016-17 and FY 2017-18				
Symptom	**FY16-17**	**%**	**FY17-18**	**%**
Increase in Symptoms	1307	24.9%	1368	23.4%
Phone Support	1347	25.7%	2180	37.3%
Information Only	862	16.4%	811	13.9%
Suicidal Ideation/Threat	901	17.2%	905	15.5%
Self-injurious Behavior	125	2.4%	96	1.6%
Access to Services	309	5.9%	282	4.8%
Aggression toward Others	178	3.4%	78	1.3%
Resources/Linkage	221	4.2%	118	2%
TOTAL	5250		5838	

As shown in Appendix E, Table 2, for the first nine months of FY 2017-18, the total number of Crisis Line Contacts is running ahead of the prior year. If the pace continues, the number of Crisis Line Contacts will be nearly 5,800 by the end of the fiscal year. Most contacts are made to address increased symptoms and for phone support.

XIV. Endnotes

[1] County Auditor's Fiscal Impact Statement – Measure B. Retrieved from https://www.mendocinocounty.org/home/showdocument?id=10497

[2] In our research, we did not find a set of specific published "goals and objectives" for Mendocino County's Health and Human Services Agency or the Behavioral Health and Rehabilitative Services (BHRS) Department

[3] Mendocino County Health and Human Services Agency Mission Statement. Retrieved from https://www.mendocinocounty.org/government/health-and-human-services-agency

[4] Mendocino County Behavioral Health and Rehabilitative Services, Mental Health Mission Statement. Retrieved from https://www.mendocinocounty.org/government/health-and-human-services-agency/behavioral-health-and-recovery-services

[5] Mendocino County Behavioral Health and Rehabilitative Services, Substance Use Disorder Treatment Mission Statement, found at: https://www.mendocinocounty.org/government/health-and-human-services-agency/behavioral-health-and-recovery-services

[6] Substance Abuse and Mental Health Services Administration (SAMHSA), *Prevention of Substance Abuse and Mental Illness.* Retrieved from https://www.samhsa.gov/prevention

[7] California Department of Health Care Services, *DHCS Medi-Cal Specialty Mental Health Services: May Estimate, Policy Change Supplement for Fiscal Years 2017-18 and 2018-19,* page 2. Retrieved from http://www.dhcs.ca.gov/services/MH/Documents/SMHS-Supplement-May2018-Est-2018-5-14-ADA.pdf

[8] Mendocino County Behavioral Health and Rehabilitative Services, Thompson, D., Program Specialist, SUDT Data Report. Email communication of July 17, 2018 (L. Kemper, J. Featherstone)

[9] Redwood Quality Management Company (RQMC), Data Dashboard – YTD FY1617 (revised 06182018), and Data Dashboard – FY1718 YTD (revised 7202018)

[10] RQMC, Data Dashboard – YTD FY1617 (revised 06182018), and Data Dashboard – FY1718 YTD (revised 7202018)

[11] RQMC, Data Dashboard – YTD FY1617 (revised 06182018), and Data Dashboard – FY1718 YTD (revised 7202018)

[12] RQMC, Data Dashboard – YTD FY1617 (revised 06182018), and Data Dashboard – FY1718 YTD (revised 7202018)

[13] RQMC, Data Dashboard – YTD FY1617 (revised 06182018), and Data Dashboard – FY1718 YTD (revised 7202018)

[14] RQMC, Data Dashboard – YTD July 2017 to March 2018

[15] RQMC, Data Dashboard - FY1718 YTD (revised 7202018)

[16] Mendocino County Sheriff's Office, Pearce, T., Captain, Jail Commander. Email communication of June 27, 2018 (L. Kemper); and, NaphCare, Inc., Carfi, A., Health Service Administrator. Email communication of June 26, 2018 (L. Kemper)

[17] RQMC, Data Dashboard - FY1718 YTD (revised 7202018)

[18] Mendocino County BHRS, Lovato, K., Acting Deputy Director. Email communications of June 25, 26 and 28, 2018 (L. Kemper). The written information contained in this section was drafted by Mendocino County's Public Guardian and BHRS Department; and, the conservatorship utilization data provided in Table 11 was provided by these two departments.

[19] Behavioral Health Concepts, Inc., *FY 16-17 Medi-Cal Specialty Mental Health External Quality Review, MHP Final Report: Mendocino,* September 13, 2016. Retrieved from http://www.caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202016-2017%20Reports/MHP%20Reports/Mendocino_MHP_EQRO_Report_Final_FY16-17_EST_v6.1.pdf Comparison county reports retrieved from https://www.caleqro.com/mh-eqro

[20] California Department of Health Care Services, *DHCS Medi-Cal Specialty Mental Health Services: May Estimate, Policy Change Supplement for Fiscal Years 2017-18 and 2018-19*. Retrieved from http://www.dhcs.ca.gov/services/MH/Documents/SMHS-Supplement-May2018-Est-2018-5-14-ADA.pdf

[21] California Department of Health Care Services, *County LPS Designated Outpatient Clinics and CSU.* Retrieved from http://www.dhcs.ca.gov/provgovpart/Documents/County_LPS_Designated_Outpatient_Clinics_and_CSU.pdf

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[27] Zeller, S., *Microsoft PowerPoint - PES Model,* December 9-10, 2013. Retrieved from http://www.calhospital.org/sites/main/files/file-attachments/pes_model_0.pdf

[28] RQMC, Data Dashboard – YTD FY1617 (revised 06182018), and Data Dashboard – FY1718 YTD (revised 7202018)

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[31] M. Evans, Crisis Manager, Sutter-Yuba Mental Health Plan, Phone interview May 25, 2018 (H. Gill)

[32] California Department of Health Care Services, *DHCS Medi-Cal Specialty Mental Health Services: May Estimate, Policy Change Supplement for Fiscal Years 2017-18 and 2018-19.* Retrieved from http://www.dhcs.ca.gov/services/MH/Documents/SMHS-Supplement-May2018-Est-2018-5-14-ADA.pdf

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Homelessness Needs Assessment and Action Steps
for
Mendocino County

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Presentation of Observations, Findings
and
Recommendation of Strategic Action Steps

by

Marbut Consulting

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Board of Supervisors Presentation of Draft Report - March 13, 2018

Community Presentation of Draft Report - March 15, 2018

Final Written Report - March 19, 2018

Prepared by Robert G. Marbut Jr., Ph.D.
www.MarbutConsulting.org

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Study Scope

Mendocino County's Health and Human Services Agency (HHSA) procured the services of Marbut Consulting to conduct a Homeless Services Needs Assessment and to develop Strategic Action Step Recommendations.

In order to develop practical recommendations, Marbut Consulting:

- conducted a wide range of interviews with stakeholders,
- conducted a series of site visits and tours of service providing agencies,
- interviewed individuals experiencing homelessness,
- studied and inventoried homeless services throughout Mendocino County,
- examined prior Point-in-Time-Count reports,
- analyzed statistics and reports from local agencies,
- made street-level observations,
- developed and conducted a 40-question survey of individuals experiencing homelessness,
- did ride-a-longs with local law enforcement agencies,
- posed as a person experiencing homelessness in order to understand what it is like to be homeless in this area and to better understand the movement and circulation of the homelessness community.

Using national best practices and the *Seven Guiding Principles of Homeless Transformation* as the key measuring tools, Marbut Consulting evaluated the current state of homeless service operations within Mendocino County. Marbut Consulting then conducted a needs assessment and gaps analysis between existing inventory and identified needs, including the types of services (qualitative) and capacity of services (quantitative) needed within Mendocino County. Dr. Robert Marbut formally started in Mendocino County on October 4, 2017. Dr. Marbut made a final community presentation of his observations, data analyses and recommendations on March 15, 2018. Marbut Consulting then finished this study and written report on March 19, 2018.

Because most of the individuals experiencing homelessness within Mendocino County are geographically located within and near the cities of Ukiah, Fort Bragg and Willits, the research conducted for this study focused in and around the cities of Ukiah, Fort Bragg and Willits.

From the signed contract:

EXHIBIT A
DEFINITION OF SERVICES

CONTRACTOR shall provide the following services:

I. Phase 1 - Inventory of Services (One trip):

A. The Consultant will review data provided by County, and then inventory and ascertain information about the types (qualitative) and volume (quantitative capacity) of services provided in the County of Mendocino.

B. The Consultant will complete:
   1. Inventory of shelter bed and mat units, transitional, recovery and long-term services
   2. Inventory of supportive services - types and volume of service (quantity and quality)
   3. Inventory of preventative services (e.g., utility assistance, rental assistance, etc.)

C. Consultant will meet with leadership from the County, City, and various service providers

II. Phase 2 – Needs Assessment (Two trips):

A. Using the above information as well as local statistical information including the Point-In-Time Count, the Consultant will conduct in-depth interviews with key service providers and stakeholders to include the following:
   1. Mendocino County Board of Supervisors
   2. City Councilmembers and City Managers
   3. City Law Enforcement and the Mendocino County Sheriff
   4. Judges, Public Defenders
   5. Librarians
   6. Representatives of the business community through merchant and realtor associations
   7. The Community Foundation of Mendocino County,
   8. Medical Providers and Street Outreach staff
   9. Service providers such as Mendocino Coast Hospitality Center, Plowshares, Ford Street Project, Redwood Community Services
   10. First responders
   11. Mendocino County Office of Education (Mckinney Vento Liaison)
   12. Family Resource Centers
   13. Faith groups who serve the Homeless
   14. Mendocino County Homeless Services Continuum of Care (MCHSCoC)

B. Consultant will conduct a Gap Analysis of services between inventory and needs.

C. Activities of Phase 1 and Phase 2 may overlap.

III. Phase 3 – Development & Framing of a Draft Action Plan:

A. The Consultant will prepare a draft action plan to include identified gaps in service needs in each area of the County based on critical homeless sub-populations, recommended reprioritization, and potential service augmentations for the community to reduce gaps in homeless services, potential funding recommendations and resources for an improved homeless services continuum in the community.

B. Consultant will perform strategic framing of the Action Plan, including in-person or tele-conferencing with elected officials, businesses, faith-based entities, civic groups, educational groups and other agencies.

IV. Phase 4 – Findings and Recommendations (One trip):

A. The Consultant will present the draft Action Plan to Health and Human Services Agency (HHSA) leadership and the MCSHCoC for comment and discussion. This phase will require the Consultant to conduct numerous briefings and forums throughout the County to government staff, elected officials, businesses, faith-based entities, civic groups, educational groups, and other agencies, including convening a homeless summit.

V. Complete and Present Draft Action Plan (One trip):

A. The Consultant will complete and submit the Draft Action Plan to HHSA. The Consultant may be requested to present the Draft Action Plan to the MCSHCoC or other community members.

B. HHSA Leadership will review the Draft Action Plan before it is finalized and will advise Consultant of any additional changes required before the Plan is considered final. Once finalized, the Consultant may be requested to conduct in person presentations of the final Action Plan with entities involved in the above-referenced phases, elected officials, businesses, faith-based entities, civic groups, educational groups, other agencies and community members. Approval of the Action Plan does not obligate HHSA to implement its recommendations.

Notes About Scope of Services:

- Many improvements will "organically" materialize during the gap and duplication analysis phase. During this time frame, Marbut Consulting may suggest improvement opportunities that naturally arise throughout this journey to HHSA and other stakeholders.

Major Observations and Findings (Qualitative Observations and Quantitative Data)

The Positives and the Opportunities

There is a tendency in such endeavors to focus on the negative rather than the positive. Therefore, before the challenges and gaps are addressed, there are a few observations that bode very well for the Mendocino County Community regarding the state of homelessness within the County that this researcher would like to share:

- Unlike many communities within California and around the USA, almost all of the stakeholders sincerely get along with each other and most of the key stakeholders truly like other stakeholders. This is highly unusual.

- Many of the recommendations contained within this report, after initially being suggested by this researcher, already have started to be implemented. Most of the service providing agencies have been very amenable to making recommended changes that will improve the effectiveness of service delivery. This too is unusual.

- This researcher believes there is a high potential of developing a consensus around most of the key issues facing the community as well as developing a consensus around strategic approaches to address the identified challenges. Since the residents of Mendocino County use so many different terms and definitions to describe sub-groups, and since different sub-groups have been incorrectly commingled, there is not an awareness of how similar some of the thinking is about the key issues facing the community.

- The number of year-round individuals experiencing "unsheltered" and street-level homelessness as defined by HUD (US Department of Housing and Urban Development's web site www.HUD.gov) is actually much lower than most stakeholders have been thinking. This means many of the recommendations contained in this report might be more manageable and doable to implement.

- Because of travel logistics and far distances among many of the cities within Mendocino County, very few individuals that are experiencing HUD-defined homelessness move from one city to another. This attribute makes it much easier to address the situation of homelessness within the County than it would be if there was a highly mobile population of individuals experiencing homelessness.

- The Willow Terrace project presents an amazing opportunity to house up to 37 individuals who are currently experiencing homelessness.

The Negatives and the Challenges

A Common Understanding of the Critical Challenges Does Not Exist: Many individuals and agencies within Mendocino County commingle a wide variety of sub-cohorts under the very broad umbrella of "homelessness." This commingling of very different groups under the one heading of homelessness blurs the real problems, and thus blurs the solutions. The reality is many individuals included under the overly broad umbrella of "homelessness" are not actually experiencing homelessness as defined by HUD. The HUD definition is important because most Federal and State funding sources utilize this definition to determine funding eligibility, and because it the most common standard definition used in the USA. The situation in Mendocino County will not improve unless there is first an accurate and common understanding of the different groups. Only after there is a common understanding of the differences between the different cohorts will the Mendocino County community be able to implement a customized set of actions to address the problems. In order to have a thoughtful dialogue and then to have a successful implementation of the ultimately adopted recommendations, the community must have a common and very clear understanding of who is actually experiencing homelessness and who is not. Furthermore, since different terms are used to describe the same group of individuals there are often blurred understandings about the different groups, as well as the overall issue. It is very important to realize that treating different groups with the same services can actually make the situation worse, and often ends up hurting the individuals who are truly experiencing homelessness. Analogous to the medical field, an incorrect diagnosis can lead to the wrong treatment which can lead to a very negative outcome.

Decision Making Has Been Mostly "Tactical" in Nature, and Not "Strategic": Historically, most decision making on issues of homelessness has been a series of tactical one-off decisions. Instead, decision making should start at the strategic level, and then move to tactical implementation.

Decision Making and Operations Have Been "Agency-centric," and Not "System-centric": Historically, most decision making has started and stayed at the agency level. This is also true with operations. Decision making needs to start at the "system-level," then move to the agencies. At the operational level, all agencies as well as informal groups, need to understand that each group is part of a larger "overall system" and thus need to operationally coordinate among groups/agencies. Agencies should no longer operate within independent silos.

