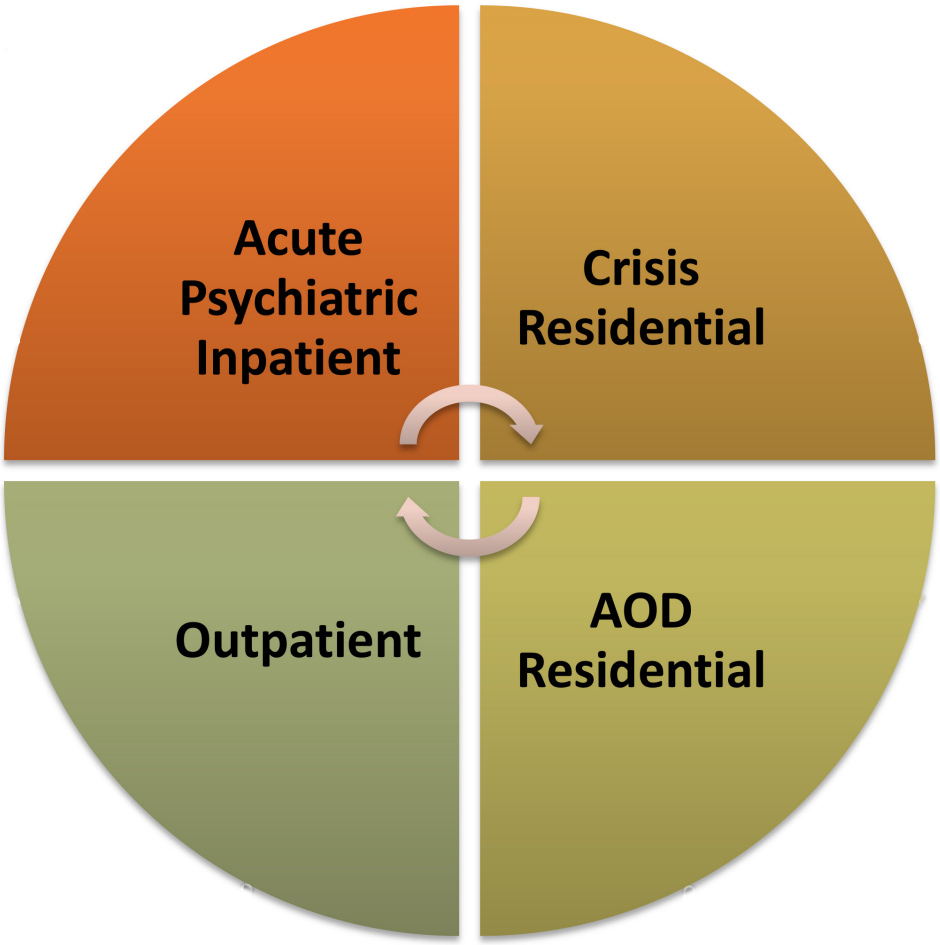
Analysis of the Proposed Behavioral Health "Crisis Continuum" Facility

The Mental Health Facility Development Ordinance of 2016



By the Mendocino County Executive Office

July 14, 2016

Attachments

Executive Summary

The proposed initiative, "The Mental Health Facility Development Ordinance of 2016" is anticipated to generate approximately $37 million dollars of revenue over the five-year term. All of this funding is available only for the development/construction and maintenance of behavioral health facilities and cannot be used for any other operational costs. Of this total, 10% or $3.7 million is restricted to use in development of a training center for public safety agencies and mental health service providers. The remaining $33.3 million would be available for development and maintenance of a facility or facilities that would provide potentially four categories of behavioral health services to the Mendocino County community. The facility as proposed is anticipated to cost approximately $30 million dollars to plan, design, construct, furnish, and finance. The remaining $3.3 million would be recommended to be placed in a facility maintenance fund to support the long term maintenance needs of the facility (10-15 years).

The $30 million dollars is expected to be sufficient to support the construction of a state of the art facility that totals approximately 44,800 sf and includes 16 acute psychiatric beds, 12 crisis residential beds, offices for outpatient service providers, and an AOD detoxification unit and a 12-bed residential facility.

The development of the facility proposed by the initiative is anticipated to increase the cost of behavioral health service delivery in Mendocino County from a total of $26.9 million to $36.7 million. Of this total annual increase in costs of $9.7 million, $4.85 million is anticipated to be directly billable through Medi-Cal or other funding, and $4.85 million would be in new annual non-reimbursable costs. This increase in costs is above and beyond currently available funding for behavioral health service delivery, such as 1991 Realignment, 2011 Realignment, or MHSA funding, and would require another unknown source of revenue or an inclusion of additional County General Fund dollars.

While the proposed facility could provide a central location for many behavioral health services in Mendocino County, some of which are currently provided outside of the county, the projected additional costs to Mendocino County to operate behavioral health programs at the facility would place a significant strain on current county resources and force a likely redirection of resources from other county needs. Further, the proposed new facility, by itself, would not be a panacea for the county's Behavioral Health system. Communities that provide a wider range of local Behavioral Health services than Mendocino, particularly comparable rural communities with limited tax bases and populations, continue to struggle with Behavioral Health service availability, coordination, training, and overall funding of the Behavioral Health system.

While this is projected to be a costly project, it is based on the County fully planning, implementing and operating the facilities. If we plan and implement alternate models, the cost could be much less to the General Fund. At this time, there are several opportunities for public-private partnerships that are providing, and will be providing additional services to our community for lesser cost. Partners such as Adventist Health, Redwood Quality Management Company, Ford Street, Partnership Health Plan of California and many more have been in discussions about working with the County to provide much needed services.

Along with that, funding such as Senate Bill (SB) 82 for mental health services, California's Section 1115 Medicaid Waiver for substance abuse and alcohol and other drug funding, and other state and federal dollars may address rates and programming needs. The Executive Office hopes that these partnerships, funding streams via SB 82 or the 1115 waiver, and the strength of this community will make this Initiative fiscally possible.

Background

On March 15th, 2016 the Board of Supervisors was informed of the Mendocino County Sheriff's intention to circulate a petition to place a temporary sales tax measure on the ballot in order to raise tax revenue to fund the construction of mental health facilities in Mendocino County. A 500-word summary of the "Mental Health Facility Development Ordinance of 2016" was provided to the Board by the Sheriff. The summary states that the initiative would enact:

> "*...a temporary (5 year) ½ cent sales tax in all parts of Mendocino County to develop facilities in Mendocino County to assist in the diagnosis and treatment of Mental Illness and addiction recovery. The initiative includes a portion of the funds to develop and maintain a training facility to be used by mental health professionals, public safety professionals and citizens to better serve the citizens in Mendocino County.*" Further the initiative states that, "*No funds may be used for other incidental but necessary purposes, including staffing of such facility.*"

Based on the Sheriff's proposal, Supervisor Gjerde brought an item to the Board of Supervisors on April 5th for consideration that resulted in the Board directing the Chief Executive Officer to prepare a report analyzing the potential impacts of the proposal, pursuant to California Elections Code Section 9111. Upon receipt of the report, the Board will consider, pursuant to Elections Code Section 9160(c), whether to provide direction to the Auditor Controller to prepare a fiscal impact statement to be placed on the ballot along with the initiative.

On June 24, 2016 the Sheriff submitted a total of 4,328 signed petitions to the Registrar of Voters for verification. Verification of the minimum required 2,502 signatures by the Registrar of Voters was completed on July 12, 2016. The Initiative will be submitted to the Board of Supervisors for inclusion on the November 2016 General Election ballot. The deadline for all materials to be presented to the Registrar of Voters for inclusion on the November ballot is August 12th.

Summary of "Mental Health Facility Development Ordinance of 2016"

Included as *Attachment A* is the full text of the "Mental Health Facility Development Ordinance of 2016." Additionally, the text of the petition (Ballot Title and Summary), signed by members of the public and prepared by County Counsel on March 23, 2016, is included for reference as *Attachment B*. The key purpose and points of the proposed measure are summarized here.

- The initiative establishes a temporary (5-year) ½ cent sales tax in all parts of Mendocino County, including the four cities within the county.
- Funding shall be used exclusively for the development (construction or renovation) of facilities in Mendocino County to assist in the diagnosis and treatment of mental illness and addiction recovery.
- Ten (10%) percent of the funding shall be used to develop a facility to provide for education and training services for public safety employees, mental health professionals and citizens.
- None of the funds shall be used for operational costs of the programs located at the facility/facilities, including staffing. Programs must be funded from other sources of revenue.
- The funds shall be deposited in a special County fund and expenditures will be reviewed by an eleven (11) person oversight committee composed of the following members:
    - A citizen selected by each member of the Board of Supervisors (5)

- Member of the Behavioral Health Advisory Board (1)
- Mental Health Director or his/her representative (1)
- Elected County Auditor or his/her representative (1)
- Mendocino County Chief Executive Officer or his/her representative (1)
- Mendocino County Sheriff or his/her representative (1)
- A representative of a Mendocino County Chapter of the National Alliance on Mental Illness (NAMI) (1)

Methodology of Report

Based on direction from the Board of Supervisors, information provided to the Executive Office on the proposed Initiative by the Sheriff, and other research and analysis, the County Executive's Office has prepared this report to provide projections of the financial impacts of the proposed Initiative. These financial projections consider four main expenditure categories pertaining to the Initiative:

- Projected revenue to be generated by the proposed sales tax
- Projected construction costs of the proposed facility/facilities
- Projected maintenance costs of the proposed facility/facilities
- Projected staffing and operational costs of the proposed facility/facilities

In preparing these financial projections, key sources of information and analysis were obtained from: the Mendocino County Health and Human Services Agency (HHSA) on current Mendocino County Mental Health and Substance Use Disorder (SUD) program revenues, by revenue source, and Behavioral Health program costs by major program component; Beacon Economics on costs associated with inpatient mental health facility construction; reported operating costs for Humboldt County's 16-bed inpatient psychiatric facility; and analysis, review, and feedback from Lee Kemper of Kemper Consulting Group.

The language of the proposed Initiative is broadly stated. As a result, there is no clear statement in the Initiative specifying the type of facility or facilities that shall be constructed with the proposed sales tax revenue to be raised by the Initiative. In discussions between the County's Chief Executive Officer and County Sheriff, the sponsor and leading proponent of the Initiative, reference was made to a "Crisis Continuum" schematic (*Attachment C*) that shows four categories of Behavioral Health programming. The Sheriff agreed that the Crisis Continuum was an appropriate representation of the intent of the Initiative and could be utilized as the model for performing a fiscal analysis. The four categories are:

- Acute psychiatric inpatient
- Crisis residential
- Outpatient
- Alcohol and Other Drug (AOD) Residential

While it may be the intention of the Sheriff and other Initiative proponents that Behavioral Health programming at the newly constructed facility or facilities will align with the referenced Crisis Continuum schematic, the Initiative language does not specify such a framework. Consequently, it will be left to the Board of Supervisors, with the advice and recommendations of the oversight committee that would be created by the Initiative, to make a determination regarding the type of facility or facilities that will be constructed using the revenue generated by the Initiative and the specific types of services that will be provided there.

Further, it is important to note that while the Initiative language is not specific about what is to be constructed, the Initiative language is specific in prohibiting the use of any sales tax revenue generated by the Initiative for the cost of Behavioral Health program operations at the new facility or facilities. Insofar as it appears Initiative proponents assume Behavioral Health program operations at the new facility or facilities would be funded by revenue currently utilized by Mendocino County for Behavioral Health services, the projections contained in this report identify the estimated available transferable Behavioral Health revenue to support such program operations at the new facility or facilities.