The Lack of Good Data Has Led to Decision Making Based on Myths and Anecdotes: There is very little useful (eg actionable) County-wide data regarding single adults experiencing homelessness. The Point-in-Time Count (PITC) data is inflated (see comments below); furthermore, most organizations do not actively participate in the Federally mandated Homeless Management Information System (HMIS). This means there is no County-wide comprehensive tracking system at the individual level of individuals experiencing homelessness on a name-by-name basis. The overall lack of meaningful data means decision making has often been made based on myths and one-off anecdotes, rather than on hard data.

The Focus Has Been on Symptoms, Rather than on the Root Triggers of Homelessness: For the most part, many agencies and almost all the informal groups focus on the "symptoms" such as food, clothing and emergency shelter, rather than focusing on and addressing the root triggers of homelessness. The root triggers and causes of homelessness are almost all behavioral health in nature, such as addiction, post-traumatic stress disorder and domestic violence. In order to engage in meaningful recovery, the focus must be on the root triggers of homelessness, not symptoms. Community meals (both formal and informal) should be co-located and coordinated with services that address the root causes of homelessness.

There Is a Dearth of Substance Abuse and Mental Health Treatment Slots/Beds: There is a need for more behavioral health, mental health and substance abuse treatment slots/beds of all lengths of time. A coordinated entry approach should be utilized to prioritize the most appropriate candidates for available programs.

The Amount of Housing Placements is Low: Because of a low inventory of affordable housing and high occupancy rates, housing placements are very low relative to the need. Unfortunately, the recent fires have exacerbated this situation. There needs to be a mix of "rapid rehousing" units (eg 6-24 month time frames) and "permanent supportive housing" (eg 2 years or longer time frames).

Panhandling Has Become a Big Issue Around the Walmart and Safeway in Ukiah: The panhandling problem has become very pronounced in the parking lots between Walmart and Jack-in-the-Box and at Safeway. Additionally, this researcher observed extensive drug abuse and/or retail drug trafficking by most of the individuals who were panhandling and residing in these two locations. Merchants were especially vocal about the negative impact panhandling and drug dealing has had on their businesses. Unfortunately, more often than not, giving cash on the street to individuals does very little to promote recovery and actually funds the negative addictions that individuals have such as alcoholism and substance abuse. The fact that the panhandling is concentrated in a relatively small area of Ukiah exacerbates this negative impact. The proliferiation of stolen shopping carts also negatively exacerbates the situation in Ukiah, especially around these two locations. It is VERY important to note that most of the individuals involved in these negative activities at these two locations do not meet the HUD definition of homelessness.

Encampments Are Dangerous: There is a wide variety of encampments within Mendocino County, ranging from quite simple to very elaborate set-ups, and have temporary accommodations consisting of a mix of blankets, sleeping bags and tents. This researcher found encampments in both urban and wooded areas. Overall, these encampments are unsuitable for habitation, and are generally unsafe and unhealthy for the individuals living within them. Additionally, this researcher found that most encampments within Mendocino County pose serious environmental and vector control risks.

A Note on Current Child Research - The Negatives of Mixing Children With Adults: This researcher observed that many programs within Mendocino County have been commingling young children with single adult males and females experiencing chronic homelessness. This is very harmful to the future development of the children, and presents many unnecessary risks and liabilities to the service providing agencies.

Over the last 20 years, a new body of research has emerged that has been studying the long term neurobiological and physiological impacts of exposure to adverse experiences during childhood. These "toxic stress" experiences are now called "Adverse Childhood Experiences" (ACEs). The groundbreaking study in this research area was *Adverse Childhood Experiences Study (ACE Study)* and was led by California researchers Dr. Vincent Felitti and Dr. Robert Anda, and surveyed more than 17,000 adults. What they and others have found is having a high number of Adverse Childhood Experiences (eg traumatic experiences) during the most formative period of a person's life can have a highly negative impact on a child's developing brain and body, and this negative impact can last a lifetime. There are 10 specific formally recognized ACEs that a child can be exposed to during childhood. See the *Data Report - A Hidden Crisis: Findings on Adverse Childhood Experiences in California* by The Center for Youth Wellness for more information.

It is highly problematic to mix adult males who are experiencing homelessness with children since these children experience many more ACEs than children in the general population. Of the overall general population, 83.3% of the general population had 3 or less ACEs in their life time, and 60.0% of the general population had 0 or 1 ACEs in their childhood. Yet, children that are mixed in with adult males experiencing homelessness generally experience at least 4 ACEs on a daily basis (eg exposure to individuals with mental illness, to individuals with substance abuse, to people who have been incarcerated, etc.). The research has found that having 4 or more ACEs is a critical tipping point between good outcomes and poor outcomes.

People who were exposed to 4 or more ACE's during their childhood had the following increased serious health conditions compared to individuals who were exposed to 3 or less ACEs (partial listing of negative outcomes):

- 5.1 times as likely to suffer from depression
- 12.2 times as likely to attempt suicide
- 2.9 times as likely to smoke
- 7.4 times as likely to be an alcoholic
- 10.3 times as likely to use injectable drugs
- 2.2 times as likely to have ischemic heart disease
- 2.4 times as likely to have a stroke
- 1.9 times as likely to have cancer
- 1.6 times as likely to have diabetes
- 39% more likely to be unemployed

Census Counts for "Street-Level" Adults within the Three Most Populated Cities

In order to develop an effective and efficient plan it is critical to first ascertain and then fully understand the precise scope, scale and structure of the real situation of homelessness within Mendocino County. This starts by first having an accurate understanding of the total number of families and individuals experiencing homelessness. Therefore, the seminal data question that needs to be answered is how many families and individuals are experiencing homelessness.

This researcher found the data for families with children commonly known as *McKinney-Vento* data as defined by the Federal "*McKinney-Vento Homeless Education Assistance Improvement Act of 2001*" to be very accurate and robust. In Mendocino County the McKinney-Vento data is collected and evaluated by the Mendocino County Office of Education - Foster and Homeless Youth Services Office. Since the data for families with children accurately reflects the situation with families with children, this researcher focused most of his efforts within this study on collecting single adult data.

It is very important to note the Federal government has two different definitions and criteria for determination of homelessness. One is the Department of Education's (DoEd) McKinney-Vento definition for families with children, and the second is the Department of Housing and Urban Development's (HUD) definition that mostly covers single adults. In over simplified terms, the McKinney-Vento DoEd definition is a broader definition that includes families at risk of becoming homeless; whereas, the HUD definition is narrower and reflects individuals currently experiencing homelessness.

The Point-in-Time-Count (PITC) was developed by HUD with the hope of ascertaining the number of families and individuals experiencing homelessness within a community. Unfortunately, for a variety of methodological reasons, PITCs across the USA are often very inaccurate and vary widely in methodological rigor. This is a national challenge and many communities across the USA are struggling with this issue. Mendocino County's experience with this issue is thus not unique. Nationally, HUD has realized the weaknesses of PITC and has stated that it would like to move from using PITC data to using Coordinated Entry and Homeless Management Information System (HMIS) data (thus the new Federal mandate for having a coordinated entry system with HMIS tracking).

When PITCs are "incentivized" around the USA, like the giving out of grocery cards in exchange for participation, there is often over counting. In some cases, individuals change their name and information so they can receive another incentive. In other cases, volunteers give out more than one incentive to an individual or pocket the incentive thus inflating the numbers. Additional problems occur when volunteers count vehicles and building structures, and then apply non-scientific multipliers instead of counting actual people. These inflationary multipliers are often based on assumptions and not on rigorous data modeling. When it comes to counting within encampments, the numbers are often highly inflated since "recent activity or presence of

individuals" is often counted rather than counting actual observed individuals. Furthermore, because of weather and police activities, people often move between encampment sites which often means an individual's "activity" ends up being counted multiple times at multiple sites rather than only once at the site where they are actually currently living. Additionally, extreme good or bad weather on the day of the count can also increase or decrease the number of volunteer counters thus affecting the overall efficacy of the count. Weather can also change the patterns of individuals experiencing homelessness. Finally, when the count time is extended past a 24-hour period, individuals are sometimes counted more than once at different locations.

It should also be noted that the cold winter weather is the most powerful deterrence to year-round street-level homelessness within Mendocino County.

In order to get a number that accurately reflects reality, it is important to count actual persons during a very short and defined period of time in order to prevent double-counting. It is also important to not use non-scientific multipliers. These counts should then be validated against community meal counts since community meals/feedings can provide great cross-validating data.

It is important to note that the number of individuals fluctuates throughout the month with fewer individuals living on the street earlier in month, and more individuals on the street later in the month. This phenomenon occurs because many individuals receive Federal support funds at the beginning of the month and are able to afford short-term lodging for 2-3 weeks. But once the funding runs out, individuals move back to the street.

The following is a summary of a variety of data counts by this researcher in and around the three most populated cities within Mendocino County. With just one exception, this researcher was accompanied by at least one staff member from a local agency or a police officer on every count.

Ukiah within the City Limits Proper:

Individuals in 24/7 homelessness programming (meals included in programs):

18	Ford Street Project Emergency Shelter
3	Ford Street Project Respite Beds (emergency room outplacement beds)
12	Ford Street Transitional Beds
1	Levine House - Mendocino County Youth Project (on day of tour)
14	Project Sanctuary
58	RCS 24/7 Programs (a variety of programs NOT counting Winter Shelter)
106	Sub-Total within "housed" programs in Ukiah
+ 93-115	Street-Level count range including individuals staying in vehicles (not duplicated with 24/7 programs)

- 115 on 10/6/2017 street grid search count
- 101 on 10/7/2017 with PD street grid search count
- 93 on 11/9/2017 with Maya Stuart street count
- 102 on 11/11/2017 with PD street grid search count (34 were in vehicles)

- 60 on 12/13/2017 lunch at Plowshares (includes working poor individuals)
- 57 on 12/13/2017 dinner at Plowshares (includes working poor individuals)
- 59 on 12/14/2017 lunch at Plowshares (includes working poor individuals)

- 39-41 between 12/12/2017 and 12/14/2017 (Winter Shelter actual heads in beds)

= 199-221	Sub-Total Ukiah
- 27-33	Less individuals who did not meet the HUD definition of homelessness
= 172-188	Individuals experiencing homelessness per HUD definition.

Ukiah Perimeter - Outside the City Limits within Mendocino County:

26-37	Variety of count dates including 10/6/2017, 10/7/2017, 11/11/2017, 12/14/2017, 1/3/2018 and 2/3/2017.

Notes:

- Counts above did not include AIDS/HIV nor the more indirect Ford Street programs.
- Based on interviews with MCSO, no Jail data was used.
- Counts above were in line with other agencies providing supportive services.
- The 11/11/2017 count distinguished between in or out of vehicles.

Fort Bragg within the City Limits Proper:

Individuals in 24/7 homelessness programming (meals included in programs):

10	Hospitality Center (Transitional Housing)
24	Hospitality House Emergency Shelter
15	Hospitality North (Transitional Housing)
49	Sub-Total within "housed" programs in Fort Bragg

\+ 32 Street-Level and Comprehensive Encampment Count (on 12/15/2017 with "Batman" of HH):

- 24 non-resident guests at the 3pm meal
- 3 in encampments (unduplicated - did not attend the 3pm meal)
- 1 active backpack inside of a cemetery
- 4 on the street (unduplicated - did not attend the 3pm meal)

= 81 Grand Total Fort Bragg

Fort Bragg Perimeter - Outside the City Limits within Mendocino County:

25-30 Duplicated count for the perimeter of Fort Bragg on a variety of dates including 11/10/2017, 12/15/2017 and 2/3/2017, and these counts were validated by Fort Bragg Police Department. This includes individuals also counted during the 3pm meal at Hospitality House.

15-17 Unduplicated count for the perimeter of Fort Bragg (eg the above count minus the number of duplicated individuals who eat at the Hospitality House). There is a large encampment just outside the northern city limits of Fort Bragg numbering 8-15 individuals. Most of the individuals within this encampment often eat at the 3pm feeding at the Hospitality House.

Notes:

- Fort Bragg's Hospitality Extreme Weather Shelter had not opened at the time of the first count and is not 24/7. After opening on December 18, 2017, the Extreme Weather Shelter has been averaging 11.7 to 13.1 people per night.
- The Mendocino Coast Hospitality Center and Hospitality North program counts above assume full capacity. Yet, on 11/10/2017 during a formal tour of both facilities there were vacancies, therefore the count above is slightly inflated by 4-7 individuals.
- In order to validate the 12/15/2017 count, two additional "hot-spot" encampment and street-level counts were conducted by Fort Bragg Police Department, one with Brian Klovski and a separate one with Robert Marbut on 2/3/2018. Both of these counts (of 8 and 11) actually identified fewer individuals within encampments within Fort Bragg City Limits than the count on 12/15/2017.

Willits within the City Limits Proper:

3-6 Using the HUD definition of individuals experiencing street-level homelessness. On 1/5/2018 Brian Klovski and Robert Marbut conducted a comprehensive street-by-every-street "grid" search and a search for encampments using the HUD definition. Then on 2/1/2017, Brian Klovski and Robert Marbut conducted a thorough "hot-spot" search of every known encampment and sleeping area using the HUD definition.

17 As counted by the Willits Community Services & Food Bank. The Willits Food Bank has outstanding accreditation and tracking procedures which leads to a very accurate accounting of families and individuals experiencing homelessness. The Food Bank specifically tracks homelessness and their definition is very close to that of the Department of Education's McKinney-Vento definition

Willits Perimeter - Outside the City Limits within Mendocino County:

0 On 1/5/2018 Brian Klovski and Robert Marbut did an extensive grid search of the perimeter areas outside of the Willits City Limits. Several inactive encampments were found, but there was no evidence of recent activity. Additionally, no individuals were observed experiencing homelessness outside of the Willits City Limits.

Note:

- As would be expected, the Food Bank's number is higher than both the grid and hot-spot searches since the HUD definition of homelessness is significantly "tighter and more restrictive" than the DoEd's McKinney-Vento definition.

Survey Data Results and Analyses

Based on interviews of Mendocino County stakeholders, street-level observations within Mendocino County, anecdotal information and surveys by this researcher in other communities, a detailed data survey was developed by this researcher and HHSA staff. The survey was then administered at Ford Street, Hospitality House Meals, Plowshares Meals, Stepping Stones and Ukiah Winter Shelter. Surveys were administered during the December 13-20, 2017 time frame. No surveys were administered in Willits since there was not an active and daily program that targeted individuals experiencing homelessness.

It is very important to note that the focus of this data survey was on the "street-level" community that lives/sleeps on the streets, in drainage ditches, within encampments, in parks and actively uses emergency services. The overall "penetration rate" for this survey of qualified individuals was very high, with participation rates above 80%, and at some locations almost 100%.

Unlike the Point-in-Time-Count, this survey instrument was specifically designed to focus on issues relating to individuals experiencing street-level homelessness within Mendocino County. It is important to note that PITC is designed to address HUD oriented issues. Finally, PITCs often ask questions in ways that "undershoot" real-life durations/timelines of homelessness and thus miss what is actually going on in the real world (eg the PITC misses some of the major underlying issues because it is not statistically sensitive enough to detect the real issues).

Taking all these issues together (eg multiple unrelated sub-groups, narrow questions, "undershooting," etc.), PITC results often "mask" what is really going on within the narrower sub-population of street-level homelessness.

By focusing clearly on individuals experiencing street-level homelessness, we are able to have a higher level of clarity and a more robust understanding of what is really going on with the group of individuals experiencing street-level homelessness. The following is aggregated data from the surveys:

Gender:

Males represent 61.0% and females represent 39.0% of the surveyed street-level population experiencing homelessness. Mendocino County has more females by 8-12 percentage points than would be expected. Some of this difference might be occurring because there are more program slots for females relative to other communities.

Age:

The average age for individuals experiencing street-level homelessness is 44.4 years old and the median age is 46.0. The spread and direction between "average" and "median" are close to what would be expected. The overall average age and the median age are slightly younger than would be expected by 3-4 years each.

Age Started Experiencing Homelessness:

The average age an individual starts experiencing street-level homelessness in Mendocino County (or before the individual moved to Mendocino County) is 39.6 years old, with a median age of 41.0. The average age is younger than would be expected and the median is especially younger than would be expected by 2-3 years.

Chronicness Levels (Duration of Chronic Homelessness):

In over simplified terms, HUD defines *chronic homelessness* as a person who has been living on the streets for more than 1 year. This researcher then adds two categorical definitions called *super chronic homelessness* and *very super chronically homelessness* which this researcher defines as individuals who have been experiencing homelessness for 5 or more years and 10 or more years respectively.

Of all the individuals surveyed, the average total time experiencing homelessness was 4.8 years and the median was 2.3 years.

Broken down by length of time living on the street:

21.9 % . . . less than 1 year on the streets (not chronic homelessness),
78.1 % . . . 1 or more years on the street (chronic homelessness).

Of the 78.1% . . .

51.4% . . . 1.00 to 4.99 years on the street (this is strikingly high in relative terms).
26.7 % . . . 5 or more years on the street (super chronic homelessness),

Of the 26.7% . . .

9.5 % . . . 10 or more years on the street (very super chronic homelessness).

Length of Time Living in Mendocino County:

On an average, individuals experiencing street-level homelessness have lived in Mendocino County for 18.6 years, and a median of 14.5 years in Mendocino County. This is relatively high compared to other communities.

Family Living in Mendocino County:

Of all the individuals experiencing street-level homelessness, 51.4% have family members living in Mendocino County. When you add in family members who have passed-on who had been living in Mendocino County, the number moves up to 61.9%. Relative to other communities, local family connectivity is extremely high.

Location of High School Attendance:

Of all the individuals surveyed experiencing street-level homelessness . . .

11.4% attended High School in Ukiah
9.5% attended High School in Fort Bragg
5.7% attended High School in Willits
12.4% attended High School somewhere else in Mendocino County

39.0% attended High School anywhere in Mendocino County (Total in Mendocino County)
32.4% attended High School in California but not in Mendocino County
28.6% attended High School in the USA but not in California

Even though 39.0% attended High School somewhere in Mendocino County, this is much lower than expected, especially since 61.9% had family members living or passed-on in Mendocino County. This means many individuals "followed" their families to Mendocino County as adults after their 18th birthday.

Inbound vs. Homegrown Homelessness:

Of all the individuals surveyed that were experiencing street-level homelessness in Mendocino County, 60.5% were already living in Mendocino County when they started experiencing homelessness. This means that about 39.5% of the individuals surveyed were "inbound" and started experiencing homelessness outside of Mendocino County.

However, it is important to note that of the 20 individuals experiencing homelessness for the longest periods of time (6.3 years or longer), 13 of the 20 or 65.0% started experiencing homelessness outside of Mendocino County. Of these 13 individuals from outside of Mendocino County, their average length of time experiencing homelessness was 18.0 years, as compared to the 4.8 years for everyone who was surveyed.

It is interesting to note that of the top 20 most chronic individuals (inbound or homegrown), only 5 (25.0%) are active in structured programming.

Job History in Mendocino County Before and After Experiencing Homelessness:

Of all the individuals surveyed . . .

53.3% did not have a job in Mendocino County before experiencing homelessness
30.5% had a full-time job before experiencing homelessness
16.2% had a part-time job before experiencing homelessness

81.9% do not have a job now . . . this is extremely high
8.6% have a full-time job now . . . this is low
9.5% have a part-time job . . . this is extremely low

Movement Between Different Cities and Different Activities within Mendocino County:

Of the individuals surveyed, 94.2% spent 7 of their last 7 days in the same city, while 5.8% of the individuals moved between cities within their last 7 days of being surveyed.

Of a list of 20 places, programs and activities that individuals could go to, 1.0% reported going to or utilizing more than 10 activities, 30.5% reported going to or utilizing more than 5 activities, and 69.5% reported going to or utilizing 5 or fewer activities. This indicates a very low level of aggregate activity and mobility.

Beyond their "home-base" activity and going to meals, the only two activities that exceeded 50% "utilization" was partaking in at least one medical service during the last month (57.1%) and going to the library (51.4%).

Individuals Living in Vehicles:

With relatively lower numbers of people living in vehicles, it is unlikely to find "statistically significant" results; however, there are definite trends that may be useful for policy making. Specifically, based on in-the-field interviews and the surveys, there are pronounced differences between individuals living in cars ("car-campers") compared to individuals living in larger vehicles such as vans and motorcoaches ("van-campers").

On 11/11/2017, 34 individuals were observed living in vehicles within Ukiah city limits. On 12/15/2017 no individuals were observed living in vehicles within Fort Bragg city limits. Based on surveys, 78.6% of all vehicle sleepers base themselves in Ukiah.

Car-campers:

- are more likely to live alone in the car
- are more likely to be an introvert and do not want to sleep/live in group settings
- 7.1% surveyed used the Winter Shelter
- 92.9% eat at Plowshares or Hospitality House 5 or more days a week
- 50.0% had family in Mendocino County
- often parked around the Ukiah airport

Van-campers:

- are more likely to live in groups of two or more persons
- are a mix of introverts and extroverts
- are mostly from outside of Mendocino County
- are mostly parked in retail parking lots

Survey Data Analyses Takeaways

Mendocino County's Basic Demographic Traits Are Similar to Peer Communities, Except . . .:

In terms of basic demographic traits, Mendocino County is similar to that of peer communities, with the very important exception that the street-level homelessness population in Mendocino County is relatively more chronic, especially for individuals who have been living on the street 1-5 years. It should also be noted that Mendocino County's street-level population is slightly younger, with a slightly higher percentage of females.

There Are Three Broad Sub-Cohorts Within the Overall HUD-defined Homelessness Population:

Based on a variety of measurements (eg family members living or passed-on in Mendocino County, local high school attendance, job history in Mendocino County, total years experiencing homelessness in Mendocino County, etc.) there are three distinct sub-population cohorts within overall population of individuals experiencing HUD-defined unsheltered street-level homelessness within Mendocino County . . .

- Very homegrown . . . about 39%
- Somewhat homegrown - followed their family to Mendocino County . . . about 23%
- Not from Mendocino County . . . about 38% (this cohort is significantly more "chronic" than the two homegrown cohorts)

There Is a Very Large "Bubble" of Individuals Experiencing Chronic Homelessness 1-3 Years:

Within the 1.00 to 4.99 years group, there is a statistically significant "bubble" with a strikingly high number of individuals experiencing homelessness within the 1-3 year range. This high number of individuals in the 1-3 year range is a major problem and will present a significant challenge to the community because the rate of successful recovery starts dropping after 1 year, and then precipitously drops after 2 to 3 years. There will be major future issues if this group is not effectively addressed as soon as possible. Since this researcher does not have individualized data that pre-dates this "bubble," it is difficult to determine with certainty the cause of this bubble. The two most plausible explanations that this researcher analyzed were . . . 1) there have been three different public adult mental health providers over the last four years, and 2) the closure of the year-round Buddy Eller Center 4 years ago in 2014.

There Is Very Little Movement Between Cities and Among Activities:

For most of the individuals experiencing street-level homelessness, there is very little movement between cities within Mendocino County; additionally, most of the individuals surveyed stayed close to their "home-base" program with the exception of partaking in meals and medical services, and going to the library.

There Are Extremely High Levels of Unemployment and Underemployment:

There is an extremely low level of employment within the individuals surveyed, both before and especially after the onset of homelessness. A shockingly high number of individuals (43.8%) did not have a job before the onset of homelessness and do not have a job now.

Recommended Action Step - In Summary

Governance and County-wide Strategy Recommendations

1 - Need to Develop a Common Understanding of the Scope, Scale and Structure of the Problem, and Need to Use Common Nomenclature in Order to Improve Decision Making

2 - Gain "Buy-in and Agreement" for One Overarching Strategic Action Plan with Specific Action Steps by Most of the Community and Key Stakeholders

3 - Move from Tactical One-off Decision Making to Strategic Decision Making Based on Data

4 - Move from Agency-Centric to System-Centric Decision Making (Need More Collaboration and Less Silos)

5 - Reduce Duplication of Services While Increasing Agency Specialization

6 - Need to Operate at Maximum Capacity by Increasing Utilization of the Overall System

7 - Need to Fully Build-out and Then Robustly Utilize HMIS

8 - Encourage All Organizations and the General Public to Engage, Rather Than Enable Individuals Experiencing Homelessness

9 - Improve Strategic Coordination Between the County and Cities (Need More Collaboration and Less Silos)

Clinical Recommendations

10 - The Different Cohorts Need To Be Treated Differently Based on Clinical Needs

11 - Establish System-wide Service Eligibility and Triage Criterion (with Emergency Protocols)

12 - Whenever Possible, Separate Children from Chronic Adults

13 - Create a County-wide Virtual Master Case Management System

14 - Create Street-Level Outreach Team Capacities, Especially in Ukiah

15 - Create/Source Meaningful Mental Health and Substance Abuse Rehabilitation Slots

16 - Need Only One Day-Service-Center in Ukiah

Sheltering and Transitional Housing Recommendations

17 - Must Have a Winter Shelter in Ukiah, However it Is Inconclusive If an Extreme Weather Shelter Is Needed in Fort Bragg

18 - Need to Strategically Optimize Placement at Willow Terrace When it Opens

19 - Source New Housing Opportunities of All Types Whenever Possible

Public Space Issues

20 - Have a Zero Tolerance Approach to Encampments

21 - Address the Issue of Stolen Shopping Carts

22 - Engage Van-campers, and Impound Vehicles When Necessary

23 - Engage Car-campers

Longer Term Recommendations

24 - After the Willow Terrace Opens, After Duplication is Reduced, and After Utilization is Increased, then Re-look at the Overall System Volume Needs

25 - Need to Conduct Deeper Data Dives Into the Issues of Employment, Out-of-towners and High Levels of Chronicness

26 - Replicate the Data Analyses Within This Study in the Remainder of the County

27 - Create and Implement a Public Relations Campaign in Order to Engage the General Public as a Proactive Partner with this Effort

28 - Set Up a Feed Back Loop to Guide Ongoing Improvements . . . Set Up a Checkup Plan

Recommended Strategic Action Steps - In Detail

Governance and County-wide Strategy Recommendations

1 - Need to Develop a Common Understanding of the Scope, Scale and Structure of the Problem, and Need to Use Common Nomenclature in Order to Improve Decision Making

In order to have a thoughtful dialogue and then successful implementation of the Strategic Action Steps below, the community needs to have a common point of departure to include a common understanding of the different cohorts of individuals and an appreciation of the distinctions between these different cohorts.

Overall, this researcher found a surprising high level of consensuses around many of the issues facing Mendocino community. But, since the local residents use so many different terms to describe the same groups and/or issues, there is not an awareness of how similar the thinking is about issues facing the community. Furthermore, since so many different terms are being used to describe the different groups of individuals being studied, there are very blurred understandings of the root causes of many of the challenges facing the community. Increasing nomenclature clarity and understanding will improve the deployment of limited resources.

In an attempt to create common nomenclature and hopefully better understandings of the root causes, this researcher proposes the following descriptive nomenclature:

Very Homegrown Individuals Experiencing Street-Level Homelessness:
- defined as individuals experiencing homelessness per Federal HUD guidelines,
- local year-round residents,
- all have deep family connections to the community,
- most attended local high schools.

Somewhat Homegrown Individuals Experiencing Street-Level Homelessness:
- defined as individuals experiencing homelessness per Federal HUD guidelines,
- local year-round residents,
- most have deep family connections to the community,
- many attended local high schools,

Out-of-Town Individuals Experiencing Street-Level Homelessness in Mendocino County:
- most of these individuals meet the definition homelessness per Federal HUD or McKinney-Vento guidelines,
- mostly year-round,
- no family connections to the community,
- almost all attended high schools outside of Mendocino County,
- significantly more chronic than homegrown individuals experiencing homelessness.

Not HUD-defined Individuals Traveling North-South (*North-South Travelers*):

- individuals are not experiencing HUD-defined homelessness,
- individuals passing through on their way north and south on SH-101 or SH-1,
- generally spend most of their time around Walmart, Jack-in-the-Box and Safeway,
- most of the "van-campers" are in this cohort,
- often episodic and seasonal – seldom continuously in Mendocino County year-round,
- most "panhandle" often,
- high incidences of drug use and drug selling,
- the number of individuals spikes before and after special events,
- includes almost all of the seasonal *trimigrants*,
- have high negative impacts on the environment,
- creates sanitary, disease and vector control issues,
- many have camp fires that can cause dangerous wild fires.

It is very important for the Mendocino community to understand that most of the individuals within the *North-South Travelers* cohort are not truly experiencing homelessness.

It is recommended to implement a public awareness campaign in order to educate the service agencies and the general public about the unique characteristics and issues associated with these four different cohorts above. Furthermore, it should be understood that different types of engagement are needed for different groups.

2 - Gain "Buy-in and Agreement" for One Overarching Strategic Action Plan with Specific Action Steps by Most of the Community and Key Stakeholders

After developing a common community understanding of the key challenges facing Mendocino County in regards to issues of homelessness [See Recommendation 1 Above], the broader community and key stakeholders need to "buy-in" to one overarching strategic action plan with specific strategic action steps.

This researcher proposes 28 specific strategic action steps within this report. However, for a plan to be successful and sustainable, the plan must become *Team Mendo's* plan, not this researcher's plan.

It is recommended that the Mendocino community move quickly to evaluate this report and its proposed recommendations, and then move to accept and/or amend and/or reject the specific recommendations.

It is critical to keep the current momentum going by quickly moving to formally adopt a set of action steps.