Additionally, the proposed Initiative does not specify whether a new facility shall be constructed or an existing facility will be renovated and developed. The Initiative language leaves open the possibility of either the construction of a new facility or facilities or the renovation of an existing facility by utilizing the definition of "development." For the purposes of this report, it is assumed that a new facility would be constructed with revenue from the Initiative. This assumption is based on three factors. First, while there may be potential alternative facilities for renovation in Mendocino County, such as the former Howard Hospital in Willits, it is assumed that the preferred option is new construction that will allow for design of a facility that meets the provision of services presented in the Crisis Continuum schematic. Second, further highly detailed analysis would be required to study existing facility options in Mendocino County and determine necessary renovations and associated costs. Current time constraints prevent this type of analysis being included in this report. In comparison, new construction costs of similar facilities can be more easily and reliably estimated. Finally, it is assumed that if the Initiative is approved by the voters, a subsequent detailed analysis of the feasibility of alternatives would be conducted to determine if cost savings could be realized through renovation of an existing facility versus construction of a new facility or facilities.

Due to the limited availability of detailed information on the Initiative proposal, it is important to describe the methodologies used in preparing this report. The following methodologies were utilized to develop the report's financial projections:

- Projected Revenue from the ½ Cent Sales Tax Increase for Facility Construction: Depending on the projections, over a five year period the proposed ½ cent sales tax increase could raise approximately $6.9 million annually of revenue for a range of $36.3 to $37.6 million. For this report, it is projected that $37 million in revenue would be generated.

- Projected Construction Costs for the Proposed Facility or Facilities: Working with Beacon Economics and using the best available information on current costs of construction of comparable mental health facilities, projections for the cost of construction will be presented and compared with the amount of revenue that would be made available for that purpose by the Initiative.

- Projected Maintenance Costs of the Proposed Facility or Facilities: Working with Beacon Economics and using the best available information on the costs of facility maintenance of comparable mental health facilities, projections for the cost of maintenance will be presented and compared with the amount of revenue made that would be available for that purpose by the Initiative.

- Projected Staffing and Operational Costs of the Proposed Facility or Facilities: Using state regulatory requirements to determine required facility personnel (required number and type of personnel), comparable county positions, and standard overhead ratios for administrative costs in

Mendocino County, the cost of program operations in the new facility or facilities will be projected. These cost projections will be compared with Behavioral Health program costs for similar services in FY 2015-16, and projections will be provided for the amount of current revenue (currently dedicated to comparable program purposes) that could potentially be transferred to support program operations in the new facility or facilities.

Additionally, a variety of approaches were used to gather information for each category of this analysis, including:

- Document review and consultation with Behavioral Health professionals across California
- On-site interviews with Humboldt County officials regarding the county's Sempervirons acute psychiatric facility
- Acute psychiatric facility construction literature review and analysis by Beacon Economics
- Sales tax revenue information gathered from the Bureau of Equalization and further projections by HdL Companies
- Consultation with the County Treasurer, other California Treasurers, and commercial lending officials (Bank of America and Savings Bank of Mendocino County)
- Review request from Fitch ratings concerning credit rating impacts
- Extensive document and data review by numerous County officials and service providers
- Data and report review by Kemper Consulting Group

In addition, it is important to define terms used in the Initiative and this report. A list of key terms and definitions is included below.

Behavioral Health (Mental Health and AOD/SUDT): Although the term "Behavioral Health" is used in a variety of settings, Counties use this term to identify the integration of Rehabilitative Mental Health treatment and Substance Use Disorder treatment services.

Mental Health: Individual and group therapies and interventions designed to reduce mental disability, and improve or maintain functioning. The County Mental Health Plan is responsible for providing rehabilitative services to adults that are seriously and persistently mentally ill (SPMI) and children with serious emotional disabilities (SED).

Substance Use Disorders Treatment (SUDT): Individual and group treatment services focused on assessment, treatment planning, crises, and collateral sessions with family members. Drug Medi-Cal Substance Use Disorder Services are defined at 22CCR 51341.1.

Acute Psychiatric Inpatient Facility: Facilities having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.

Psychiatric Health Facility (PHF): Facilities licensed by the CA Department of Health Care Services (DHCS) under the provisions of Chapter 9, Division 5 of Title 22, beginning with Section 77001. Psychiatric health facilities are certified by DHCS as Medi-Cal providers of inpatient hospital services

and are governed by the provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context. Maximum number of beds limited to 16.

72-hour locked facility: Treatment facilities designated by the CA Department of Social Services to provide mental health services to individuals admitted in an involuntary treatment status under Welfare and Institutions Code section 5150 et. Seq.

Drop-in Clinic: Mental health drop-in clinics are open 24-hours a day, seven days a week for crisis counseling, assessments, and referrals. These clinics have staff that is able to help with crisis intervention and behavioral emergencies on a walk-in basis. Drop-in clinics provide treatment for emergencies such as panic attacks, suicidal crisis, danger to others, sudden loss of memory, and any other mental health or emotional crisis. The services generally associated with a "drop-in clinic" are assumed to be provided by the outpatient providers described in the Crisis Continuum model.

Crisis Residential Facility: A non-institutional residential facility that provides a structured program as an alternative to hospitalization for individuals experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The services are designed to support individuals in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24-hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

AOD Residential Facility: Facilities licensed by Department of Health Care Services to provide 24/7 non-medical substance abuse treatment services. The California Code of Regulations, Title 9, defines residential facilities licensed by the Department of Health Care Services (DHCS) as "any facility, building or group of buildings which is maintained and operated to provide 24-hour residential, nonmedical alcoholism or drug abuse recovery or treatment services."

Specialty Mental Health Services (includes Inpatient and Outpatient Services): Medication support services; Day treatment intensive; Crisis Intervention, Crisis Stabilization, Adult residential treatment services, Crisis residential treatment services.

Medi-Cal Eligible Expenses: Services provided in accordance with Title 9 Specialty Mental Health Services and Title 22 Drug and Alcohol Services. To be eligible for reimbursement by Medi-Cal, services must be provided consistent with regulations.

Further, prior to the release of this report, either a draft or the findings was presented to local mental health professionals and the Sheriff to solicit feedback. Where appropriate, the feedback provided by these parties has been incorporated into this report.

Overview of the Status of Psychiatric Beds in California

There has been a continuing reduction in the number of available psychiatric beds across the State of California. This report does not attempt to identify or explain all of the factors in this trend, but simply recognizes this is a statewide issue and that should be considered in a careful analysis, as a part of public consideration of the proposed ordinance. In 2013 (with information updated in October of 2015) the Center for Behavioral Health at the California Hospital Association prepared a white paper on "California's Acute Psychiatric Bed Loss." This paper is included as *Attachment D*.

The paper analyzes various types of psychiatric facilities and bed types. For the summary provided in this report, the focus is on acute psychiatric inpatient beds because these are the type of beds to be provided in the proposed Mendocino County facility. Between 1995 and 2013 the State of California has lost 43 similar psychiatric facilities, representing a nearly 24% reduction and a loss of nearly 2,700 beds across the state. While experts recommend a minimum level of 50 beds per 100,000 residents, as of 2013 the state had 17.44 psychiatric inpatient beds per 100,000 residents. Of the 58 counties in California, 25 (including Mendocino County) do not have inpatient psychiatric services. Humboldt County, with a population of 135,000, is the smallest county that currently has a similar acute psychiatric facility, with a total of 16 beds. This facility struggles to maintain operations with much of the professional staff being outsourced, and alternative funding sources beyond available mental health dollars required for operation. The facility is one of only two licensed "Super-PHF" facilities in California which allows them reimbursement through Medi-Care. This is a certification that reportedly cannot be obtained by new facilities. According to Humboldt County officials, coordination and training remain a significant problem within the system, and they are currently researching alternative models for their services.

This information illustrates that the need for inpatient psychiatric beds is not unique to Mendocino County, but one that is felt across the State of California. If a local facility is constructed in Mendocino County it is likely to result in a new demand for bed space by out of county clients. These clients may impose new demand for other Behavioral Health services in the county that is not quantified in this report.

Anticipated Revenue

Sales Tax Revenue: The proposed initiative calls for a temporary (5 year) ½ cent sales tax increase. The ½ cent tax would be collected in all jurisdictions within the borders of Mendocino County, including each of the four cities. Based on actual receipts by all jurisdictions in Fiscal Year (FY) 2015-16 as reported by the California State Controller's Office, and projected by HdL Companies, the ½ cent sales tax would generate approximately $6.9 million in the first year. Depending on the range of annual sales tax growth projected, the proposal is estimated to result in total revenue of between $36.3 and $37.6 million over five years, utilizing a range of 1.5% to 2.5% annual increases. For the purposes of this report, the estimate of $37 million will be utilized as the total anticipated revenue, which would result in $3.7 million in revenue for the purposes of a training facility and $33.3 million for the proposed behavioral health facilities. It is important to note that revenue will begin flowing from the initiative in the second year following enactment and revenue will be fully received by the end of the sixth year following enactment.

Projected Sales Tax Revenue	
Approximate annual receipts	$6,900,000
Estimated annual increase	1.5% to 2.5%
Total estimated 5-yr receipts	**$37,000,000**

Available for training center construction (10%)	$3,700,000
Available for Crisis Continuum construction	$33,300,000

Available funding from Mental Health Initiative	**$37,000,000**
Training center construction (10%)	**$3,700,000**
Crisis Continuum construction funding	**$33,300,000**

Set-aside for long-term facility maintenance	$3,300,000
Total available for Crisis Continuum facility construction/development	$30,000,000

It should also be noted that while there is some consistency and reliability with sales tax revenue, there is significant potential for volatility. The relatively recent reduction in fuel prices has significantly impacted the County's sales tax receipts. The good news in forecasting receipts in the future is that further significant reductions in fuel prices are not anticipated, reducing potential volatility.

Financing Costs: It is somewhat unusual for a public agency to fund the costs of a solely capital project with sales tax revenue. Generally bonds are sold which provide the funding up front to allow construction of a facility or infrastructure. In this case, if the proposal is approved by the voters, the full amount of revenue will not be realized until approximately six years after the election. This will require some type of financing mechanism to allow the construction project to start prior to receipt of all of the sales tax revenue. This will add significantly to the costs of the project and may impact the County credit rating.

Outreach was made to two commercial lenders to determine their interest in providing financing should the initiative be approved and the costs of providing that financing. The assumptions used to determine the financing costs were that the sales tax revenue stream could cover the initial planning and design costs, but $20 million of financing would be required to initiate the construction phase. The $20 million would be paid off over a five (5) year period with the sales tax revenue. The two lenders contacted were Bank of America, due to their existing relationship with the County, and Savings Bank of Mendocino County, due to the potential desire to identify a "local" partner. Both lenders expressed an interest in providing financing for the possible project and offered potential rates varying from 1.02% to 3.5%. While these rates appear very favorable, they are based on a number of assumptions that may or may not be realistic based on the limited detail in the proposed initiative. If financing is available at the lowest 1.02% interest rate, it would add approximately $520,000 of financing costs to the project, while a 3.5% interest rate would result in approximately $1.8 million of interest.

Estimated Financing Costs	
Assumed financing need	$20,000,000
Assumed financing term	5 years
Projected interest rates	1.02% to 3.5%
Total estimated costs for financing	$520,000 to $1.8 million

Additionally, the Executive Office worked with the County Treasurer to identify options for utilizing County Pool funds to provide the financing. State law appears to exclude the possibility of the Treasurer loaning Pool funds to the County for this type of project. The Treasurer is interested in further investigation should the Initiative pass and is willing to look at other options for utilizing county funds to provide upfront financing until sufficient tax revenue is received to cover the construction costs of the project. One option used by some California counties in certain situations has been to issue bonds, all of which would be purchased by the County Treasurer with Pool funds. The bond would be short term and paid with the sales tax revenue. While still complex and labor intensive it would be significantly quicker and a more streamlined process than a typical bond issuance. Should the Initiative pass the Chief Executive Officer would convene the Debt Committee and further investigate this alternative. However, it should be noted that this option may have a greater negative impact on the County's credit rating.

The Executive Office is aware of informal discussion in the community regarding the potential to acquire financing through the Mendocino County Employees Retirement System. County officials understand that this type of funding faces similar restrictions to those mentioned above with borrowing County Pool funds. It is important to note that this would not be a feasible option even if allowed by law in the current lending environment. The pension assets assume an annual rate of return of 7.25%, therefore there is little likelihood of the Retirement Board of Directors approving any loan that did not achieve at least that level of return. Based on the availability of commercial financing, potentially as low as 1.02%, this option would not be feasible.