3 - Move from Tactical One-off Decision Making to Strategic Decision Making Based on Data

Unfortunately, with very little actionable scientific data available, past decision making has often been based on myths and anecdotes, and not been based on facts. This lack of quality data has allowed un-validated "myths" to become operational "facts." This means decisions have been mostly "tactical/stand-alone/one-off" actions rather than being part of an overarching strategy.

Myth and anecdote driven decision making more often than not wastes precious resources and seldom leads to improved outcomes, and sometimes can actually make things much worse. Instead, decisions should be grounded within an overall strategic plan (and not be a series of one-off tactics). Furthermore, the lack of good data inhibits good strategic level policy making and discourages coordination and integration of the "continuum of care."

Going forward, decision making should always start first with scientific data. When data is not available, then efforts must be made to find good data. Once good data is available, then and only then can thoughtful strategic decisions be made. Finally, once the overarching strategy has been set, then start implementing specific tactical actions.

4 - Move from Agency-Centric to System-Centric Decision Making (Need More Collaboration and Less Silos)

Unfortunately, the current approach is very "agency-centric" and not "system-centric." The Mendocino Community needs to change how it addresses the issue of homelessness by becoming more of a "team" and less of a collection of individual players. This includes service agencies, faith-based organizations, volunteers, staffs, donors, funders, government agencies, programs, residents, and the individuals experiencing homelessness. The mission should no longer be to "serve" the homelessness community, instead the mission should be to dramatically and consequentially increase "street graduation" rates.

To do this, the Mendocino community needs to move from the current "Agency-Centric" model to a *"System-Centric"* model in all aspects of operations to include strategic decision making, policies, protocols, grant funding and tactical operations.

A coordinated strategic "systems-approach" throughout Mendocino County should be implemented. This effort should not be agency-centric nor should it be a series of isolated "one-off" arrangements, instead, it should be fully coordinated and integrated. This can be accomplished effectively through changes in funding requirements by Mendocino County, the Continuum of Care (MCHSCoC) and other funding organizations. Additionally, decisions should be made based on performance and not be based on historic funding levels. Service providers need to work together as partners within a single coordinated holistic system in order to better help individuals move from the streets and encampments into formal service programs.

5 - Reduce Duplication of Services While Increasing Agency Specialization

Considering the size of the community and the number of individuals experiencing homelessness, it was very surprising to this researcher to identify many areas of service duplication. For example:

* Currently, within Ukiah, there are 3 functioning "day-centers" (eg locations that provide a variety of day-time services). Two are formal operations, the 1st is at MCAVHN (Mendocino County AIDS/Viral Hepatitis Network) and the 2nd is at Manzanita Services, Inc's Wellness Center. The Ukiah Library also operates as an informal defacto 3rd day-center. Looking to the future, a 4th day-center is planned to be opened by RCS adjacent to the Ukiah Winter Shelter. Additionally, Nor Cal Christian Ministries has submitted an application to the City of Ukiah to operate a would be 5th day-center in South Ukiah. In addition to general services, most of these service centers provide specialized niche services to specific groups. As a practice, in most cases, individuals beyond the targeted service groups have also utilized these service centers. The current situation has not been strategically coordinated.

* In Fort Bragg, there are 3 different medical clinics within a 2-block radius that service individuals experiencing homelessness: Mendocino Coast Clinics (MCC), Ukiah Valley Rural Health Center Medical Clinic and North Coast Family Health Center. These are beyond the extensive services accessed at the Mendocino Coast District Hospital.

* In Ukiah, the Ford Street Project and RCS have been offering overlapping services to both adults and families with children. After inquiring about the overlap by this researcher, Ford Street Project has taken positive steps to start reducing prior overlaps in services.

* On occasion shortly after the Ukiah Winter Shelter had opened in the Fall of 2017, both RCS's Ukiah Winter Shelter and the Ford Street Project were saving hospital outplacement beds for the hospital. Beyond the duplication problem, this situation was creating an unnecessary excess inventory of outplacement beds, thus crowding out other possible and better uses for the inventory. Again, after inquires by this researcher, both RCS and the Ford Street Project have taken steps to address these inefficiencies.

Service duplications such as above have several negative effects to the overall system: creates inter-agency inefficiencies, creates intra-agency ineffectiveness, crowds out utilization of excess inventory by other programs, dilutes core competencies of agencies, and opens the "system" up to "service-shopping."

Strategic thinking and meaningful dialogue are needed in order to reduce duplication of services, improve inter-agency efficiencies and increase intra-agency effectiveness. This in turn will lead to higher levels of agency specialization.

6 - Need to Operate at Maximum Capacity by Increasing Utilization of the Overall System

Interconnected with the reducing duplication [See Recommendation 5 Above], is the concept of attaining maximum utilization of the overall system's physical capacity at all times. Unfortunately, at times, many agencies have had physical excess capacity (eg they have functional vacancies).

This researcher observed three different incidences when individuals were told there were no beds/rooms for them, yet that agency had vacant beds/rooms. There are a variety of reasons for this underutilization. In the first case it was triggered by governmental restrictions, in the second case it was caused by operating procedures, and in the third case is was an inter-agency contract restriction.

Agencies and governments must work to reduce institutional impediments that impede 100% utilization of physical capacity 100% of the time. This is especially important since the housing vacancy rate is so low in Mendocino County.

7 - Need to Fully Build-out and Then Robustly Utilize HMIS

Mendocino County's HMIS (Homeless Management Information System) participation rates are significantly lower than general participation rates within California. The existing HMIS data is thus "thin," which limits meaningful strategic decision making based on HMIS data. For the most part, HMIS data is currently limited to the Federal requirements and does not provide a rich enough understanding of the "uniquenesses" that exist within Mendocino County. Additionally, the lack of universal quality data allows un-validated "myths" to become operational "facts," thus hindering thoughtful strategic decision making. This lack of quality real-time data also prevents the "system" from being integrated and coordinated, and weakens the coordinated entry system.

Currently the HMIS system is predominantly being used as a "score-keeper" for Federal compliance, and is not being utilized to coordinate master case management nor is it being used to track individual recovery plans.

Going forward, HMIS could become much more robust and powerful, and HMIS could move from being a passive score-keeper to being a proactive case management tool within a truly integrated case management system. A high functioning and universally utilized HMIS system could become the *e-backbone* to a "*County-wide virtual case management system*" [See Recommendation 13 Below].

In order to promote universal agency participation, all funding to any service agency provided by any governmental source and/or from a foundation should become contingent on the service agency being a proactive participant within HMIS. Carrots need to be created to encourage agencies to use HMIS, likewise, there must be financial consequences for not using HMIS.

Additionally, in order to maximize agency use of HMIS, a system-wide all-agency information release-form should be developed and utilized by all agencies.

Simply put, HMIS data entry needs to be in "real-time," it needs to be universal and it needs to extend well beyond HUD-funded programs in order to facilitate coordination of care across the entire service Continuum of Care (CoC).

8 - Encourage All Organizations and the General Public to Engage, Rather Than Enable Individuals Experiencing Homelessness

While many efforts within Mendocino County are well natured and well intended by good-hearted individuals, many efforts within Mendocino County are actually enabling and do little to engage individuals who are experiencing homelessness into recovery programs. Cash from panhandling - although well intended by nice folks - more often than not actually perpetuates and increases homelessness through enablement. A much more effective and affective way of helping individuals experiencing homelessness is to make direct donations to high performing agencies rather than giving street handouts of food and cash. Some individuals and organizations within the Mendocino community need to move from a *Culture of Enablement* to *a Culture of Engagement*.

The mission should no longer be to "serve" the community of homelessness, instead the mission should be to dramatically and consequentially increase "street graduation" rates. A "culture of service" is more often enabling than engaging. Providing basic "band-aid" services is not the same as having a mission that is proactively focused on recovery and increasing the number of street graduations. Street graduations occur when individuals move from living on the streets (or within encampments) into sustainable quality of life situations that allow individuals to be more productive community citizens.

To maximize positive outcomes, support services such as feeding and clothing efforts should be provided within the context of a comprehensive holistic recovery environment. Recovery very seldom occurs on the street, instead, recovery most often occurs when an individual is actively engaged in a 24/7 treatment/recovery program. The community should help everyone who wants help, and the individuals who want help, should always be provided engaging help. Likewise, individuals who turn down help, should not be enabled. Furthermore, "hanging-out" should be replaced by "program participation." Every effort possible must be made to engage individuals into programming.

If unproductive activities continue in the same way, the number of individuals experiencing street-level chronic homeless (as well as the North-South Travelers) will continue to increase significantly. Furthermore, the North-South Travelers cohort will likely become more aggressive and emboldened.

It is very important to note that engagement should never be hateful or mean, instead, engagement should always be kind, caring and compassionate.

There needs to be an across-the-board *"Change in Thinking and Change in Doing*." A public awareness campaign needs to be developed to educate and encourage the community to move from a culture of enablement to a culture of engagement with the goal of increasing street-graduations.

9 - Improve Strategic Coordination Between the County and Cities (Need More Collaboration and Less Silos)

Just as homelessness service providing agencies need to collaborate more and be less siloed, so do all the government agencies.

In the past, within the realm of homelessness issues, many governmental actions of one jurisdiction have been made without collaborating and coordinating with other governmental jurisdictions within the County.

The same principles and concepts of Recommendation 4 apply to this recommendation [See Above]. To get the best overall outcomes and results, all governmental jurisdictions should proactively collaborate and coordinate all their decision making and activities as it relates to issues of homelessness.

The County and City Governments need to collaborate more and become less siloed.

Furthermore, it is important that all changes of services, whether at the tactical or strategic level, be implemented on a regional basis whenever possible.

Finally, It is very important not to spend limited resources in such a way as to relocate problems and challenges to other parts of the County. It is simply very unproductive to move the challenges rather than to directly address the core issues.

Clinical Recommendations

10 - The Different Cohorts Need To Be Treated Differently Based on Clinical Needs

The service agencies and the general public within Mendocino County need to realize that it is critical to treat the 4 different cohorts identified in Recommendation 1 differently based on behavior and clinical needs [See Recommendation 1 Above].

Because of the different clinical needs within each cohort, it is critical that each cohort be treated uniquely. Furthermore, if these cohorts are treated the same there then will be a variety of very negative outcomes for both the individuals within the cohorts and for the community-at-large. These 4 different groups must be treated differently based on behavior and clinical needs.

For example, a home-grown individual experiencing HUD-defined year-round homelessness needs engagement and help. On the contrary, providing the same type of support to a North-South Traveler will actually encourage the traveler to stay longer, thus increasing the number of negative outcomes. Additionally, because of the robust communication channel within these cohorts, providing support to North-South Travelers will actually attract more North-South Travelers to Mendocino County.

Very Homegrown and Somewhat Homegrown Cohort: In order to not dilute the effectiveness of the finite available resources, the focus should be to proactively helping the two homegrown cohorts who are actually experiencing homelessness. It is especially important to focus on the individuals who have been experiencing homelessness for the 1-3 year range. The Federally mandated Homeless Management Information System (HMIS) would be an ideal tool to help determine need and eligibility for support services.

Out-of-town Cohort: In order to maximize the funding available for the 2 homegrown cohorts, individuals who started experiencing homelessness before they moved into Mendocino should be encouraged to reunify with their families when clinically appropriate. Additionally, at a clinical level, in most but not all situations, there is a better chance of recovery when the individual is within familiar surroundings and near family. Therefore, Out-of-Town individuals should be encouraged to receive services in their hometowns where there are higher chances of recovery.

North-South Travelers: It is simply illogical for citizens and service agencies with limited resources to be giving clothing, backpacks, food, money, gas and camping equipment to individuals who are not actually experiencing HUD-defined homelessness. These types of handouts actually enable and exacerbate the negative environmental and economic impacts while raising the risks of serious fire incidents. Furthermore, criminal elements within this cohort should not be enabled, even at the misdemeanor level. It is very important to remember that North-South Travelers are not experiencing homelessness.

Simply put, if an individual is not on the year-round local HUD-defined HMIS list, they should not receive services over an extended period of time. Additionally, there must be universal resolve not to hand out limited resources to individuals not truly experiencing homelessness. A public awareness campaign needs to be developed then implemented to educate the services agencies and the general public about who is eligible to receive services once eligibility standards have been established. The community needs to reserve the limited available resources for the most needy families and individuals who are really experiencing homelessness.

11 - Establish System-wide Service Eligibility and Triage Criterion (with Emergency Protocols)

The Mendocino County Homeless Services Continuum of Care (supported by HHSA) should lead an effort to establish system-wide eligibility requirements for services across the County.

If all the service providing agencies had excess available funding to cover all the out-of-Mendocino County individuals, then this would not be an issue. However, most agencies are barely at break-even while some are struggling to fund existing operations. The data clearly indicates that just over 1/3rd of the individuals utilizing services within Mendocino County started experiencing homelessness outside of Mendocino County and subsequently came later to Mendocino County. In reality, this means funding for homegrown individuals experiencing homelessness is being diluted and crowded out by individuals from outside of Mendocino County that are receiving services.

Ideally all formal service agencies and informal organizations providing services within Mendocino County should be using the same eligibility criterion.

Beyond addressing legitimate budget issues, establishing common eligibility criterion will also help to streamline the coordinated entry process and will deter non-residents from coming to Mendocino County in search of services. Common criteria will also reduce the "service-shopping" phenomenon.

This does not mean individuals should not receive services! In times of emergencies, enough services should be provided to allow the individual to make it back home. The Willits food bank has successfully addressed this issue in a very compassionate way. When individuals do not meet residential requirements based on thoughtful and rigorous criterion, individuals are given a "3-day" bag of food. Furthermore, Willits Food Bank limits non-residents to just two "3-day" bags per year.

This concept can easily be replicated across other service types. At the time of the drafting of this report, RCS's Ukiah Winter Shelter has already started to move to such a model by allowing individuals from outside of Mendocino County to stay just 3-days and 2-nights thus allowing time for the individual to make arrangements to get back home.

It should be noted that in some limited cases there might be Federal or State funding requirements that supercede the new system-wide criterion. These exceptions will be few.

12 - Whenever Possible, Separate Children from Chronic Adults

This researcher observed families with children closely commingled with chronic single adult males at almost every agency within Mendocino County, including but not limited to sleeping overnight at the Ukiah Winter Shelter together, being on the grounds at Hospitality House together and eating at Plowshares together.

Families with children must be separated away from single adult males as much as possible, and as soon as possible. This includes all types of contact including queuing in lines for meals.

By all measures, the mixing of children with adult males who are experiencing homelessness does not meet national best practices as it is risky, dangerous and unnecessarily increases legal exposure. It is very important to note that this type of commingling also creates unhealthy and negative developmental issues in children. Furthermore, this mixing can exacerbate the inefficiencies in the placement process and inhibit optimal utilization of service inventory. This is why centers/programs/shelters across the USA have moved to separate families with children from single men (and sometimes single women).

Ideally, all families with children should be separated at least from adult males, and when possible separated from adult females. However, the realities of building capacities and physical layouts may not allow for the ideal setup, at least in the short term.

Additionally, at a clinical level, it would be good for all single adult females to be separated from the single adult males. Ideally, single adult females would have their own dedicated shelter or dedicated section within a shelter that focuses solely on adult females. On a practical level, single adult females could be a subsection of a shelter for families with children. Although less desirable, if properly designed and operated, single adult females can live in a separately demarcated section of an adult male shelter.

More due diligence needs to be conducted in order to successfully address this issue.

13 - Create a County-wide Virtual Master Case Management System

Unfortunately, there are not enough financial resources available within Mendocino County to create an actual face-to-face master case management system. However, a "virtual" case management system could and should be developed within Mendocino County for individuals experiencing homelessness by using HMIS as the data "*e-backbone*" for the overall system.

As part of this virtual system, a monthly Case Conference Meeting could be organized with agency case managers, police officers, fire rescue personnel, hospital social workers, and representatives from HHSA. It is suggested to have a coastal meeting in Fort Bragg and a separate inland meeting in Ukiah. Other communities around the USA have found the first Friday of every month between 2p-4p works really well. It is recommended to proactively focus on 2-3 individuals each month prioritized by individuals with higher service use levels (eg relatively more contacts with EMS, hospital ERs/EDs and social service agencies). These meetings could be hosted by HHSA or the CoC.

Because of the unique 1-3 year bubble group in Mendocino County, it might be productive on a monthly basis to also focus on one or two individuals who have been experiencing homelessness for 1-3 years, thus trying to reduce the number of individuals who will become "very chronic" due to the lack of treatment intervention.

It is recommended to start with single adult males, and then move to single adult females. When needed, families with children could be addressed at these monthly case conference meetings. The key to success is to focus on only 2-3 individuals per meeting and to develop individualized action plans for each person for the following month.

Ideally overtime, HHSA and the CoC could work to improve and develop the virtual case management system into a comprehensive coordinated entry system that mirrors a fully operational master case management "system" for individuals experiencing homelessness.

"Master Case Management" and "agency level case management" are often wrongly presented as the same functionality. There is a major difference between master case management and agency level case management – the first is holistic case management across the entire system of all agencies, while the second is only within an individual agency.

14 - Create Street-Level Outreach Team Capacities, Especially in Ukiah

More than 20 years ago, San Diego California was the first city in the USA to formally create a "Homeless Outreach Team," often known as a HOTeam. Under the San Diego model, two sworn police officers were given specialized social service training and then partnered together and focused solely on engaging individuals experiencing homelessness. Overtime, other jurisdictions such as St. Petersburg Florida, improved on this concept by partnering a sworn Law Enforcement Officer (LEO) with a highly trained and specialized non-sworn social worker.

These HOTeams have proven to be very useful in engaging individuals experiencing homelessness and have aided in significantly reducing street-level homelessness in numerous communities across the USA. These HOTeams have proven to be positive segues between law enforcement, service providing agencies and the community of homelessness.

Because of the unique characteristics and high number of individuals experiencing homelessness in Ukiah, it is strongly recommended to create one HOTeam in Ukiah. Because of funding realities, it is recommended to start this initiative as a 90-day pilot program. Then evaluate the this initiative after 90 days to see if it is worth continuing (eg did it work?, is there more work to be done?, etc.). Possibly partner a Ukiah PD Officer with a County funded social worker from either Street Medicine or RCS.

Ideally, this HOTeam would be the primary engagement tool for street-level engagement of individuals into 24/7 service programs. This HOTeam would be the initial proactive point of contact for both individuals experiencing homelessness and the North-South Travelers.

In addition to the specialized HOTeam, most LEOs in the County should go through at least a minimal level of homelessness engagement and sensitivity training.

15 - Create/Source Meaningful Mental Health and Substance Abuse Rehabilitation Slots

There are a limited number of short-term and long-term referral treatment options for individuals within Mendocino County. A critical need exists for additional behavioral health and substance abuse rehab beds/slots of all kinds, including long term treatment options for individuals receiving 5150s (State of California 72-hour holds for mental health crisis intervention). An action oriented task-force within the umbrella of either HHSA and/or CoC should be tasked with working to create and source added inventory.

16 - Need Only One Day-Service-Center in Ukiah

This recommendation is closely tied to Recommendation 5 (See Above - reduce duplication). Currently Ukiah has 3 functioning "day-service-centers" that provide a variety of services during the day:

1st MCAVHN (Mendocino County AIDS/Viral Hepatitis Network),
2nd Manzanita Services, Inc's,
3rd A defacto day-center at the Ukiah Library.

Beyond general services, most of these service centers have been providing specialized niche services to specific groups (eg specialized medical and mental/behavioral health services). As a practice, in most cases, individuals beyond the targeted service groups also have been utilizing these service centers.

There is a 4th service-center that is planned to be opened in Ukiah adjacent to RCS's Winter Shelter and an application is pending for a 5th service-center to be operated by Nor Cal Christian Ministries.

The current situation is not the result of a strategically developed decision making process.

Having so many day service centers in a small area will likely produce many unintended negative affects and effects for both the individuals experiencing homelessness and for the general public within Ukiah. The negative issues will likely include:

- Reduction of case management accountability,
- Dilution of service impacts,
- Increased "service shopping,"
- Expansion of the bread-crump trail through neighborhoods.

Looking to the future, based on the number of individuals experiencing homelessness, there only should be one location where "day services" are provided in Ukiah. This researcher understands that there has been efforts to coordinate in this area, but during the time of this research project, the services being delivered in this area were a series of individualized tactical decisions, rather than being part of a coordinated strategic effort.

All the above agencies should work together to merge their efforts and resources at one single location (a possible logical single location would be adjacent to RCS's Winter Shelter).

Sheltering and Transitional Housing Recommendations

17 - Must Have a Winter Shelter in Ukiah, However it Is Inconclusive If an Extreme Weather Shelter Is Needed in Fort Bragg

Based on the survey data and actual shelter use data, there is a critical need for a Winter Shelter within Ukiah. As for Fort Bragg, the data is less conclusive on a need for an Extreme Weather Shelter within Fort Bragg.

For the purpose of this report, a "winter shelter" is a facility that opens and then continuously operates for a defined period of time during the winter, whereas, an "extreme weather shelter" only opens on an as needed basis when the weather is so extreme that it hits certain codified thresholds that trigger the opening of a facility on a temporary basis.

In Ukiah, based on the research data, there is an actual need for a year-round emergency shelter for homegrown individuals, especially for single adult males and to a lesser extent adult females. Since the RCS Winter Shelter already exists, the most cost effective way to create year round inventory would be to add additional operating months to the current Winter Shelter schedule (rather than creation of a new facility).

It is critical to thoroughly think through sheltering options well in advance of any possible new openings and changes. If sheltering is developed without admission criterion, and if thoughtful clinical protocols/procedures are not utilized, it is then possible that the overall situation could get worse for both the individuals experiencing homelessness and the community-at-large. Like medical patients that are harmed by receiving an incorrect diagnosis that leads to a bad treatment plan, individuals can be harmed by having bad screenings, protocols and procedures at a shelter.

In order to have positive outcomes, any sheltering operation in Mendocino County, whether seasonal or year-round, must have and/or do the following (partial listing of key protocols and procedures):

- be limited to individuals experiencing HUD-defined homelessness,
- guests need to be established within HMIS,
- stays longer than 3 days should be limited only to homegrown residents of Mendocino County,
- have holistic wrap-around services that address the core triggers of homelessness on-site,
- have proper design buffers.

As for Fort Bragg, the data does not indicate the need for a "winter shelter," and the data is inconclusive on the possible need for an "extreme weather shelter." Ideally, further evaluation would occur after realizing the improvements connected to implementing the recommendations of this report, especially Recommendations 5, 6, 10 and 11. After assessing the improvements, there might be a need for an extreme weather shelter - or - there might be a simpler alternative that addresses the lower residual need - or - it might not be needed at all.

18 - Need to Strategically Optimize Placement at Willow Terrace When it Opens

The Willow Terrace project presents an amazing opportunity to positively house up to 37 individuals who are currently experiencing homelessness. This is an one-time opportunity that must get done correctly from the start. Doing it correctly would create an amazing opportunity to reduce street-level homelessness while helping 37 individuals. However, inappropriate placements could actually make things worse for the adjacent neighborhood and fail to help the individuals that the program is trying to help.

This researcher recommends that HHSA take the lead in working with the developers, key stakeholders and other relevant agencies to develop admission placement protocols and procedures that would maximize the chances for success for the incoming residents.

Based on analysis of the survey data, especially around the issues of homegrowness and mobility, this researcher strongly recommends placing as many Ukiah residents into Willow Terrace as possible.

19 - Source New Housing Opportunities of All Types Whenever Possible

There is a critical need to increase the number of both "short term" and "longer term" housing placements across the spectrum for men, women and families with children. To be successful, there needs to be an increase in inventory capacity of all types of housing within Mendocino County.

Because of Federal budget cuts, which started during the Obama administration and have continued under the Trump administration, the financial burden is shifting to local governments to fund additional short-term transitional rapid-rehousing units and longer-term supportive housing units. The reality is there likely will be less Federal funding going forward for programs such as Rapid Rehousing and Permanent Supportive Housing.

Less Federal funding is only the first challenge. The second challenge is the fact that Mendocino County's housing vacancy rate is functionally at 0%, and the recent fires have only exacerbated this tight housing market.

The Willow Terrace project could be a great source for housing placements especially for Ukiah residents. Additionally, the proposed monthly case management meetings outlined in Recommendation 13 [See Above] would be ideal forums to vet and select housing candidates when housing opportunities arise.

The CoC should proactively pursue multiple initiatives to increase the affordable housing stock:

+ as challenging it will be, try to obtain more Federal vouchers,
+ partner with developers to maximize the use low-income-housing-tax-credits,
+ pursue housing first developers,
+ tap into the state housing trust fund,
+ encourage faith-based organizations to adopt, mentor and fund one-person/family a year,
+ conduct due diligence on the possibility of developing and placing "tiny-houses."

All of the possible initiatives listed above have pros and cons. Vouchers are very useful and effective, but Federal budget cuts combined with higher rental rates will likely reduce the number of vouchers available. Low income tax credit housing is one of the best Federal programs in existence, however, this program is very competitive. Many of the housing first type programs are very expensive since it would likely entail developing/constructing new inventory. Tiny-houses have been proven to be useful for short periods of stay, but the evidence is inconclusive for longer term habitation. Additionally, most if not all of these solutions will have highly emotionally charged NIMBY'ism zoning and siting challenges.

Finally, service providers need to develop educational training programs that better prepare individuals and families for the challenges they will face in the future once they receive housing placements.

Public Space Issues

20 - Have a Zero Tolerance Approach to Encampments

For a variety of health and safety reasons, there must be a zero tolerance approach to encampments. Proactive efforts need to occur to locate encampments, and then engage the individuals living in encampments and cleanup the associated rubbish.

Overall, encampments are unsafe, unhealthy and unsuitable for habitation for the individuals living within them. Additionally, this researcher found encampments in Mendocino County that pose serious environmental contamination issues, disease transmission concerns, vector control risks and potential fire hazards.

It is critically important to cleanup encampment trash as soon as an encampment is identified, especially during times of drought since encampments pose major fire risks. Over the last 24 months, several fires in Northern California have originated within encampments.

Beyond potential fire hazards, the encampments with their accompanying trash heaps, are creating dangerous disease and vector control issues. Ironically, much of, if not most of the discarded rubbish within the encampments are items given to the individuals residing in the encampments free of charge by agencies and individuals.

In addition to the fire hazards and vector control issues, encampments are negatively threatening the environment in a variety of ways including threatening to contaminate water ways.

21 - Address the Issue of Stolen Shopping Carts

There are many incidences within Mendocino County where stolen shopping carts have become "encampments on wheels." All the negative health and safety issues outlined in Recommendation 20 [See Above] also pertain to stolen shopping carts. It is important to realize that because of the mobility of shopping carts, disease transmission and vector control issues can actually become worse because the negative effects are moved around the community.

Beyond all the negative effects listed above, it should always be remembered that a stolen shopping cart is an actual theft of property and should not be tolerated.

The City of Buena Park California very successfully addressed a severe stolen shopping cart problem that the City had been dealing with for years. Within in 2 months of approving their action plan, the number of stolen shopping carts within the City went from over 500 stolen shopping carts to functionally 0. The really good news is Buena Park has sustained functionally 0 stolen shopping carts on the streets since implementation of their initiative.

The key to Buena Park's success was a full and equal partnership between the police department and merchants. In Buena Park, the initial recovery phase of stolen shopping carts was led by the police department. Once Buena Park got to functionally 0, which occurred within 14 days of street-level implementation, the maintenance phase was then led by the merchants.
This researcher has shared the nuanced details of the Buena Park initiative with key stakeholders within Mendocino County. With just a few small tweaks, the Buena Park initiative can easily be replicated within Mendocino County within a period of 30-45 days.

22 - Engage Van-campers, and Impound Vehicles When Necessary

Most "*van-campers*" are part of the *North-South Travelers* cohort and are from outside of Mendocino County. Additionally, it is very important to note that most of the van-campers are not experiencing HUD-defined homelessness.

Like the overall cohort of North-South Travelers, most van-campers reside most of the time in the parking lots around Walmart, Jack-in-the-Box and Safeway. This researcher observed many van-campers frequently involved in drug use, in drug sells and in panhandling. Additionally, some of the van-camper vehicles present serious sanitary, vector control and environmental safety concerns.

Many van-camper licence plates were expired and/or were from out of state.

In order to address these issues, law enforcement officers need to engage these van-campers. Furthermore, when appropriate, law enforcement needs to cite and impound these vehicles, and all trespass laws should also be fully utilized.

23 - Engage Car-campers

It should be noted that "*car-campers*" are not a sub-set of van-campers, but are instead part of the homegrown cohort of individuals experiencing street-level homelessness. Specifically, most car-campers are experiencing HUD defined homelessness and about half have family ties within Mendocino County. It is interesting to note that relative to other sub-groups experiencing homelessness, car-campers have higher levels of employment.

It is strongly recommended that HOTeams be utilized to engage car-campers with the goal of placing car-campers into longer-term supportive housing [See Recommendation 14 Above].

Longer Term Recommendations

24 - After the Willow Terrace Opens, After Duplication is Reduced, and After Utilization is Increased, then Re-look at the Overall System Volume Needs

Several individuals that this researcher interviewed felt there was an immediate need to fund construction of new service inventory (eg construct new buildings and create new programs). This researcher agrees there is a critical need for additional inventory, but this researcher is not yet convinced that there is a need to construct new buildings nor establish new programs in order to create "new" inventory.