Credit Rating: There is the possibility that any additional debt issued by the County would result in negative impacts to our credit rating. The Executive Office has communicated with Fitch Ratings to solicit a response, but to date has not received any specific indications. The Executive Office, as directed by the Board of Supervisors, does not recommend the County add any additional debt, and to pursue options to eliminate existing debt as quickly as feasible. Due to the relative short term nature of the debt and the dedicated revenue stream to pay down the debt in this case, there may be less of an impact to the County's credit rating than a more traditional debt issuance.

Facility Construction/Development Costs

The proposed initiative leaves open the possibility of either the construction of a new facility or facilities or the renovation of an existing facility by utilizing the description of "development." For the purposes of this review we identify costs for the construction of a new facility. This is based on two factors. While there may be available alternatives, such as the former Howard Hospital in Willits, the preferred option is assumed to be new construction in order to design a facility to meet the diverse provision of services as presented in the Crisis Continuum. Additionally it requires a higher level of detailed analysis to study an existing facility to determine renovation costs, where new construction costs of similar facilities can be more consistently estimated. It is further assumed that if the initiative were to be approved by the voters, a more detailed analysis of the feasibility of alternatives would be conducted to determine if cost savings could be realized over new construction.

Beacon Economics, a leading economics research firm, was utilized to conduct a literature review of recent mental health facility construction, maintenance, and operational costs to determine comparable data. The review focused on the most expensive and complex portion of the proposed facility, being the acute psychiatric facility. Four similar facilities were identified that have been recently constructed in the United States. This is acknowledged to be a high level review, but is important to provide a baseline sample of comparable data to give context to additional and more detailed analysis provided by others, including County staff. This report is included as *Attachment E*, with a summary of the key information included here.

Construction Cost per Bed: The costs of construction can vary widely, however they range from approximately $600,000 to $1.5 million per bed or approximately $620 to $1,000 per square foot. Newly constructed facilities range between 900 to over 2,000 square feet per bed.

Construction Data from Beacon Report (Table 1 & 2 combined)

Name (Year Opened)	# of beds	Sq. Ft.	Sq. ft./bed	$/sq. ft.	Cost
Horizon View (2015)	16	15,000	938	$627	$9,400,000
Vermont Psychiatric Care Hospital (2014)	25	53,000	2,120	$717	$38,000,000
El Camino Hospital (est. 2017)	36	52,000	1,444	$962	$50,000,000
DMH Psychiatric Hospital (2012)	320	428,000	1,338	$706	$302,000,000
Proposed Mendocino Facility*	**16**	**18,400**	**1,150**	**$900**	**$16,560,000**

* Acute Psychiatric Inpatient portion of the Crisis Continuum only

Based on these numbers, the construction of a 16-bed facility (acute psychiatric inpatient facility only) would range in cost from $9,000,000 to $24,000,000. This is a wide range, but construction estimating is difficult based on design complications, difficulty with desired locations, environmental impact review, cost escalations from project delays, and other factors. As an example, the 16-bed facility, Horizon View, constructed in Ventura County, California was originally estimated at $5.3 million, but delays and revisions brought the final projected project cost to $9.4 million. The facility was expected to open on July 5, 2016. The project is currently not finished and continues to be delayed with increasing costs, and the final completion date and construction cost are still unclear.

The total cost of the Horizon View facility shown above does not include land costs or equipment and infrastructure costs. Therefore, in order for the costs of the Ventura County facility to be directly comparable to the proposed Mendocino facility, it would require the addition of equipment and fixture costs, which is estimated to bring the total costs from $9.4 million to approximately $12.5 million according to available information. This is an important comparable project as it is a similar size to the proposed facility and is the most recent project example in California. It should be noted that anecdotally there could be some savings as a result of reduced construction costs in rural Mendocino County, although it is unlikely that there would be significant savings as few if any local construction firms are expected to have the experience and expertise to construct a facility of this type, therefore resulting in higher costs for out of county contractors. Local contractors are expected to be competitive for some of the subcontracts.

The cost per square foot for the psychiatric facility will be significantly higher than other portions of the facility, however an anticipated extended construction timeline and the uncertainty over whether the proposed project could result in one or multiple facilities, leads us to provide a broad estimate based on the available information. As a result, for the purposes of this report an assumed construction budget of $30 million is utilized which includes construction, architectural design, construction management, furnishings, and financing costs. The facility is assumed to be a total of 44,800 sf, with 18,400 sf for a 16-bed acute facility, 11,000 sf for a 12-bed Crisis Residential facility, 6,000 sf for Outpatient provider services, and 9,400 sf for AOD services (both 12-bed residential and detoxification). The Acute Psychiatric Inpatient, Crisis Residential, and AOD Residential facilities all require licensure and certification, some from different entities. The time and costs for each certification is unknown, but for the purposes of this report is assumed to be paid from the available sales tax revenue for the planning, design and construction of a facility or facilities.

	Assumptions			
Crisis Continuum Facility	**# of beds**	**Sq. Ft.**	**$/sq. ft.**	**Cost***
Acute Psychiatric Inpatient	16	18,400	$900	$16,560,000
Crisis Residential	12	11,000	$600	$6,600,000
AOD Residential	12	9,400	$600	$5,640,000
Outpatient	N/A	6,000	$200	$1,200,000
Totals	**34**	**44,800**	**$669.64**	**$30,000,000**

*Includes planning, design, construction, furnishings, financing, etc.

A projected cost of $30 million for construction of the facility/facilities is significant, but with approximately $37 million in revenue anticipated from the Initiative, it appears total available revenue would be sufficient for construction of the facility or facilities along with the $3.7 million dedicated to the training facility, as required by the Initiative. Additionally, the remainder of roughly $3.3 million would be available to fund the provision of facility maintenance for a period into the future. Further discussion of maintenance costs is presented in the following section.

Maintenance Costs

Maintenance costs covered in this section are specific to costs that are expected to be eligible for payment from the proposed sales tax revenue. Based on a total facility size of 44,800 sf, anticipated maintenance costs, including custodial services, are estimated to be between $3.57 to $3.65 per sf or an approximate total of $160,000 per year. This amount will vary somewhat depending on the use of each specific portion of the building, but is consistent with a 24-hour, 365-day operation in a locked and/or restricted use facility. This cost is expected to reach $1.5 million to $2 million over a 10-year period. Additional costs not included in this amount that need factored in would be for major equipment replacement. This would include furnishings; heating, ventilation, and air conditioning equipment; etc. Utilizing the model that assumes a total of $3.3 million reserved in a specific fund for facility maintenance, the funding should support facility maintenance and major equipment replacement for 10 to 15 years.

Projected Staffing and Operating Costs

Mental Health Funding Overview: Funding for Behavioral Health services in Mendocino County is provided from a variety of sources through the State of California and the federal government. The total funding available in the FY 2016-17 budget is $21,267,274 in Mental Health (BU 4050), $6,255,119 in Mental Health Services Act funding (BU 4051) (of this amount $2,607,012 is a transfer to BU 4050 for Administrative Service Organization funding), and $2,067,715 in Alcohol and Other Drug funding (BU 4012). This amounts to a combined available total of $26.9 million in behavioral health funding. A chart showing the combined funding from all three budget units (BU) by source is below with descriptions of each funding source.

Total Behavioral Health Revenue (BU 4012, BU 4050, BU 4051)

Behavioral Health Revenue	FY 16-17 Adopted Budget
1991 Realignment	$4,005,794
2011 Realignment	$6,995,068
Medi-Cal Reimbursment	$8,055,952
MHSA	$2,607,012
AOD/SUPT	$1,050,046
Misc. Revenue/Fund Balance	$4,180,853
Other Sources (GF, etc.)	$88,371
Total	**$26,983,096**

1991 Realignment Funding: In response to the 1990 Recession, the State "realigned" funding for a range of health, mental health and social services programs. Under this realignment, responsibility for County Community Mental Health programs was shifted from State General Fund to counties. Mendocino County utilizes 1991 Realignment funds for county Mental Health Department program operations and administration, including audits. The source of deposits into the State 1991 Realignment Fund is from Vehicle License Fees and a statewide distribution of a 0.5% Sales Tax. FY 2016-17 budgeted amount: $4,005,794.

2011 Realignment Funding: In response to the 2007-2009 Recession, under Proposition 30 the State further realigned funding for county Mental Health and Substance Abuse Treatment programs. Under Proposition 30, specified state sales taxes are provided to counties to be utilized as the "Non-Federal Share" to replace State General Funds for the following programs:

- Substance Abuse Treatment Programs
- Mental Health Managed Care Program
- Mental Health Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The source of the funds for the Behavioral Health Subaccount that are deposited into the Protective Services Account are from a 1.0625% Sales Tax. FY 2016-17 budgeted amount: $6,317,127 (MH) $677,941 (SA).

Mental Health Services Act (MHSA) Funding: Under the provisions of Proposition 63, MHSA funds are intended to fund new, or expanded, services to the underserved mentally ill population. The largest program areas are Prevention and Early Intervention (PEI) and Community Services and Supports (CSS). While MHSA funds can be used for the "Non-Federal Share" or match against allowable Medi-Cal expenditures, the funds are primarily intended to be used for services above and beyond Medi-Cal allowable activities. The source of deposits into the State Mental Health Services Fund that houses all MHSA contributions from the State is a tax on incomes in excess of $1 million and represents 1.0% of all California Personal Income Taxes. FY 2016-17 budgeted amount: $2,607,012.

Medi-Cal Funding: The Federal Government reimburses counties a "Federal Share" at a certain percentage of the total costs of providing certain prescribed services. This is called Federal Financial Participation, or FFP. This FFP is determined by the percentage set by the Federal Government called

Federal Medicaid Assistance Percentage, or FMAP. California's FMAP is currently 50%. This source of funds is reimbursed through the California Department of Health Care Services and comes from the Federal Government's Tax Receipts. FY 2016-17 budgeted amount: $7,804,595 (MH) $251,357 (SA).

Alcohol and Other Drug (AOD) or Substance Abuse Prevention and Treatment (SAPT) Funding: SAPT funds are received by Mendocino County as a Federal "pass through" from the State, which means that the funds are received by the State and allocated to counties for specified program purposes. These funds are categorical in nature and can only be used for designated service modes/programs, with the exception of discretionary funds. This source of SAPT deposits is from the Federal Substance Abuse & Mental Health Services Agency (SAMHSA). FY 2016-17 budgeted amount: $1,050,046.

Available Operating Revenue for the Crisis Continuum: According to the review performed by Beacon Economics, the operating costs per bed for similar acute psychiatric facilities ranges from approximately $170,000 to $470,000 per year. The facilities studied ranged in size from 320 beds to 25 beds, with the cost per bed significantly higher as the size of the facility decreases. The costs for a 16-bed facility were estimated to be from $250,000 to $400,000 per bed per year for a total operating cost of between $4 million to $6.4 million. This study provides a baseline assessment of anticipated operational costs for the acute psychiatric portion of the proposed facility only.

In the earlier section above on revenue sources, a chart and description of Behavioral Health revenues included a breakdown of the available funding for both mental health and substance abuse treatment programs. The chart below includes the same information with the inclusion of the projected revenue available under the proposed Crisis Continuum model. Under this model, a total increase in costs of $9.7 million is projected, of which $4.85 million would be reimbursable and the remaining $4.85 million would be non-reimbursable. Non-reimbursable costs would require an additional or alternate revenue stream, with the County General Fund acting as the source of last resort.

Total Behavioral Health Revenue (BU 4012, BU 4050, BU 4051)

Behavioral Health Revenue	FY 16-17 Adopted Budget	Projected Crisis Continuum	New Costs
1991 Realignment	$4,005,794	$4,005,794	$0
2011 Realignment	$6,995,068	$6,995,068	$0
Medi-Cal Reimbursment	$8,055,952	$11,679,644	$3,623,692
MHSA	$2,607,012	$2,607,012	$0
AOD/SUPT	$1,050,046	$1,050,046	$1,233,583
Misc. Revenue/Fund Balance	$4,180,853	$4,180,853	$0
Other Sources (GF, etc.)	$88,371	$4,945,646	$4,857,275
Total	**$26,983,096**	**$36,697,646**	**$9,714,550**

It is anticipated that some portion of existing Behavioral Health funding would be available to be shifted or transferred to provide services at the proposed mental health facility/facilities. The total estimate of transferrable costs for Acute Psychiatric, Crisis Residential and AOD Residential that currently occur outside of Mendocino County and which could be transferred to fund the new facility is $2.6 million. This leaves a funding gap estimated at $9.7 million.

Funding streams, such as Medi-Cal revenue, are based on qualifying billable services provided to eligible Medi-Cal members. The majority of revenue streams described above are based on receipts at the state level and then distributed as allocations to each county. Some of these revenue streams do not provide the opportunity to drawdown additional Medi-Cal funds, and are often used to cover the costs of non-billable services. With this understanding, each facility component will be presented in the following section with a projected cost to operate programming at that facility component and an estimate of the maximum Medi-Cal revenue potentially available to support those program operations if services were designed to maximize Medi-Cal eligible services to Medi-Cal eligible individuals.

Even with this model of maximizing Medi-Cal reimbursement based on the Federal Medical Assistance Percentage of 50%, the proposed facility would result in additional expenses above the available current revenue for billable services of $4.85 million. Based on the estimates included in this report, it is projected that costs will exceed available revenue by approximately $4.85 million per year or, with a total increase in annual costs of $9.7 million. This would increase total Behavioral Health expenditures from $26.9 million per year to $36.7 million per year. At this time there is no identified revenue stream to cover these additional expenses. More detail is provided below on the specifics of the estimated costs for each section of the proposed facility.

Projected Annual Operating Costs for Behavioral Health Crisis Continuum

Crisis Continuum	FY 15-16 (Est.)	Projected Crisis Continuum Costs	Transferrable Costs	New Reimbursable Costs	New Non-reimbursable Costs
Acute Psych.	$1,447,432	$6,703,095	$1,230,317	$2,736,389	$2,736,389
Crisis Residential	$1,378,059	$3,152,660	$1,378,059	$887,303	$887,303
AOD Residential	$374,984	$2,523,414	$56,248	$1,233,583	$1,233,583
Outpatient	$10,200,000	$10,200,000	$10,200,000	$0	$0
Total	**$13,400,475**	**$22,579,169**	**$12,864,624**	**$4,857,275**	**$4,857,275**
Other BH services	$13,582,621	$14,118,476	$14,118,477	$0	$0
Total BH Budget	**$26,983,096**	**$36,697,646**	**$26,983,101**	**$4,857,275**	**$4,857,275**

Of the current $26.9 million budgeted for Behavioral Health services in FY 2016-17, over $9.4 million is contracted for mental health services for children with severe emotional disorders. The additional costs for other Behavioral Health services for adults (those not included in the Crisis Continuum), such as administration, clinical staff, program oversight, residential care homes, and other contracted services are anticipated to remain relatively consistent regardless of the establishment of the proposed facility.

Acute Psychiatric Inpatient Facility: According to the review performed by Beacon Economics, the operating costs per bed for inpatient psychiatric facilities ranges from approximately $170,000 to $470,000 per year. The facilities studied ranged in size from 320 beds to 25 beds, with the cost per bed significantly higher as the size of the facility decreases. The costs for a 16-bed facility were estimated to be from $250,000 to $400,000 per bed per year for a total operating cost of between $4 million to $6.4 million. This study provides a baseline assessment of anticipated operational costs for the acute psychiatric inpatient facility only.

Based on analysis provided by Mendocino County HHSA, the projected annual cost for staffing and operating a 16-bed psychiatric facility in Mendocino County would be $6,703,095. As described in the methodology section above, this projection is based upon the following: 1) required staffing for such facilities (type of personnel and number) under state regulation; use of county personnel; average statewide cost of such personnel in California; and, the standard Mendocino County overhead rate. Because the facility is a 24-hour facility, the projection must include staffing for a 24-hour period. This calls for a total of 33 required staff to operate the facility, which includes one (1) Physician/Psychiatrist, and one (1) on-call Psychiatrist; one (1) Psychologist; one (1) Clinical Social Worker; ten (10) Registered Nurses; ten (10) Mental Health Clinicians; ten (10) Licensed Vocational Nurses (LVN); and, three administrative staff.

For comparison, the Humboldt County Department of Health Services reported estimated actual operating costs for Humboldt County's 16-bed acute inpatient psychiatric facility, Sempervirons, were $6.2 million in FY 2015-16.

As presented in the table below, over the past three years Mendocino County spent between $1.2 million and $1.44 million on out-of-county acute psychiatric inpatient placements. Approximately 10% of the cost has been for clients aged 24 and below, with the remaining 90% of cost for clients aged 25 years of age and above.

Total Acute Psychiatric Inpatient Costs

	FY 13-14	FY 14-15	FY 15-16 (Est.)
24 years old and below	$118,725	$164,614	$126,347
25 years old and above	$1,067,303	$1,091,585	$1,321,085
Total	**$1,186,028**	**$1,256,199**	**$1,447,432**

The proposed acute psychiatric inpatient facility would be licensed to accommodate clients 18 years old and above. Of the total projected cost of $1.44 million in FY 2015-16, it is estimated that roughly 85% of this service revenue would be available for transfer to support operations of the new acute inpatient facility. The remaining 15% is estimated to be non-transferrable because the level and type of services needed by the patients would not be met by the new facility (due to their complex medical needs, co-occurring conditions, or similar patient complications). Based upon FY 2015-16 expenditures and an estimate of 85% transferability, approximately $1.23 million would be available for transfer to assist in meeting operating costs of the facility.

If the operational cost of the new facility is $6.7 million annually, after accounting for the transfer of $1.23 million to support the facility (associated with client placements at the facility and associated patient revenues), a net shortfall of approximately $5.4 million in annual operating costs for the new facility would remain. While up to 50% of this operating gap may be reimbursed by Medi-Cal if all of the services and patients were Medi-Cal eligible, this still leaves a funding shortfall of approximately $2.7 million annually.

There are some potential options for addressing this projected $2.7 million shortfall. This shortfall may be able to be bridged if the facility could operate as a regional facility for patients beyond residents of Mendocino County. In light of the loss of acute inpatient psychiatric facility capacity across California since 1995, as reported by the California Hospital Association and referenced earlier in this report, this new capacity could potentially be met through placements into the new facility by Behavioral Health

Departments in other counties. To assess the viability of this strategy, an in-depth business analysis would need to be conducted that takes into consideration the needs, utilization and interest of neighboring counties as well as County-specific Medi-Cal reimbursement rates.

A second option to address the shortfall may be possible if one were to assume that the facility would be operated by a non-county entity. Under this scenario, it is possible that operational costs could be less than the amount projected; presuming that staff salaries and benefits of this non-county entity would be less than the average public agency costs statewide for such facilities. It is also possible that the overhead operating cost ratio for this non-county entity could be somewhat less than the county's ratio. Insofar as data for such a comparison was not readily available for this report, a projection of costs under such an alternative has not been included in this report.

Crisis Residential Facility: For the purposes of this projection, it is assumed that a 12-bed Crisis Residential Facility would be constructed. In keeping with the referenced cost projection methodology, operational costs were determined based upon: 1) required staffing for such facilities (type of personnel and number) under state regulation; use of county personnel; average statewide cost of such personnel in California; and, standard Mendocino County overhead rate. Because the facility is a 24-hour facility, the projection must include staffing for a 24-hour period. Due to the schedule, a total of 15 required staff to operate the facility, which would include: one (1) Physician/Psychiatrist (on call); two (2) Psychologist/Mental Health Clinicians; six (6) Registered Nurses; and six (6) Mental Health Rehabilitation Specialists/Human Service Workers.

Based upon the factors identified above, the County HHSA projects operational costs for the proposed Crisis Residential Facility of approximately $3.15 million annually.

In FY 2015-16 the HHSA reported that Mendocino County will spend approximately $1,378,059 on services related to Crisis Residential care. All (100%) of these expenditures are anticipated to be transferrable to the proposed mental health facility. This leaves a shortfall of approximately $1.77 million in meeting total operational costs. While up to 50% of this operating gap may be reimbursed by Medi-Cal if all the services and patients were Medi-Cal eligible, this still leaves a local projected funding shortfall of $887,303 annually.

AOD Residential Facility: Although there is very limited information available about the type of AOD Residential Facility envisioned by the Initiative for the Crisis Continuum, for purposes of this analysis it is assumed that the detoxification unit and the residential Alcohol and Drug Treatment facility would operate as a social model and not a medical detoxification unit or medically supervised chemical dependency recovery. The facility analysis presented earlier in this report presumes two beds for detoxification and 12 residential treatment beds at a total of 9,400 square feet.

The California Code of Regulations, Title 9, defines residential facilities licensed by the Department of Health Care Services (DHCS) as "any facility, building or group of buildings which is maintained and operated to provide 24-hour residential, nonmedical alcoholism or drug abuse recovery or treatment services." This 24-hour, seven days a week, adult residential alcohol and/or other drug (AOD) recovery and treatment facility would include social detoxification and nonmedical residential treatment. Social detoxification means detoxification in an organized residential nonmedical setting delivered by trained staff that provide safe, 24-hour monitoring, observation and support in a supervised environment for a client to achieve initial recovery form the effects of alcohol and/or other drugs.

Social detoxification differs from medical detoxification in that the latter refers to a detoxification process done under medical supervision in a facility that is staffed with doctors and nurses who are trained in helping patients cope with withdrawal symptoms through medical treatment measures. Medical detoxification and chemical dependency recovery that is supervised by medical professionals would require licensing as a health facility and would add substantial costs. A social detoxification and nonmedical residential facility cannot admit severely intoxicated or impaired individuals if they require medical clearance or oversight.

The operational cost structure of $2,523,400 annually for a 12-bed substance use disorder treatment facility is based on the minimum staffing requirements for a social detoxification and nonmedical residential service model. In keeping with the referenced cost projection methodology, operational costs were determined based upon: 1) required staffing for such facilities (type of personnel and number) under state regulation; use of county personnel; average statewide cost of such personnel in California; and, standard Mendocino County overhead rate. Because the facility is a 24-hour facility, the projection must include staffing for a 24-hour period. This calls for a total of 12 required staff to operate the facility, which would include: one (1) Facility Administrator; one (1) certified Counselor; one (1) Registered Counselors; two (2) Community Health Workers, four (4) Staff Assistants, one (1) Fiscal Manager, and two (2) Department Analysts.

Based upon the factors identified above, the County HHSA projects operational costs for the proposed AOD Residential facility of approximately $2.5 million annually. In FY 2015-16 the HHSA reported that Mendocino County will spend approximately $374,984 on services related to AOD Residential care. Of these expenditures a total of $56,248 is anticipated to be transferrable to the proposed mental health facility. This leaves a shortfall of approximately $2.46 million in meeting total annual operational costs.

Currently there is not an available revenue stream to cover the additional $2.53 million in costs. However, Mendocino County is currently in the planning phase of the State of California's Drug Medi-Cal expansion project, which would expand Medi-Cal reimbursement structures to cover residential treatment for all Medi-Cal eligible beneficiaries Therefore, a similar maximum Medi-Cal reimbursement methodology of 50% is being applied, and there is room to be hopeful that additional operational costs for Alcohol and Drug treatment could be substantially reimbursed under the new Drug Medi-Cal Waiver structure if the programming is designed to maximize services to eligible Medi-Cal beneficiaries. As a result the analysis assumes a total of $1.23 million in costs would be Medi-Cal reimbursable and $1.23 million in costs would require an additional revenue stream.