There are 4 recommendations in this report that could significantly increase "new" service inventory which would be available to locally homegrown individuals that are experiencing homelessness. The 4 recommendations are:

+ Recommendation 5 - reduce duplication of services,
+ Recommendation 6 - increase utilization of current physical infrastructures,
+ Recommendation 11 - establish and follow eligibility criterion,
+ Recommendation 18 - optimize placements into Willow Terrace.

This researcher beleives that it might be possible to organically gain enough increased inventory through implementation of the 4 recommendations above to meet the need. Additionally, it is possible with improved case management and outreach, that the need for services could also drop. Therefore, the question of "whether to construct new inventory" should be re-asked after the results of implementing these 4 recommendations are fully realized.

25 - Need to Conduct Deeper Data Dives Into the Issues of Employment, Out-of-towners and High Levels of Chronicness

Building on the individualized survey data for this study and report, deeper data dives need to occur regarding the interrelated issues of employment, levels of chronicness and why out-of-towners come to Mendocino County after the onset of homelessness.

Specifically, this researcher suggests conducting a series of "research focus groups" in order to gain a better understanding of how these 3 issues interrelate. This researcher has already begun to work with HHSA staff on how to conduct these focus groups.

It is hoped that deeper information gained regarding these 3 topics will be useful in developing strategies on how to address the "1-3 year chronic bubble" and in developing strategies that deter out-of-towners from coming to and then remaining in Mendocino County after the onset of homelessness.

26 - Replicate the Data Analyses Within This Study in the Remainder of the County

This researcher can make some educated assumptions about the remainder of the County, but these assumptions would be based on unscientific observations, anecdotal stories and data inferences, rather than on direct observations and scientific data.

At some point in the near future, the data analyses that were conducted in and around Fort Bragg, Ukiah and Willits should be replicated throughout the rest of Mendocino County.

27 - Create and Implement a Public Relations Campaign in Order to Engage the General Public as a Proactive Partner with this Effort

Once the recommendations within this report have been adopted and/or amended and/or rejected [See Recommendation 2 Above], a comprehensive public relations campaign needs to be developed and implemented in order to gain buy-in and support by the general public for the approved set of strategic recommendations.

28 - Set Up a Feed Back Loop to Guide Ongoing Improvements . . . Set Up a Checkup Plan

Communities that have had the long term sustainable success have all set up checkup processes to make sure the adopted recommendations are properly implemented.

Furthermore, and maybe even more important, these successful communities have created feed back loops that give guidance in real-time on when adjustments need to be made.

There are three things leaders need to be aware of when a comprehensive strategic plan is implemented:

1- some mid-course adjustments will need to be made,
2- system improvements will in turn unveil new opportunities not previously seen,
3- the law of "unintended consequences" always kicks in . . . sometimes this is good – while other times it means underlying issues that were hidden before, now become exposed and need to also be addressed.

Checkup Plans and Feed Back Loops:

- should not become bureaucratic and should not become a bunch of meetings,
- need to be rigorous,
- need to be independent,
- should have a regular set of check points (after 2 months, after 6 months, after a year, etc.).

Next Steps

* Adopt and/or amend and/or reject the above recommendations.

* Assign ownership of each adopted recommendation to one person by name with a targeted timeline of implementation.

* Just start implementing.

* Establish a checkup plan.

Exhibit 1 -
Program/Agency Site Visits, Tours, Meetings and Conference Calls (partial listing)

Judy Albert, MFT
Project Sanctuary
Program Director

Sheriff Tom Allman
Mendocino County
Sheriff-Coroner

Lara Anderson
Mendocino Coast Hospitality Center
Former Hospitality House Administrator

Carmel J. Angelo
Mendocino County
Chief Executive Officer

Amanda Archer
Mendocino County Youth Project (MCYP)
Levine House Care Manager III

Tami Bartolomei
City of Ukiah
Community Services Administrator

Julie Beardsley, MPH
County of Mendocino Health and Human Services Agency
Senior Public Health Analyst

Heather Blough
Community Development Commission of Mendocino County (Housing Authority)
Housing Manager

Traci Boyl
Plowshares
Executive Director

Officer Joe Breyer
Fort Brag Police Department
Police Officer

Deputy Matthew Carlson
Mendocino County Sheriff's Office
Sheriff's Deputy

Valicia Catching
DSR Security Services
Manager

Tammy Moss Chandler
Mendocino County
Health and Human Services Director and Acting Recovery Director

Chief Chris Dewey
Ukiah Police Department
Chief of Police

Becky Driscoll
Little Lake Health Center
Health Center Director

Bekkie Emery
County of Mendocino
Health & Human Services Assistant Director

Angelica Figueroa
Rural Communities Housing Development Corporation
Project Manager

Sarah Gavette
Manzanita Services, Inc.
Program Coordinator

James “Batman” Gibney
Hospitality House
Senior House Manager

Lt. Charles P. Gilchrist
Fort Bragg Police Department

Hon. Gerry Gonzalez
Willits City Council
Mayor

Sarah Gravette
Manzanita Services, Inc.
QA Program Coordinator

M. Lynette Guenther
Walmart
Store Manager

Libby Guthrie, Ed.D.
MCAVHN
Executive Director

Drew Hair-Iacomini
Ford Street Project
Community Support and Housing Programs Director

Kristina Harju
Mendocino Coast Hospitality Center
Programs Manager

Elizabeth Hart
Willits Community Services & Food Bank
Client Services

Ed Haynes, DVM
Ukiah Veterinary
Owner

Tony Huerta
Nor Cal Christian Ministries
Executive Director

D.E. (Rick) Johnson, PE
Plowshares
Former Board Member

Lynelle Johnson
Mendocino Coast Hospitality Center
Board President

Jody J. Johnston
Mendocino County - Health & Human Services Agency
Senior Program Manager - Adult and Aging Services Division

Brian Klovski
Mendocino County Health & Human Services Agency
HOME Team Unit Program Specialist

Ryan LaRue
Rural Communities Housing Development Corporation
Director of Development

Sgt. Brandon Lee
Fort Bragg Police Department

Wendy Lee
MCAVHN
Outreach Testing Counselor

Officer Kevin Leef
Willits Police Department
Police Officer

Chief Fabian E. Lizarraga
Fort Bragg Police Department
Chief of Police

Tony Marsh
Redwood Community Services
Winter Shelter

Patrice Mascolo
Plowshares
Office Manager and Executive Assistant

Dennie Maslak
Mendocino County Health and Human Services Agency
Staff Assistant III

Hon. John McCowen
County of Mendocino
Chair and Second District Supervisor

Brad McDonald
Rural Communities Housing Development Corporation
Chief Executive Officer

Daniel McIntire
Rural Communities Housing Development Corporation
Director of Property Management

Lt. David McQueary
Ukiah Police Department

Anne Molgaard
Mendocino County Health and Human Services Agency
Chief Operations Officer, Acting HHSA Director

Adrienne Moore
City of Willits
City Manager

Mark P. Mountanos
M.P.Mountanos Coffee
Owner

Hon. Maureen Mulheren
City of Ukiah / Connect Insurance
City Councilperson / Independent Insurance Agent

Wynd Novotny
Manzanita Services, Inc.
Executive Director

Joanna Olson
Mendocino County Youth Project (MCYP)
Executive Director

Paul Otto
Not Cal Christian Ministries
Board Member

Jennifer Owen
City of Fort Bragg
Special Projects Manager

Mike Pallesen
Rural Communities Housing Development Corporation
Special Projects Manager

Blythe Post
Mendocino County Office of Education
Foster and Homeless Youth Services - Manager IV

Debra Ramirez
Project Sanctuary
Shelter Director

Stacey Ramsey
DSR Security Services
Owner

David Rapport
City of Ukiah
Contract Assistant City Attorney

Paula Redding
Manzanita Services, Inc.
Benefits Advocate

Sarah Reith
Stories / Mendo Voice
Author / Journalist

Lucresha Renteria
Mendocino Coast Clinics, Inc. (MCC)
Executive Director

Shannon Riley
City of Ukiah
Deputy City Manager

Kelsey Rivera
Mendocino County Health and Human Services Agency
Deputy Director - Adults and Aging Services Division

Hon. Saprina Rodriguez
Willits City Council
Councilwoman

Linda Ruffing
City of Fort Bragg
City Manager

Hon. Stephen Scalmanini
City of Ukiah
Councilman

Craig Schlatter
City of Ukiah
Community Development and Planning Director

Camille Schraeder, MA
Redwood Community Services (RCS)
Executive Director

Tim Schraeder, MFT
Redwood Quality Management Corporation
Chief Executive Officer

Anna Shaw
Mendocino Coast Hospitality Center
Executive Director

Officer Joseph Shaw
Fort Bragg Police Department
Police Officer

Faith Simon, RN, MSN and FNP
Fort Bragg Rural Health Center - Adventist Health
Street Medicine Project

Joel Soinila
Adventist Health Ukiah Valley
Productivity Engineer

Linda Jo Stern, MPH
Fort Bragg Street Medicine
Advocate

Maya Stuart, MA
Mendocino County Health & Human Services Agency
Program Administrator & MCHSCoC Chair

Leanna Sweet, RN
Adventist Health Ukiah Valley
Director of Population Health Care Management

Elizabeth Swenson
North Coast Housing Action Team
Coordinator

Darcy C. Vaughn
City of Ukiah
Contract Assistant City Attorney

Sgt. Noble Waidelich
Ukiah Police Department
Police Sergeant

Jacqueline Williams
Ford Street Project
Executive Director

Sage Wolf
Redwood Community Services, Inc. (RCS)
Homeless Services

Captain Justin Wyatt
Ukiah Police Department

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Conversations and interviews with numerous individuals experiencing homelessness

Conversations with numerous area citizens and merchants

Conversations with several individuals from the faith-based community

Experienced homelessness on streets

Fort Bragg Police Department Ride-a-long

Mendocino Sheriff Department Ride-a-long

Met with the Board of Directors of Plowshares

Met with the Mendocino County Homeless Services Continuum of Care

Spent time at Libraries

Ukiah Police Department Ride-a-long

Visited several Federal, State, County and City Parks within Mendocino County

Many others, some of whom requested anonymity

Exhibit 2 -
Robert G. Marbut Jr., Ph.D. Biography

Dr. Robert Marbut has worked on issues of homelessness for more than three decades: first as a volunteer, then as chief of staff to San Antonio Mayor Henry Cisneros, next as a White House Fellow to President H.W. Bush (41, the Father), later as a San Antonio City Councilperson/Mayor-Pro-Tem and more recently as the Founding President & CEO of *Haven for Hope* (the most comprehensive homeless *transformational center* in the USA).

In 2007, frustrated by the lack of real improvement in reducing homelessness, and as part of the concept development phase for the *Haven for Hope Campus*, Dr. Marbut conducted a nationwide best practices study. After personally visiting 237 homelessness service facilities in 12 states and the District of Columbia, he developed *The Seven Guiding Principles of Homeless Transformation* which focuses on root causes and recovery, not on symptoms and short term gimmicks. Since then, Dr. Marbut has visited a total of 839 operations in 25 states, plus Washington, DC and Mexico, DF, and has helped hundreds of communities and agencies to dramatically reduce homelessness. He has consulted with more communities and organizations than anyone else in the USA.

These *Seven Guiding Principles of Transformation* are used in all aspects of his work to create holistically transformative environments in order to reduce homelessness.

He earned a Ph.D. from The University of Texas at Austin, Austin, Texas in International Relations (with an emphasis in international terrorism and Wahhabism), Political Behavior and American Political Institutions/Processes from the Department of Government.

He also has two Master of Arts degrees, one in Government from The University of Texas at Austin and one in Criminal Justice from the Claremont Graduate School. His Bachelor of Arts is a Full Triple Major in Economics, Political Science and Psychology (Honors Graduate) from Claremont McKenna (Men's) College.

Dr. Marbut also has completed three post-graduate fellowships, one as a White House Fellow (USA's most prestigious program for leadership and public service), one as a CORO Fellow of Public and Urban Affairs, and one as a TEACH Fellow in the Kingdom of Bahrain and the State of Qatar (1 of 13 USA educators selected). He was also a member of the Secretary of Defense's Joint Civilian Orientation Conference (JCOC-63) 2000 class which focused on Special Operations. JCOC is the Secretary of Defense's premier civic leadership program.

Contact Information:

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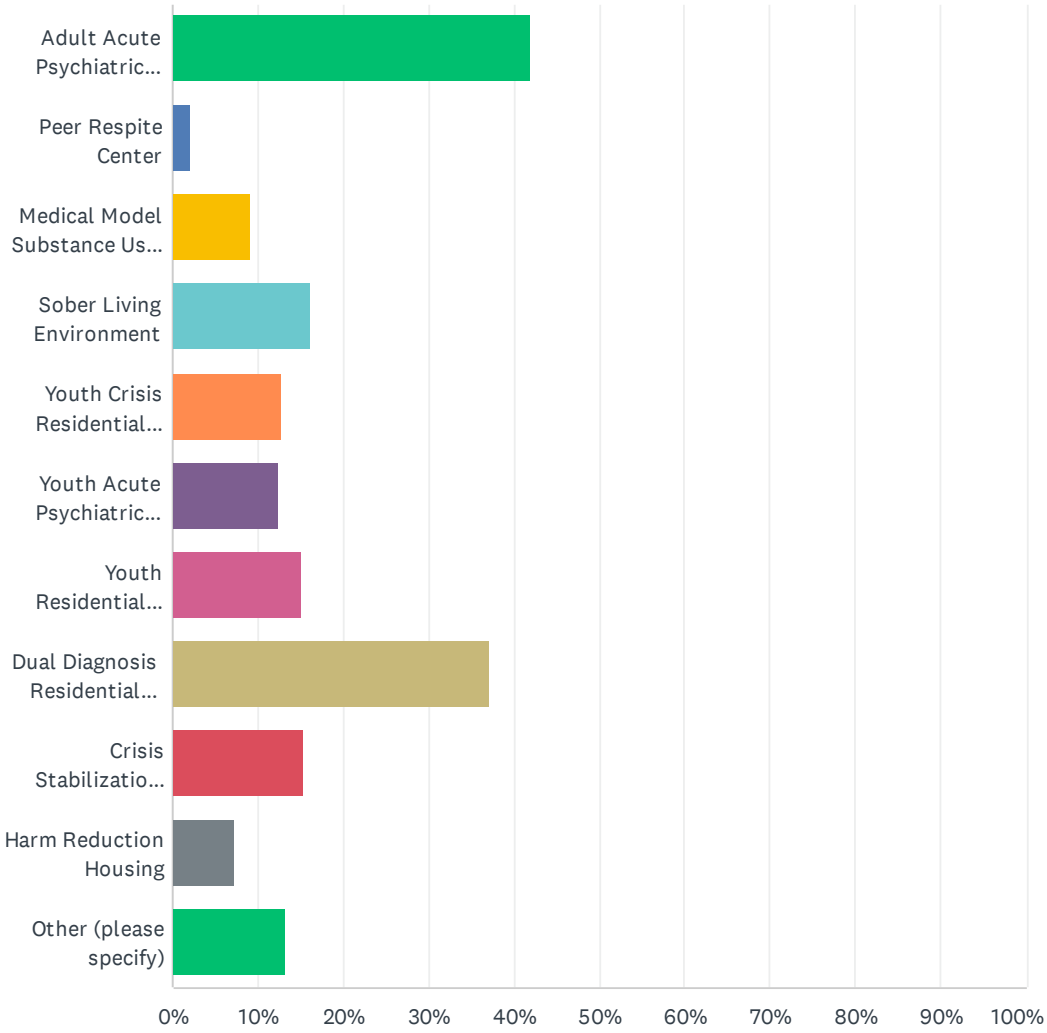
6726 Wagner Way MarbutR@aol.com
San Antonio, TX 78256 210-260-9696

Q1 Of the following options, which facilities are currently the most needed in Mendocino County? (please select two)

Answered: 385 Skipped: 0



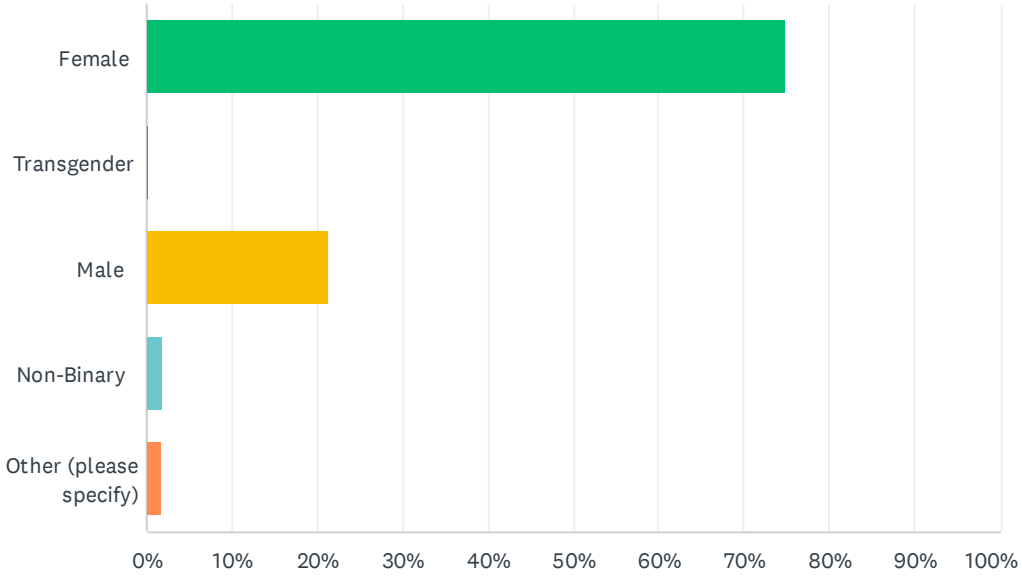
ANSWER CHOICES	RESPONSES	
Adult Acute Psychiatric Inpatient Center	42.08%	162
Peer Respite Center	2.08%	8
Medical Model Substance Use Disorder Detox	9.09%	35
Sober Living Environment	16.10%	62
Youth Crisis Residential Treatment	12.73%	49
Youth Acute Psychiatric Inpatient Center	12.47%	48
Youth Residential Substance Use Treatment	15.06%	58
Dual Diagnosis Residential Treatment - Substance Use and Mental Health	37.14%	143
Crisis Stabilization Unit	15.32%	59
Harm Reduction Housing	7.27%	28
Other (please specify)	13.25%	51
Total Respondents: 385		

#	OTHER (PLEASE SPECIFY)	DATE
1	Sobering Center in lieu of jail	2/2/2023 11:58 AM
2	more shelter options throughout the county	1/29/2023 7:35 PM
3	any form of mental health that does not include substance abuse	1/24/2023 11:25 AM
4	Low cost walk in counseling for all residents	1/18/2023 7:45 AM
5	ALL of the Above	1/11/2023 4:56 PM
6	When you go to a Medical Appointment they'll only address one issue per medical visit of which is a waste of time and money, need a diagnostic center for humans	1/11/2023 4:43 PM
7	Moms and babies after birth bonding care.	1/11/2023 4:25 PM
8	Housing	1/11/2023 4:23 PM
9	Housing for adults age 18-64 that don't have children.	1/11/2023 2:39 PM
10	Places that offer MH counseling/therapy	1/11/2023 2:19 PM
11	Homeless Housing	1/11/2023 2:08 PM
12	None	1/11/2023 2:02 PM
13	Community Milieu/Regular Support Groups	1/11/2023 1:24 PM
14	anything for the aged	1/11/2023 12:36 PM
15	none	1/11/2023 12:05 PM
16	All of the above.	1/11/2023 11:39 AM
17	faster and easier access to SUD/BH treatment for all age groups	1/11/2023 11:25 AM
18	Mental health services for Willits, coast and north county	1/11/2023 11:24 AM
19	Senior Assisted Living Facilities	1/11/2023 11:16 AM
20	Mental Health for people that have insurance	1/11/2023 11:14 AM
21	How do we ensure that our community has the information as to what resources are currently available to them? Communication appears to be a problem for our county.	1/11/2023 11:13 AM

22	ICWA approved or Native American resource families (desperate need!)	1/11/2023 11:08 AM
23	Local young adult (18-26) substance use and MH programs for insuraned patients	1/11/2023 11:07 AM
24	Intervention services for minorities	1/11/2023 10:58 AM
25	Dear God, all of the above!	12/19/2022 9:16 AM
26	Detox	12/8/2022 11:52 AM
27	Assisted Outpatient treatment	11/19/2022 10:26 PM
28	Outpatient psych services	11/17/2022 10:49 AM
29	Counseling for adults from seasoned professionals	11/17/2022 10:08 AM
30	Narcan T4T	11/15/2022 2:30 PM
31	Long term inpatient treatment-dual diagnosis medical or no insurance abstinence based or harm reduction to sober living facility then to housing	11/8/2022 9:38 AM
32	Sober living	11/7/2022 9:22 AM
33	Street counselors	10/28/2022 4:35 AM
34	Counselor	10/27/2022 9:35 AM
35	SUDT, Behavioral Health and Recovery Services	10/26/2022 8:05 AM
36	A visible available building & staff that addresses ALL mental health concerns	10/26/2022 7:26 AM
37	I thought the facility next to the post office was a crisis stabilization unit? Am I wrong?	10/25/2022 4:02 PM
38	Native American Residential Treatment Program	10/25/2022 1:40 PM
39	Positive gathering places for youth.	10/23/2022 2:47 PM
40	Medication Management with availability of a psychiatrist.	10/22/2022 5:45 PM
41	Anything not run by RQMC/RCS	10/20/2022 9:25 AM
42	After Care Program Center	10/19/2022 2:34 PM
43	long term locked mental health facility, joining with other North Coast Counties to build/run such a facility.	10/18/2022 12:29 PM
44	Native /Latino Treatment Center	10/18/2022 8:20 AM
45	lack data to respond as to true needs	10/17/2022 6:24 PM
46	How can I pick just two when most of these are equally needed	10/14/2022 8:47 PM
47	Mental Health Outpatient	10/14/2022 5:05 PM
48	There’s a real need for longer term psychiatric housing for homeless. Peer housing would be fine with rules, regs and med mgmt	10/14/2022 4:48 PM
49	Jail/prison Diversion treatment programs	10/14/2022 4:30 PM
50	Substance Use Disorder Detox, doesn't have to be a Medical Model.	10/12/2022 3:30 PM
51	Crisis Stabilization Unit	10/9/2022 4:09 PM

Q2 What is your gender?

Answered: 375 Skipped: 10

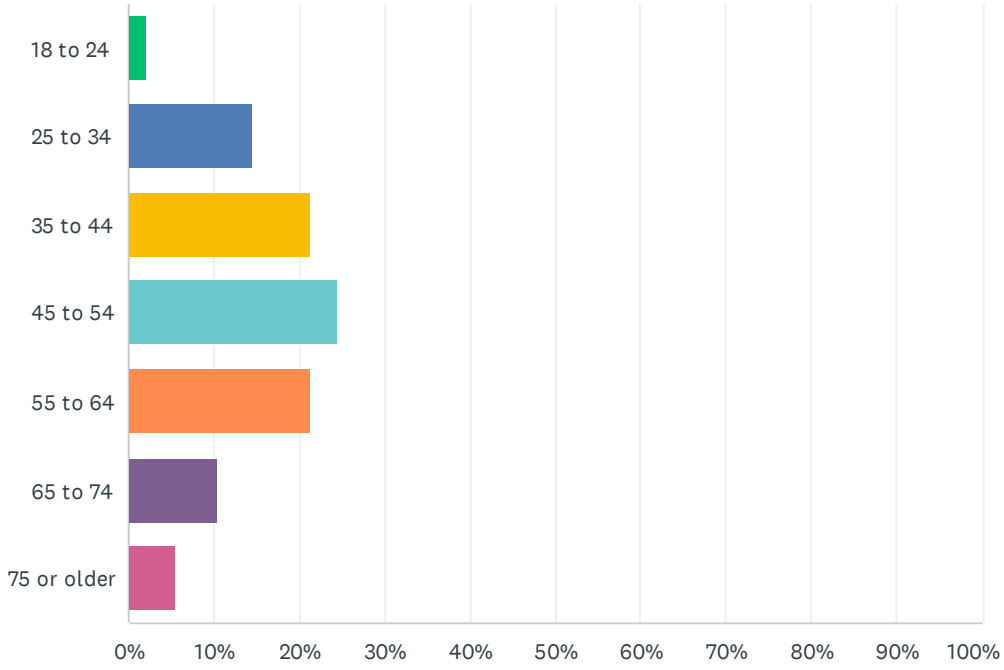


ANSWER CHOICES	RESPONSES	
Female	74.93%	281
Transgender	0.27%	1
Male	21.33%	80
Non-Binary	1.87%	7
Other (please specify)	1.60%	6
TOTAL		375

#	OTHER (PLEASE SPECIFY)	DATE
1	non-conforming	2/2/2023 12:00 PM
2	I do not understand how gender applies to this?	1/11/2023 1:10 PM
3	none	1/11/2023 12:06 PM
4	Prefer not to say	10/17/2022 7:53 PM
5	Trans non-binary	10/14/2022 6:55 PM
6	Decline to Answer	10/14/2022 5:07 PM

Q3 What is your age?

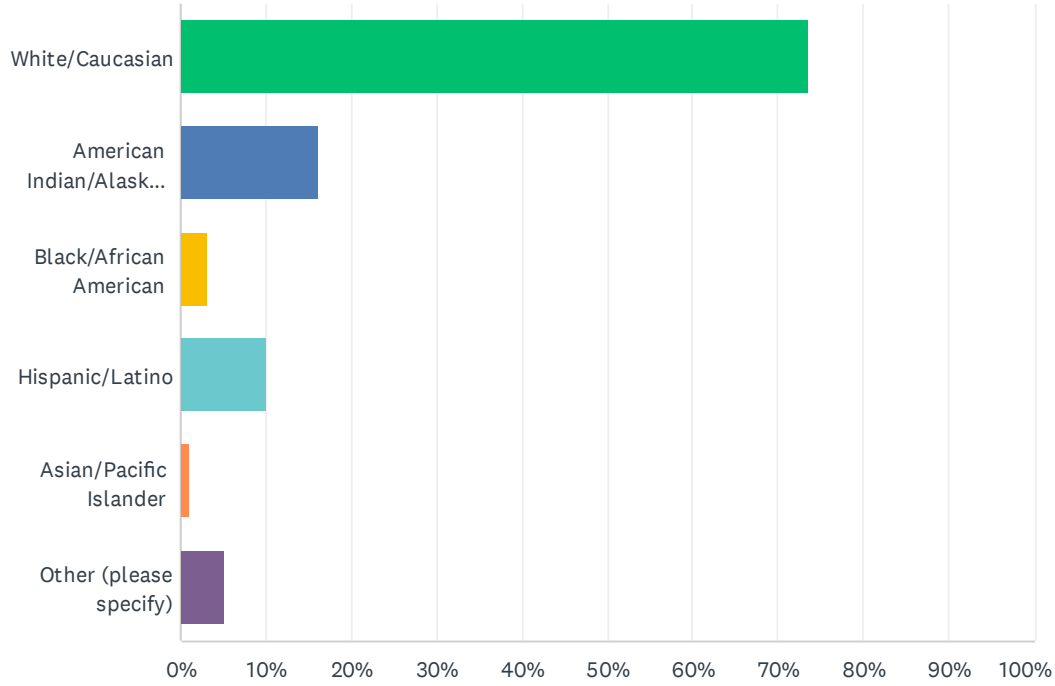
Answered: 374 Skipped: 11



ANSWER CHOICES	RESPONSES	
18 to 24	2.14%	8
25 to 34	14.44%	54
35 to 44	21.39%	80
45 to 54	24.60%	92
55 to 64	21.39%	80
65 to 74	10.43%	39
75 or older	5.61%	21
TOTAL		374

Q4 Are you:

Answered: 366 Skipped: 19



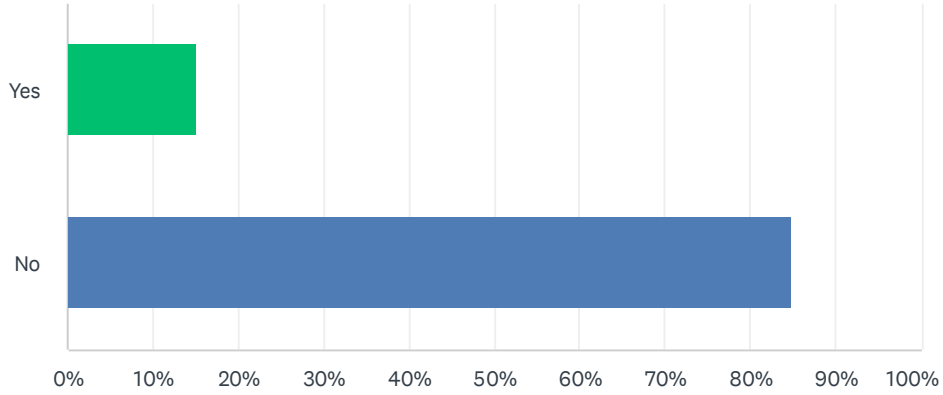
ANSWER CHOICES	RESPONSES	
White/Caucasian	73.50%	269
American Indian/Alaska Native	16.12%	59
Black/African American	3.28%	12
Hispanic/Latino	10.11%	37
Asian/Pacific Islander	1.09%	4
Other (please specify)	5.19%	19
Total Respondents: 366		

#	OTHER (PLEASE SPECIFY)	DATE
1	non-conforming	2/2/2023 12:00 PM
2	Appalachian American	1/29/2023 7:36 PM
3	human	1/25/2023 11:26 AM
4	MEXICAN	1/16/2023 3:33 PM
5	American Mix	1/11/2023 4:45 PM
6	Not sharing	1/11/2023 2:22 PM
7	Not sharing	1/11/2023 2:16 PM
8	human	1/11/2023 1:09 PM

9	other	1/11/2023 12:37 PM
10	Atlantic Islander	1/11/2023 11:31 AM
11	Jewish	1/11/2023 10:59 AM
12	white, native latino	11/10/2022 6:08 PM
13	white with some black dna	10/30/2022 1:47 PM
14	Why	10/26/2022 5:05 PM
15	mixed	10/26/2022 9:25 AM
16	American so...	10/23/2022 2:49 PM
17	tribal	10/18/2022 8:21 AM
18	Prefer not to answer stupid questions	10/17/2022 7:53 PM
19	Decline to respond to a man-made illusion	10/14/2022 5:07 PM

Q5 Do you identify as a member of a tribal community?