Based on the currently available information on the intent of the Initiative, there is concern that the population of an AOD Residential facility will largely be shifted from the County Jail. It is difficult to determine how this model would operate as there is not a similar known facility in the state with which to compare. According to Mendocino County Jail statistics for calendar year 2015, there were 5,043 total bookings, and of those 2,942 were drug or alcohol related and 1,220 were for public intoxication (with no other charges). However, due to questions on accessing adequate booking information from the Jails system, the Jail Commander estimates that the drug and alcohol only arrests are closer to 80% of total bookings. Under a social model it remains unknown how many members of this population would be eligible clients at the proposed AOD Residential facility.

Outpatient Services: Outpatient services are currently provided through contract with service providers in various locations around Mendocino County. The County funds these services through its Administrative Services Agreement with Redwood Quality Management Company (RQMC), which provides delivery of outpatient services through subcontracted providers. Currently, there is no direct

facility support for outpatient services. Rather, subcontractors utilize their own facilities at their own expense to provide services. Since Outpatient Services is one of the four service categories on the Crisis Continuum schematic, it is assumed that Initiative proponents intend for these services to be provided at office space in the new facility.

Initially, the ongoing cost for providing services through existing subcontractors is not expected to be impacted by the proposed facility because outpatient services are expected to continue to be delivered in their current manner until such time as the facility is constructed. At this time, it is not possible to project whether currently subcontracted service providers are interested in relocating their service locations to the new facility or how many providers would assume space in the central county facility. However, since there is considerable time until the facility will be constructed, there should be ample time for a "Outpatient Services Co-Location" assessment to be completed that considers each current outpatient services subcontractor by age of population served; type of service; location of current services; need for future space; current budget amount allocated to rent/lease; need for distribution of services across the county; and other relevant factors. Following development of this type of assessment, a more complete picture should emerge of the relative utility of a central county location for co-located service delivery and a plan could be developed.

Conclusion

The cost projections contained in this report are estimates based on the best information available to the County Executive and the County HHSA at this time. These projections are based upon a set of assumptions and methodologies that have been described in this report and which are recommended as fair and reasonable. Use of other assumptions and/or methodologies could lead to different financial projections.

In summary, the proposed Initiative is anticipated to generate approximately $37 million dollars of revenue over the five-year life. Of this total, 10% or $3.7 million is restricted to use in development of a training center for public safety agencies and mental health service providers. The remaining $33.3 million would be available to develop a facility or facilities that would provide four categories of mental health services to the Mendocino County community. The facility as proposed is anticipated to cost approximately $30 million dollars to plan, design, construct, furnish, and finance. The remaining $3.3 million would be available to be placed in a facility maintenance fund to support the long-term (estimated at 10-15 years) maintenance needs of the facility.

The projected total of $30 million dollars is expected to be sufficient to support the construction of a facility that totals 44,800 sq. ft. and provides all of the following:

- Acute Inpatient Psychiatric Inpatient Facility (16-bed) @ 18,400 sf
- Crisis Residential Facility (12-bed) @ 11,000 sf
- Outpatient Treatment Center @ 6,000 sf
- AOD Services (Detoxification and 12-bed Residential Treatment) @ 9,400 sf

In addition, the $3.3 million available to fund the provision of facility maintenance is projected to be sufficient to fund the costs of facility maintenance, including furnishings, heating, ventilation, and air conditioning equipment and major equipment replacement for 10 to 15 years.

With respect to the financing of Behavioral Health program operations in the new facility or facilities, a financing shortfall is projected for the Acute Inpatient Psychiatric Facility of $2.73 million annually.

Further, an annual financing shortfall is projected for the Crisis Residential Facility of $887,000. Finally, a projected annual shortfall of $1.23 million is anticipated for the proposed AOD Residential facility. Options to partially address these shortfalls have been provided in this report.

With respect to the financing of Outpatient Service operational costs at the new facility, it is premature to offer specific cost projections until such time as assessment is completed that considers each current outpatient services subcontractor and the opportunity for colocation in a central county location based on each subcontractor's age of population served; type of service; location of current services; need for future space; current budget amount allocated to rent/lease; need for distribution of services across the county; and other relevant factors.

In consideration of the estimates provided in this report, a total projected operating funding shortfall for the proposed facility is anticipated to be $4.85 million annually, above existing revenue sources.

While this is projected to be a costly project, it is based on the County fully planning, implementing and operating the facilities. If we plan and implement alternate models, the cost could be much less to the General Fund. At this time, there are several opportunities for public-private partnerships that are providing, and will be providing additional services to our community for lesser cost. Partners such as Adventist Health, Redwood Quality Management Company, Ford Street, Partnership Health Plan of California and many more have been in discussions about working with the County to provide much needed services.

Along with that, funding such as Senate Bill (SB) 82 for mental health services, California's Section 1115 Medicaid Waiver for substance abuse and alcohol and other drug funding, and other state and federal dollars may address rates and programming needs. The Executive Office hopes that these partnerships, funding streams via SB 82 or the 1115 waiver, and the strength of this community will make this initiative fiscally possible.

NOTICE OF INTENT TO CIRCULATE PETITION FOR THE PURPOSE OF REVITALIZING MENTAL HEALTH SERVICES IN MENDOCINO COUNTY.

The Mental Health Facility Development Ordinance of 2016

Notice is hereby given by the persons whose names appear hereon of their intention to circulate the petition within the County of Mendocino for the purpose of revitalizing Mental Health Services throughout Mendocino County. The purpose is to initiate a temporary (5 year) 1/2 cent sales tax in all parts of Mendocino County to develop facilities in Mendocino County to assist in the diagnosis and treatment of Mental Illness and addiction recovery. The initiative includes a portion of the funds to develop and maintain a training facility to be used by mental health professionals, public safety professionals and citizens to better serve the citizens in Mendocino County.

This initiative impresses upon the Mendocino County Board of Supervisors that the treatment of mentally ill citizens is a priority, and that this priority should be reflected in the staffing and budgeting of Mental Health Services.

These sales tax proceeds, and any interest or penalties collected that relate to this tax, shall be deposited into a special fund of the county treasury and used exclusively for the planning, preparation, development, furnishing and maintenance of county-designated facilities that will provide mental health services. No funds may be used for other incidental but necessary purposes, including the staffing of such facility.

10% of the funds shall be used for the purpose of establishing and maintaining a public safety/mental health training facility which will be used for training first responders and mental health professionals in proper and modern mental health methods of treatment techniques. These funds shall be deposited into a special fund of the county treasury and used exclusively for the planning, preparation, development, furnishing and maintenance of county-designated facilities that will provide education and training services for Public Safety employees, Mental Health professionals and citizens. No funds may be used for other incidental but necessary purposes, including the staffing of such facility.

The funds approved for the revitalization of these services shall be reviewed (Prior to expenditure) by a politically independent oversight committee. This committee shall be comprised of a citizen selected by each member of the Mendocino County Board of Supervisors, a Member of the Behavioral Health Advisory Board, The Mental Health Director or his/her representative, The Elected County Auditor or his/her Representative, The Mendocino County CEO or his/her Representative and the Sheriff or his/her Representative. The final member of the 11 person oversight committee shall be a representative of a Mendocino Chapter of the National Alliance on Mental Illness

Tom Allman — Tom Allman
Name (Printed) Signature

2501 Hearst Road, Willits, CA 95490
Address of above

Barbara Newell — Barbara Newell
Name (Printed) Signature

11820 West Road Potter Valley CA 95469
Address of above

Jennifer Frew — Jennifer Frew
Name (Printed) Signature

211 Main Circle Ukiah CA 95482
Address of above

Betty Lacy — Betty Lacy
Name (Printed) Signature

932 Helen Ave Ukiah, Ca 95482
Address of above

LINNEA J HUNTER — Linnea J Hunter
Name (Printed) Signature

139 Barker Blvd Ukiah, CA 95482
Address of above

RECEIVED
MAR 15 2016
SUSAN M. RANOCHAK
COUNTY CLERK-RECORDER

Kathleen Louise Carter Gaston
Name (Printed) Signature

518 N. Bush St, Ukiah CA 95482
Address of above

Elizabeth Evangelatos
Name (Printed) Signature

460 Sherry Dr, Ukiah, CA 95482
Address of above

SONYA NESCH
Name (Printed) Signature

8025 Flynn Creek Road Comptche CA 95427
Address of above

Ace Barash MD MD
Name (Printed) Signature

1494 Dawnwood Dr Ukiah
Address of above

Name (Printed) Signature

Address of above

Initiative Measure to be Submitted Directly to the Voters

The County Counsel has prepared the following title and summary of the chief purpose and points of the proposed measure:

An initiative to propose a sales tax to develop facilities for the treatment of mental health.

The ballot title is as follows:

An Initiative to Add a Temporary Half-Cent Sales Tax to Fund Facilities in Mendocino County to Assist in the Diagnosis and Treatment of Mental Health and Drug Dependency

The stated purpose of the initiative is as follows:

1. To impose a temporary five-year one-half (1/2) cent sales tax for the specific purpose of developing facilities to assist in the diagnosis and treatment of mental illness and drug dependency;
2. To create a special fund for these tax proceeds to be used exclusively for planning, preparation, development, furnishing and maintenance of mental health facilities. They are not to be used for staffing said facilities. Ten (10) percent of this fund is to be dedicated to establishing and maintaining a public safety/mental health training facility; and
3. To establish an eleven (11) person oversight committee to review the expenditure of these funds.

This Initiative must be adopted by two-thirds (2/3) of the voters.

Dated: March 23, 2016

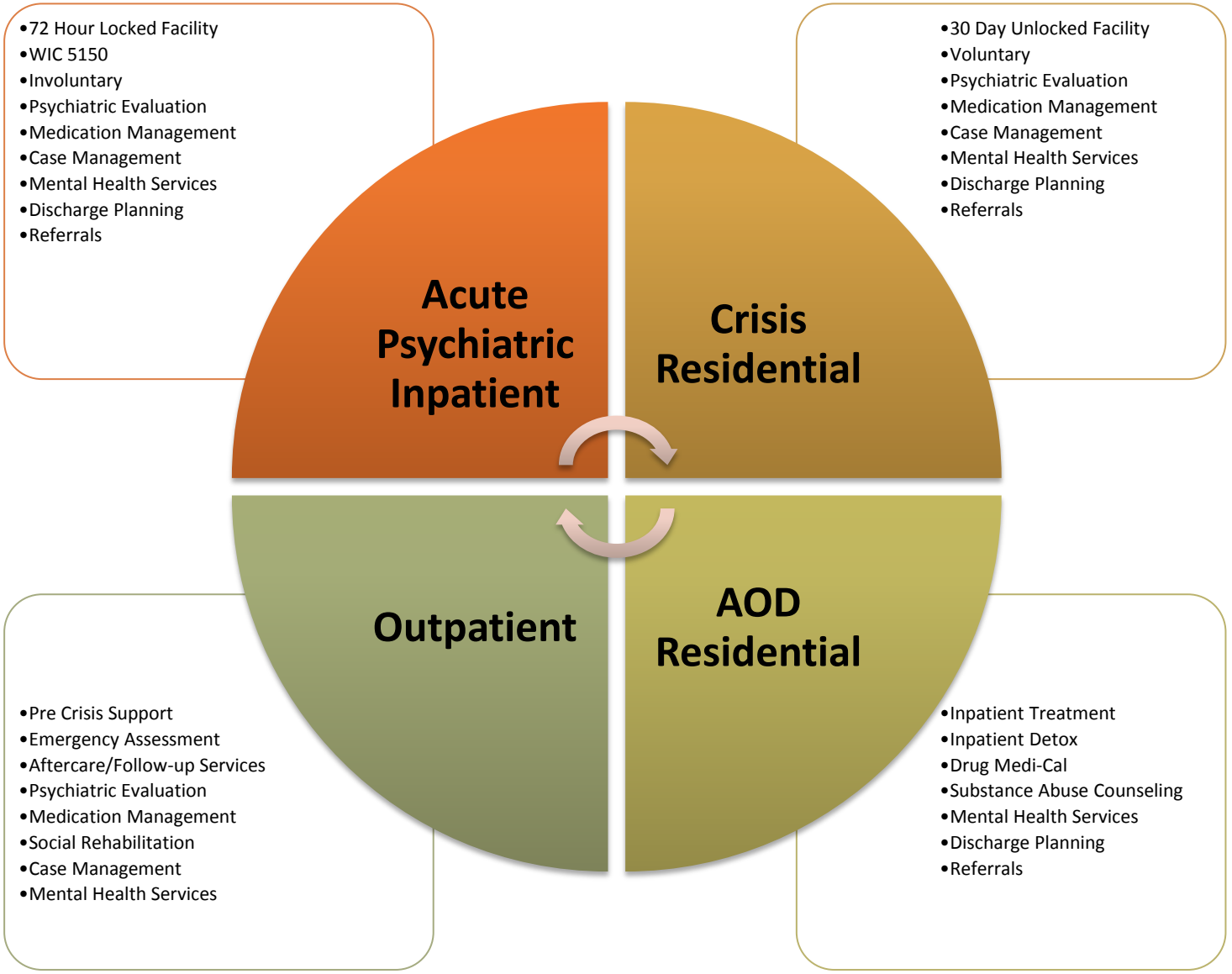
s/KL Elliott
KATHERINE L. ELLIOTT
County Counsel
County of Mendocino

"NOTICE TO THE PUBLIC
THIS PETITION MAY BE CIRCULATED BY A PAID SIGNATURE GATHERER OR A VOLUNTEER, YOU HAVE THE RIGHT TO ASK".

Each of the undersigned states for himself/herself that he or she is a registered and qualified elector of the County of Mendocino.

	Print Your Name 1.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 2.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 3.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 4.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 5.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 6.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 7.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 8.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 9.	Residence Address Only		
	Your Signature	City	Zip	
	Print Your Name 10.	Residence Address Only		
	Your Signature	City	Zip	

MENTAL HEALTH FRAMEWORK: CRISIS CONTINUUM



By increasing Pre/Post Mental Health Crisis Services and Supports, we can better serve emergency mental health situations without relying on Law Enforcement agencies to be the de facto mental health provider. We can build a Crisis Continuum that puts less strain on county emergency services, medical services, and communities, while still empowering consumers, families, and providers to access mental health supports.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

California's Acute Psychiatric Bed Loss

As of 2013, California had 27 hospitals licensed as freestanding Acute Psychiatric Hospitals (APH) and 23 county-run Psychiatric Health Facilities, which provide care only to individuals with acute behavioral needs. The remaining 88 facilities are dedicated psychiatric units within General Acute Care Hospitals (GACHs). California has nearly 440 GACHs, of which about one-fifth have such dedicated psychiatric units. Combined, these hospitals supply the 6,680 beds available around the state for individuals in need of short-term, acute level of care, psychiatric inpatient services.

What follows is CHA's attempt to illustrate the devastating drop in psychiatric inpatient services during the past several years. Our primary data source is the current (2013) financial data reports from the Office of Statewide Health Planning and Development (OSHPD). It is important to note that none of the data in this document includes beds from the five very large, state-owned hospitals in Fresno, Napa, Los Angeles, San Bernardino, and San Luis Obispo Counties, since the beds in these facilities are typically not available to the general public, with most patients being admitted by court order. The remaining pages of this document are described below.

Acute Psychiatric Inpatient Bed Closures/Downsizing – Page 2

This page contains graphs illustrating the severity of the bed loss in the state. The first chart shows the loss in the number of facilities with inpatient psychiatric beds since 1995. The state has lost 43 facilities, either through the elimination of psychiatric inpatient care, or complete hospital closure, representing a nearly 24% drop.

The second chart shows the decline in beds from 1995 to the present. While there has been an increase in beds over the past two years, as of 2013 data, California had lost nearly 30% of the beds it had in 1995, a drop of almost 2700 beds.

The third chart displays the increase in the patient-to-bed gap, statewide. A panel of 15 leading psychiatric experts was consulted and asked to look at specific criteria such as number of individuals who need hospitalization, the average length of hospital stays, and current state and federal financing structures. Using these criteria, the panel concluded that 50 public psychiatric beds per 100,000 individuals (or 1:2000) is the absolute minimum number required to meet current needs. This number, however, is contingent upon the availability of appropriate outpatient services in the community. In 1995, California fell short of this target by nearly 1,400 beds, having only 29.5 beds per 100,000 residents. That gap has increased to nearly 4,000 beds in 2013, with the state having 17.44 psychiatric inpatient beds for every 100,000 residents. This is a loss of nearly 41% of the beds per capita in California since 1995.

The fourth chart shows the increase in California's population over the same period of time. Since 1995, the state has gained roughly five and a half million people, a growth of more than 20%, with the 2013 population approaching 38 ½ million.

Psychiatric Inpatient Care Units and Freestanding Psychiatric Hospitals Comparative Data – Page 3

This page provides a comparison of California to the rest of the United States. National data comes from the American Hospital Association's (AHA) Annual Survey of Hospitals. From these figures, we subtracted California's numbers to arrive at the 49-state data. Census data was used to calculate the number of beds per person. As mentioned above, California's bed rate is one bed for every 5,572 people, as of 2013, worse than the rest of the nation's average of one bed for every 4,953 people. This illustrates that, while California's crisis is not unique, we fare far worse, comparatively.

Acute Care Inpatient Psychiatric Bed Distribution by County – Page 4

This page of the document breaks California data down by county in an attempt to illustrate the different types of beds available. Also listed are beds reserved for chemical dependency patients and beds in Psychiatric Health Facilities. All data is from OSHPD annual reports. The chart also shows that 25 of California's 58 counties have no inpatient psychiatric services. The remaining pages 5-12 visually show the bed distribution across the state, illustrating the vast areas between and without particular services.

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Acute Psychiatric Inpatient Bed Closures/Downsizing
California, 1995 - 2013

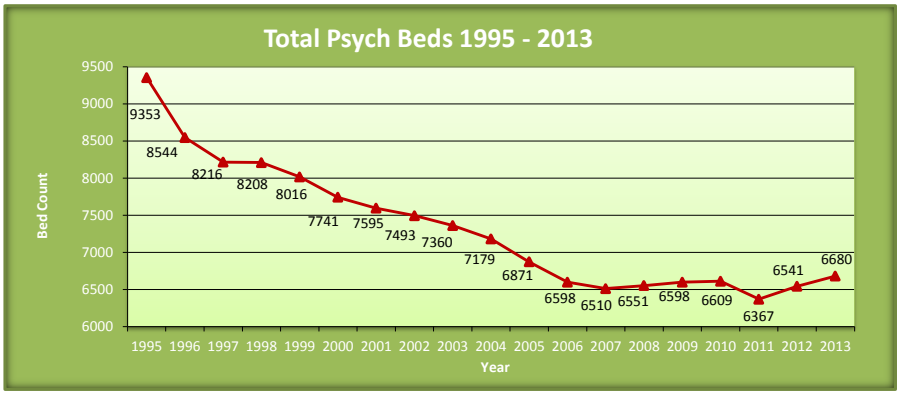
CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

PSYCH FACILITY CHANGE

1995	181
2013	138
Total Change	-43
% Change	-23.8%

PSYCH BED CHANGE

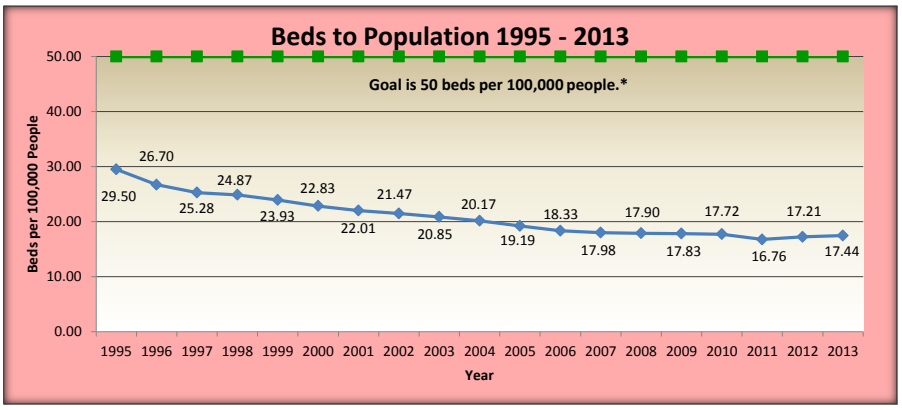
1995	9353
2013	6680
Total Change	-2673
% Change	-28.6%



BED GAP PROGRESS

1995	29.50
2013	17.44
Total Change	-12.06
% Change	-40.9%

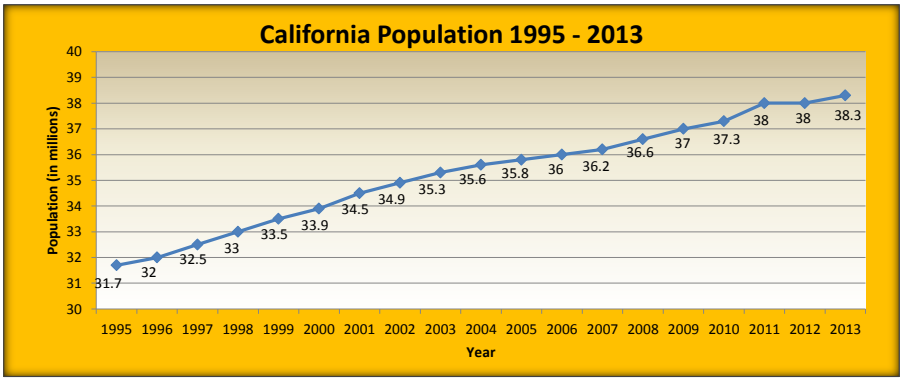
*Extrapolated from Treatment Advocacy Center figure of 1 bed per 2000.



POPULATION* GROWTH

1995	31.7
2013	38.3
Total Change	6.6
% Growth	20.8%

*estimated in millions



Psych Data Source: OSHPD (General Acute Care Hospitals include city and county hospitals, but not state hospitals.
Acute Psychiatric hospitals include city and county hospitals, but not state hospitals. Also includes county-owned Psychiatric Health Facilities.)
Population Data Source: U.S. Census Bureau

Updated 9/17/15

This document is updated annually, typically in September or October.
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CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

Psychiatric Inpatient Care Units and Freestanding Psychiatric Hospitals
2013 Comparative Data – Nation and California

	GACHs[1] w/Psych	# Psych Beds	APHs[2] & PHFs[3]	# Psych Beds	Total Hospitals	Total Beds
Nation	1208	37,345	223	25,495	1431	62,840
49 States	1120	33,492	173	22,668	1293	56,160
California	**88**	**3853**	**50**	**2827**	**138**	**6680**

2013 Population Comparison

Nation	316,497,531	1 psych bed for every 5037 people
49 States	278,165,010	1 psych bed for every 4953 people
California	**38,332,521**	**1 psych bed for every 5572 people**

Experts estimate a need for a ***minimum*** of 1 public psychiatric bed for every **2000** people for hospitalization for individuals with serious psychiatric disorders.* This number is contingent upon the availability of appropriate outpatient services in the community.**

[1] General Acute Care Hospitals *[2] Acute Psychiatric Hospitals* *[3] Psychiatric Health Facilities*

Sources
National data: Health Forum, AHA Annual Survey of Hospitals
Hospitals with psychiatric or alcoholism/chemical dependency units are registered community hospitals that reported having such a unit for that year. Acute Psychiatric Hospitals also include children's psychiatric hospitals, but exclude chemical dependency hospitals. State owned facilities are similarly excluded.

California data: OSHPD
General Acute Care Hospitals include city and county hospitals, but not state hospitals. Acute Psychiatric Hospitals include city and county hospitals, but not state hospitals. Also includes county-owned Psychiatric Health Facilities.

49 State data: OSHPD data subtracted from AHA data. Includes the District of Columbia.

Population data: U.S. Census Bureau

**Torrey, E. F., Entsminger, K., Geller, J., Stanley, J. and Jaffe, D. J. (2008). "The Shortage of Public Hospital Beds for Mentally Ill Persons."*

***Stetka, B. (2010). "US Psychiatric Resources: A Country in Crisis."*

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Revised 9/18/15

This document is updated annually (typically September or October).
The current version can be found on the CHA website at www.calhospital.org/PsychBedData.