Answered: 372 Skipped: 13



ANSWER CHOICES	RESPONSES	
Yes	15.05%	56
No	84.95%	316
TOTAL		372

Q6 If you answered yes to the previous question, which tribal community are you a member of?

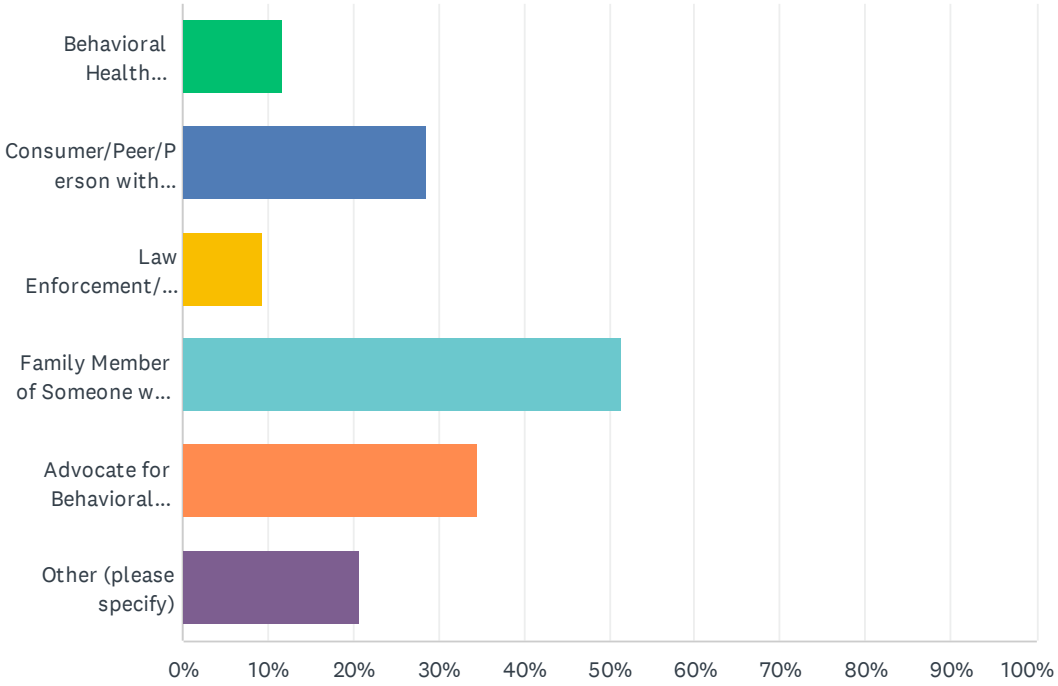
Answered: 57 Skipped: 328

#	RESPONSES	DATE
1	N/A	2/2/2023 12:00 PM
2	Round Valley	1/23/2023 5:10 PM
3	Round valley Indian tribes	1/17/2023 9:31 AM
4	Pomo	1/11/2023 5:10 PM
5	Miwok	1/11/2023 2:06 PM
6	Earth	1/11/2023 1:09 PM
7	Hopland	1/11/2023 11:54 AM
8	Round Valley	1/11/2023 11:19 AM
9	Redwood Valley Little River Band of Pomo Indians	1/11/2023 11:15 AM
10	Round Valley	1/11/2023 11:14 AM
11	Choctaw	1/11/2023 11:09 AM
12	Blackfoot Indian	1/11/2023 11:07 AM
13	N/A	1/11/2023 11:03 AM
14	Sac & Fox Nation	1/11/2023 11:01 AM
15	n/a	1/11/2023 11:00 AM
16	Scott’s Valley Band of Pomo	12/29/2022 4:58 PM
17	Pomo	12/29/2022 4:58 PM
18	Pinoleville Pomo Nation	12/21/2022 4:16 PM
19	big valley band of pomo indians	12/21/2022 9:15 AM
20	Mohawk	12/19/2022 10:03 AM
21	PINOLEVILLE POMO NATION	12/18/2022 8:37 PM
22	Hopland Band of Pomo Indians	12/16/2022 12:47 PM
23	Redwood valley little river band of Pomo indians	12/16/2022 10:47 AM
24	Scotts Valley Band of Pomo Indians	12/16/2022 9:43 AM
25	Pinoleville Pomo Nation	12/15/2022 2:33 PM
26	Yurok Tribe	12/15/2022 10:54 AM
27	Pomo	12/15/2022 10:38 AM
28	Manchester/Point Arena	11/16/2022 7:45 AM
29	Round Valley	11/15/2022 3:08 PM
30	Delaware Tribe of Indians	11/14/2022 11:38 AM
31	Cherokee Nation	11/14/2022 8:46 AM

32	Pinoleville Pomo Nation	11/14/2022 7:40 AM
33	Cahto	11/11/2022 10:46 PM
34	Cahto Tribe of Laytonville	11/11/2022 7:06 PM
35	Round Valley	11/11/2022 6:31 PM
36	Manchester Band Of Pomo Indians	11/11/2022 3:46 PM
37	Northern Circle	11/10/2022 6:08 PM
38	Redwood Valley and NCIHA	11/10/2022 9:51 AM
39	big valley band of pomo indians	11/7/2022 8:38 AM
40	Hopland	11/1/2022 5:23 PM
41	Wiyot	10/27/2022 4:34 AM
42	Undocumented Lakota	10/26/2022 9:25 AM
43	Cahto Tribe of the Laytonville Rancheria	10/26/2022 7:57 AM
44	Pinoleville Pomo Nation	10/25/2022 1:41 PM
45	Creek Nation	10/23/2022 7:51 PM
46	Pomo	10/23/2022 7:36 PM
47	Pinoleville Pomo Nation	10/19/2022 2:36 PM
48	Round Valley	10/19/2022 2:35 PM
49	Redwood valley Rancheria	10/19/2022 9:43 AM
50	Mpa	10/18/2022 1:41 PM
51	Coyote Valley	10/18/2022 11:29 AM
52	homeless/disenrolled	10/18/2022 8:21 AM
53	Scotts Valley Band of Pomo Indians	10/15/2022 2:41 PM
54	Cahto Tribe of Laytonville	10/14/2022 1:09 PM
55	Cahto Tribe of the Laytonville Rancheria	10/14/2022 7:24 AM
56	Hopland Band of Pomo Indians	10/13/2022 10:33 PM
57	Sherwood Valley Rancheria Band of Pomo Indians	10/13/2022 2:14 PM

Q7 Do you identify as any of the following? (select all that apply)

Answered: 339 Skipped: 46



ANSWER CHOICES	RESPONSES	
Behavioral Health Clinician/Provider	11.80%	40
Consumer/Peer/Person with Lived Experience with a Behavioral Health Condition	28.61%	97
Law Enforcement/First Responder	9.44%	32
Family Member of Someone with a Behavioral Health Condition	51.33%	174
Advocate for Behavioral Healthcare Services	34.51%	117
Other (please specify)	20.65%	70
Total Respondents: 339		

#	OTHER (PLEASE SPECIFY)	DATE
1	Crisis Worker	1/29/2023 7:36 PM
2	Social Services	1/23/2023 5:10 PM
3	Work for BHRS but not a clinician	1/13/2023 9:36 AM
4	FCS Social Worker	1/12/2023 10:25 AM
5	Social Services employee dealing with a lot of citizens with mental health issues	1/11/2023 5:00 PM
6	I just try to stay Healthy as just about all medical sucks	1/11/2023 4:45 PM
7	Social Worker	1/11/2023 4:14 PM
8	Community Member	1/11/2023 2:40 PM

9	Work in social services	1/11/2023 2:16 PM
10	Program Specialist II for HHSA/PH	1/11/2023 2:06 PM
11	Being part of this community, I see where many persons would benefit from having a secure and safe place to be/live when you have negative mental issues that can cause harm to themselves and others.	1/11/2023 1:26 PM
12	human	1/11/2023 1:09 PM
13	Child Welfare Professional	1/11/2023 12:47 PM
14	specialist	1/11/2023 12:37 PM
15	County Employee	1/11/2023 12:08 PM
16	none	1/11/2023 12:06 PM
17	Admin Services Manager DA's Office	1/11/2023 11:40 AM
18	County Employee	1/11/2023 11:38 AM
19	Former Behavioral Health Provider	1/11/2023 11:28 AM
20	Concerned citizen	1/11/2023 11:23 AM
21	I advocate in this community for more access to behavioral health care which is desperately needed here.	1/11/2023 11:18 AM
22	Building Official	1/11/2023 11:17 AM
23	Eligibility worker for Mendocino County	1/11/2023 11:13 AM
24	Social Worker	1/11/2023 11:09 AM
25	Public Health practitioner	1/11/2023 11:08 AM
26	Just a guy who got the survey link!	1/11/2023 11:03 AM
27	an observant and informed county contractor	1/11/2023 11:03 AM
28	Social Services	1/11/2023 11:02 AM
29	n/a	1/11/2023 11:00 AM
30	Social Worker for adults experiencing homelessness & disability	1/11/2023 11:00 AM
31	Social Worker	1/11/2023 10:58 AM
32	Clergy	1/3/2023 11:59 AM
33	Tribal Government	12/29/2022 4:58 PM
34	Education, working with students and families	12/22/2022 8:02 AM
35	Advocate	12/21/2022 8:50 AM
36	work with Youth	12/16/2022 12:47 PM
37	Victim Advocate	12/15/2022 10:38 AM
38	A concerned citizen	12/9/2022 10:20 AM
39	CBT/SUD Treatment Provider	11/25/2022 1:00 AM
40	Criminal Defense Attorney	11/19/2022 10:27 PM
41	Superior Court of CA, Mendocino County Employee	11/17/2022 2:57 PM
42	Decline to state	11/17/2022 1:20 PM
43	interested community member	11/17/2022 11:23 AM
44	I have handed out over 10,000 narcan kits.	11/17/2022 11:17 AM

45	Public Defender	11/17/2022 10:42 AM
46	Local citizen with large family in the area.	11/17/2022 10:10 AM
47	Psychology student	11/17/2022 10:08 AM
48	Substance Abuse Counselor	11/14/2022 7:40 AM
49	Volunteer firefighter/first responder	11/11/2022 3:46 PM
50	Case Manager	11/3/2022 11:23 AM
51	Mother of an adult son with long term off/on meth addiction	11/1/2022 7:59 PM
52	Tribal Government	11/1/2022 5:23 PM
53	end user	10/28/2022 4:36 AM
54	Person WITH mental illness.	10/27/2022 5:02 PM
55	Nurse	10/26/2022 8:44 PM
56	Receptionist/ Childcare provider	10/26/2022 8:06 AM
57	Reentry Service Provider	10/25/2022 8:08 PM
58	Nurse practitioner	10/25/2022 4:03 PM
59	Substance Abuse Counselor II	10/25/2022 1:41 PM
60	Native American Advocate	10/23/2022 7:51 PM
61	I have a mental illness	10/22/2022 10:15 PM
62	Im the mother of a person with SMI it is not a behavioral problem! I am a staunch advocate for families & their loved ones struggling with mental illness!	10/19/2022 2:54 PM
63	Substance Abuse Counselor	10/19/2022 2:36 PM
64	BHRS Employee	10/19/2022 10:33 AM
65	Behavioral Health Center Administrator	10/18/2022 1:33 PM
66	Indian Child Welfare Act Director	10/17/2022 4:55 PM
67	social worker	10/17/2022 2:09 PM
68	Medical provider	10/16/2022 7:08 PM
69	Social worker/ childrens	10/15/2022 12:03 AM
70	Substance use disorder	10/11/2022 12:22 PM

Attachment F: BHBH Program Applicant Attestation

As an authorized representative of Mendocino County Behavioral Health (county behavioral health agency [BHA]), I, Jenine Miller, Psy.D. (name) certify that:

1. The information, statements, and attachments included in this application are, to the best of my knowledge and belief, true and correct.
2. I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification of unclear or ambiguous statements made in the application and other supporting documents submitted for Behavioral Health Bridge Housing (BHBH) Program funding.
3. The county BHA shall use BHBH Program funds to serve the targeted population(s) as described in the application. Further, the county BHA will meet all of the program requirements described in the request for applications (RFA) and attachments.
4. The county BHA will be responsible for ensuring that its BHBH Program and all components, including bridge housing start-up infrastructure, are on schedule and on budget.
5. Funding received for the BHBH Program will be spent only on allowable uses as stated in the RFA and attachments, or on those uses for which the applicant has received express DHCS approval.
6. The county BHA shall be solely responsible for any costs needed to complete the proposed bridge housing start-up infrastructure in excess of the BHBH Program award amount. Neither DHCS nor Advocates for Human Potential, Inc. (AHP), the BHBH Program administrative entity, will be responsible for any cost overruns.
7. The funding received through the BHBH Program will supplement, and not supplant, other funding available from existing local, state, or federal programs or from grants with similar purposes.
8. The county BHA will respond to general inquiries and provide information requested from DHCS and/or AHP pertaining to the inquiry within three (3) business days of receipt, unless an alternate timeline is approved or determined necessary by DHCS and/or AHP.
9. The county BHA understands that DHCS and AHP will review progress in meeting deliverables and expending funds annually, and that if it is not on track to meet funding deliverables and spend its full contracted amount, DHCS will engage the county to discuss potential extensions or modifications. DHCS may redistribute those funds to other eligible county BHAs.
10. The applicant shall defend, indemnify, and hold harmless DHCS and the State of California and all officers, trustees, agents, and employees of the same, as well as AHP, from and against any and all claims, losses, costs, damages, or liabilities of any kind or nature, including attorneys' fees, whether direct or indirect, arising from or relating to the grant funding or related project.

Signature of authorized representative	Date: 4/27/23
Name of authorized representative: Jenine Miller, Psy.D.	Title: Director of Behavioral Health