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

Acute Care Inpatient Psychiatric Bed Distribution

Not all beds are available to individuals on LPS involuntary holds. Does not include data from state-operated hospitals.

County	Adult	Child/Adol	Gero-Psych*	Psych IC**	Chem/Dep	PHF***[1]	Beds per 100k[2]	Population	County
Alameda	234	45	0	22	74	42	19.06	1,578,891	Alameda
Alpine	0	0	0	0	0	0	0.00	1,159	Alpine
Amador	0	0	0	0	0	0	0.00	36,519	Amador
Butte	46	0	0	0	0	16	20.71	222,090	Butte
Calaveras	0	0	0	0	0	0	0.00	44,515	Calaveras
Colusa	0	0	0	0	0	0	0.00	21,358	Colusa
Contra Costa	80	28	0	0	8	0	9.87	1,094,205	Contra Costa
Del Norte	0	0	0	0	0	0	0.00	27,873	Del Norte
El Dorado	10	0	0	0	0	10	5.50	181,737	El Dorado
Fresno	77	0	0	0	0	16	8.06	955,272	Fresno
Glenn	0	0	0	0	0	0	0.00	27,940	Glenn
Humboldt	16	0	0	0	0	16	11.90	134,493	Humboldt
Imperial	0	0	0	0	0	0	0.00	176,584	Imperial
Inyo	0	0	0	0	0	0	0.00	18,467	Inyo
Kern	140	0	0	0	0	16	16.20	864,124	Kern
Kings	0	0	0	0	0	0	0.00	150,960	Kings
Lake	0	0	0	0	0	0	0.00	63,860	Lake
Lassen	0	0	0	0	0	0	0.00	32,163	Lassen
Los Angeles	2053	243	0	86	375	32	23.78	10,017,068	Los Angeles
Madera	0	0	0	0	0	0	0.00	152,389	Madera
Marin	17	0	0	0	0	0	6.58	258,365	Marin
Mariposa	0	0	0	0	0	0	0.00	17,755	Mariposa
Mendocino	0	0	0	0	0	0	0.00	87,192	Mendocino
Merced	16	0	0	0	0	16	6.08	263,228	Merced
Modoc	0	0	0	0	0	0	0.00	9,147	Modoc
Mono	0	0	0	0	0	0	0.00	14,074	Mono
Monterey	40	0	0	0	0	0	9.33	428,826	Monterey
Napa	37	0	0	0	0	0	26.37	140,326	Napa
Nevada	0	0	0	0	0	0	0.00	98,200	Nevada
Orange	481	32	0	0	115	0	16.47	3,114,363	Orange
Placer	16	0	0	0	0	16	4.36	367,309	Placer
Plumas	0	0	0	0	0	0	0.00	18,859	Plumas
Riverside	182	12	0	9	131	16	8.85	2,292,507	Riverside
Sacramento	321	64	0	15	0	82	27.36	1,462,131	Sacramento
San Benito	0	0	0	0	0	0	0.00	57,600	San Benito
San Bernardino	304	76	0	0	38	0	18.20	2,088,371	San Bernardino
San Diego	523	65	0	152	95	0	23.04	3,211,252	San Diego
San Francisco	239	35	47	0	0	0	38.33	837,442	San Francisco
San Joaquin	49	0	0	0	2	16	6.96	704,379	San Joaquin
San Luis Obispo	16	0	0	0	0	16	5.79	276,443	San Luis Obispo
San Mateo	60	13	24	0	13	0	12.98	747,373	San Mateo
Santa Barbara	36	0	0	0	0	16	8.26	435,697	Santa Barbara
Santa Clara	166	0	0	0	0	40	8.91	1,862,041	Santa Clara
Santa Cruz	28	0	0	0	0	0	10.39	269,419	Santa Cruz
Shasta	16	0	0	0	0	16	8.94	178,980	Shasta
Sierra	0	0	0	0	0	0	0.00	3,047	Sierra
Siskiyou	0	0	0	0	0	0	0.00	43,799	Siskiyou
Solano	48	13	0	0	0	0	14.36	424,788	Solano
Sonoma	95	0	0	0	0	0	19.19	495,025	Sonoma
Stanislaus	67	0	0	0	0	0	12.75	525,491	Stanislaus
Sutter	32	0	0	0	0	32	33.56	95,350	Sutter
Tehama	0	0	0	0	0	0	0.00	63,057	Tehama
Trinity	0	0	0	0	0	0	0.00	13,448	Trinity
Tulare	63	0	0	0	0	0	13.87	454,143	Tulare
Tuolumne	0	0	0	0	0	0	0.00	53,874	Tuolumne
Ventura	131	29	0	0	0	0	19.06	839,620	Ventura
Yolo	31	0	0	0	0	0	15.15	204,593	Yolo
Yuba	0	0	0	0	0	0	0.00	73,340	Yuba

TOTALS

All Psych	Adult	Child/Adol	Gero-Psych	Psych IC	Chem/Dep	PHF[1]	Beds per 100k[2]	State
6680	**5670**	**655**	**71**	**284**	**851**	**414**	**17.43**	**38,332,521**

25 Counties w/o Adult Beds (45% of state)
46 Counties w/o Child/Adolescent Beds (79% of state)
56 Counties w/o Gero-Psych (Long-Term Care) Beds (97% of state)
53 Counties w/o Psych Intensive Care Beds (91% of state)
49 Counties w/o Chemical Dependency Beds (84% of state)
25 Counties Have ZERO Inpatient Psych Services (45% of state)

Sources: Population data from US Census Bureau
All other data from OSHPD 2012 reports

[1] NOTE: PHF bed totals are included in their respective categores (e.g., adult, child/adolescent, etc.).

[2] NOTE: Beds per 100,000 residents goal is 50

***Gero-Psych** - Medical care, nursing and auxiliary professional services and intensive supervision of the chronically mentally ill, mentally disordered or other mentally incompetent geriatric persons, rendered in the structured, secure, therapeutic milieu of a psychiatric long-term care program.

****Psych IC** (Psychiatric Intensive Care) - Provides nursing care to psychiatric patients which is of a more intensive nature than the usual nursing care provided in Medical, Surgical, and Psychiatric Units.

*****PHF** (Psychiatric Health Facility) - Defined as a health facility, licensed by the State Department Health Care Services, that provides 24-hour inpatient care. This care includes, but is not limited to: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. (Health & Safety Code Section 1250.2)

Revised: 9/27/2015
This document is updated annually, typically in September or October.
The current version is posted at: www.calhospital.org/PsychBedData

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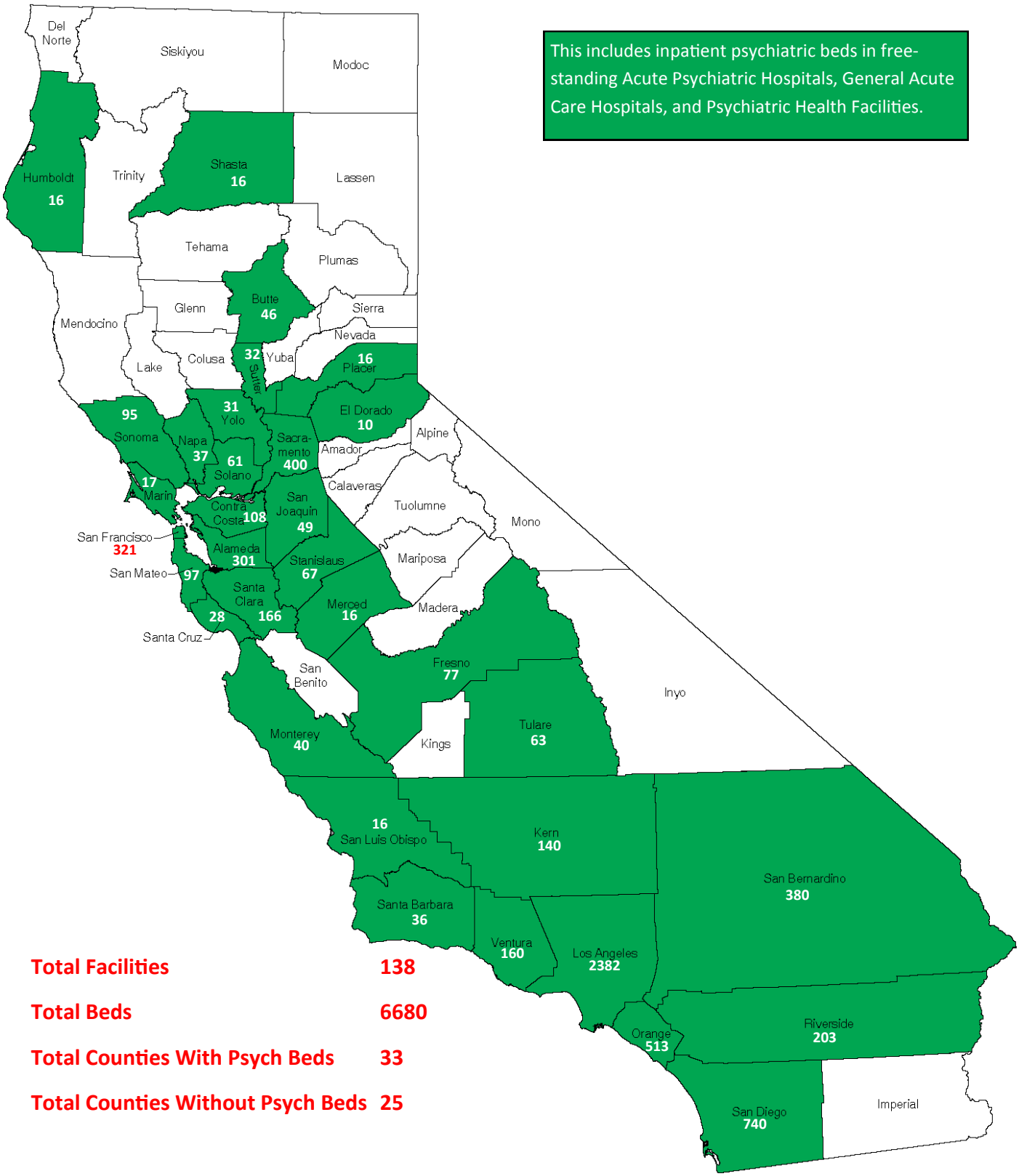
Acute Care Inpatient Psychiatric Bed Distribution

Counties with Psychiatric Inpatient Beds

This includes inpatient psychiatric beds in free-standing Acute Psychiatric Hospitals, General Acute Care Hospitals, and Psychiatric Health Facilities.



Total Facilities	**138**
Total Beds	**6680**
Total Counties With Psych Beds	**33**
Total Counties Without Psych Beds	**25**

Source: OSHPD 2013 data

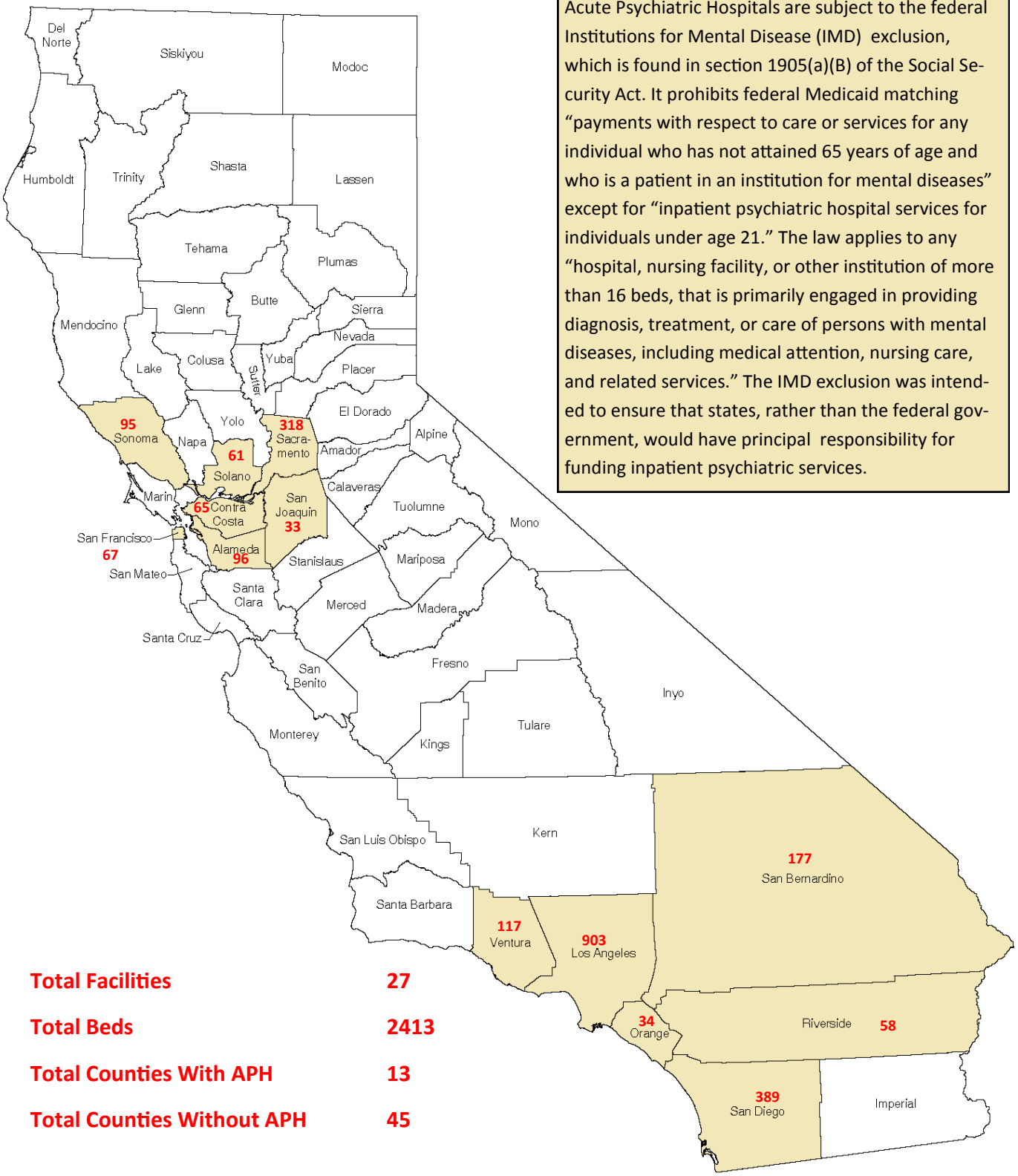
Updated October 29, 2015

This document is updated annually, typically in September or October.

The current version can be found at www.calhospital.or/PsychBedData

Acute Care Inpatient Psychiatric Bed Distribution
Counties with Freestanding Acute Psychiatric Hospitals (APH)

Acute Psychiatric Hospitals are subject to the federal Institutions for Mental Disease (IMD) exclusion, which is found in section 1905(a)(B) of the Social Security Act. It prohibits federal Medicaid matching "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age 21." The law applies to any "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services.



Total Facilities	**27**
Total Beds	**2413**
Total Counties With APH	**13**
Total Counties Without APH	**45**

Source: OSHPD 2013 data

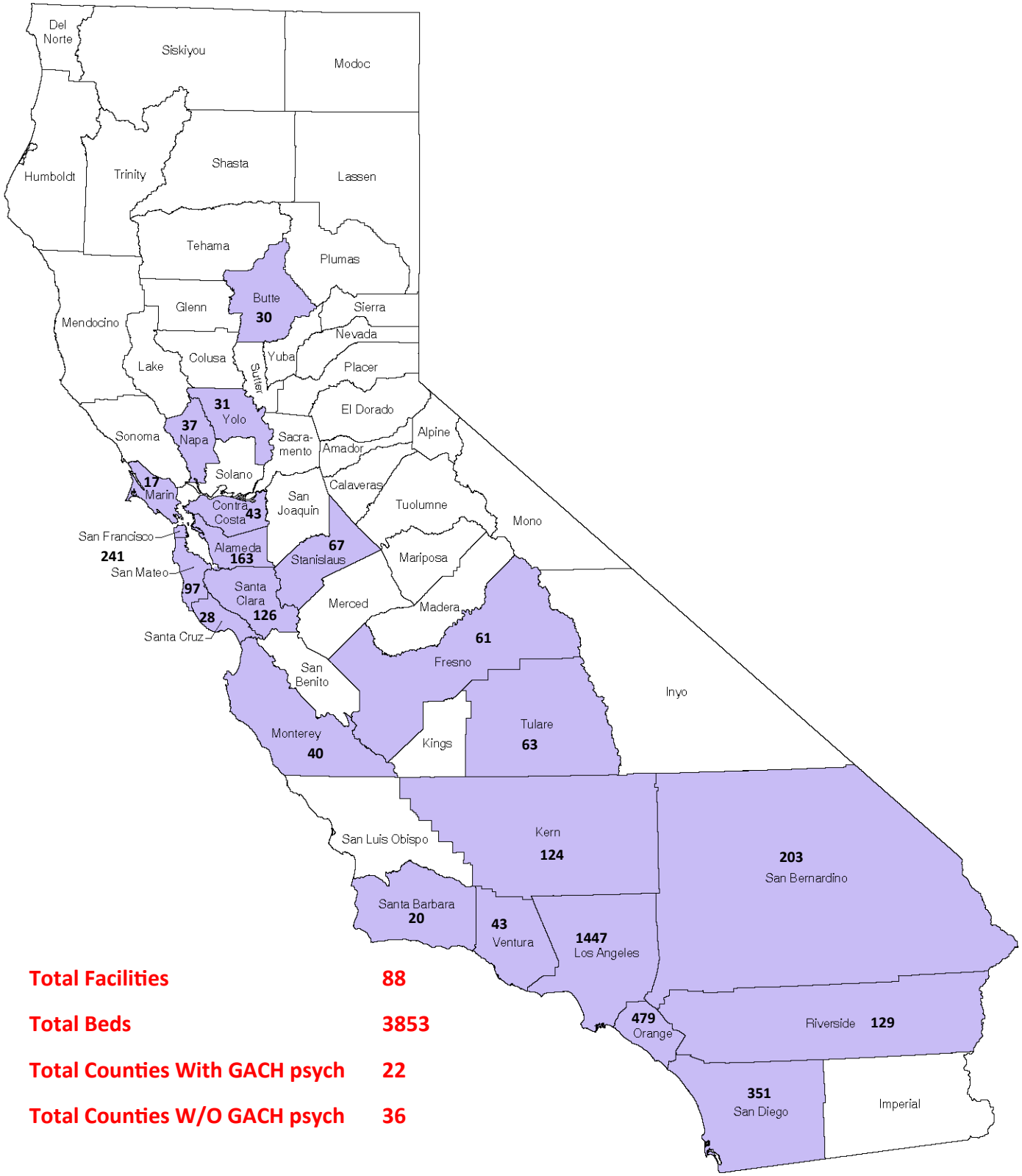
Updated October 29, 2015

This document is updated annually, typically in September or October.

The current version can be found at www.calhospital.or/PsychBedData

Acute Care Inpatient Psychiatric Bed Distribution

Counties with General Acute Care Hospitals (GACH) with Dedicated Psychiatric Units



Total Facilities	**88**
Total Beds	**3853**
Total Counties With GACH psych	**22**
Total Counties W/O GACH psych	**36**

Source: OSHPD 2013 data

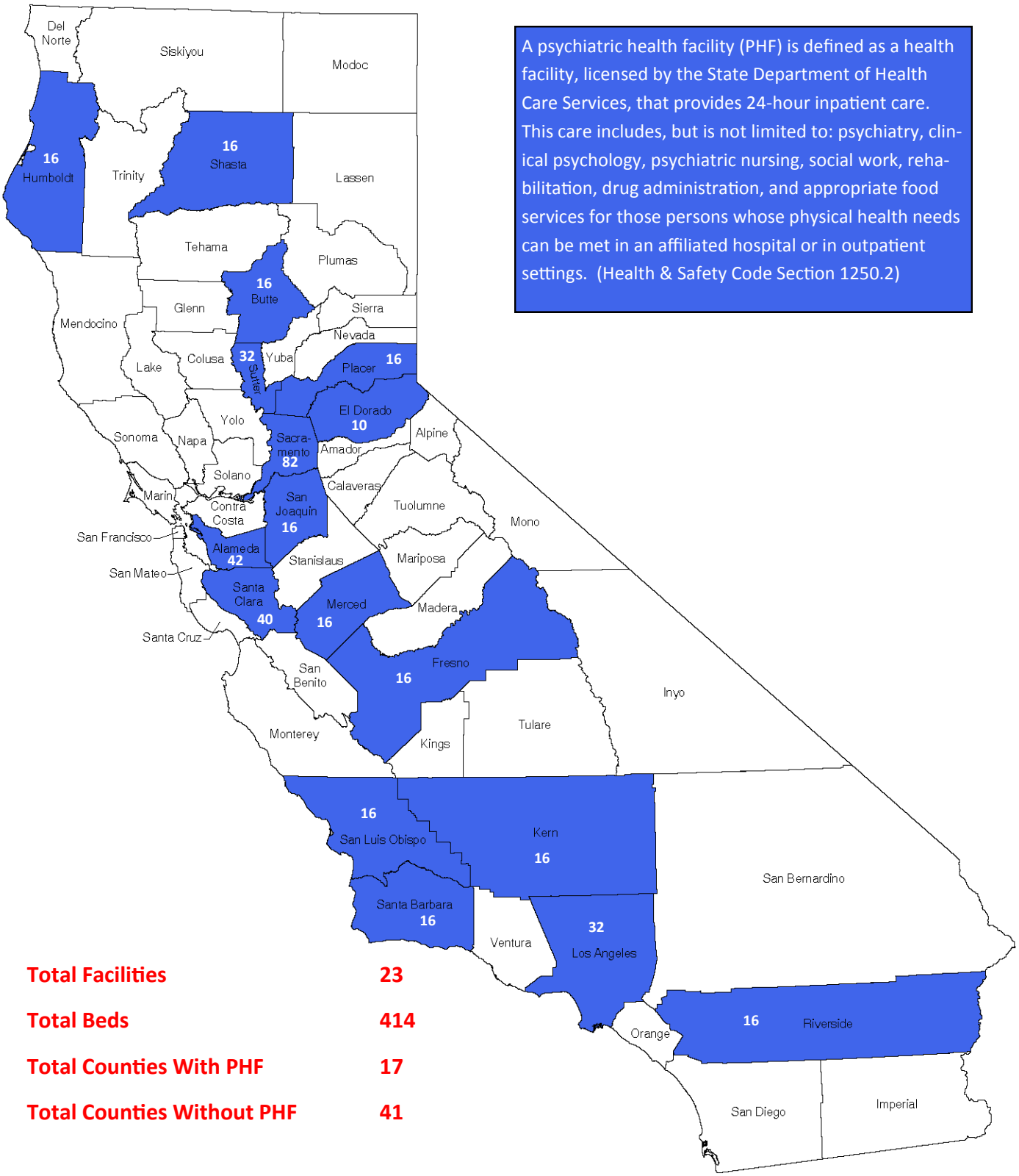
Updated October 29, 2015

This document is updated annually, typically in September or October.

The current version can be found at www.calhospital.or/PsychBedData

Acute Care Inpatient Psychiatric Bed Distribution
Counties with Non-Hospital Psychiatric Health Facilities (PHF)

A psychiatric health facility (PHF) is defined as a health facility, licensed by the State Department of Health Care Services, that provides 24-hour inpatient care. This care includes, but is not limited to: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. (Health & Safety Code Section 1250.2)



Total Facilities	**23**
Total Beds	**414**
Total Counties With PHF	**17**
Total Counties Without PHF	**41**

Source: OSHPD 2013 data

Updated September 18, 2015

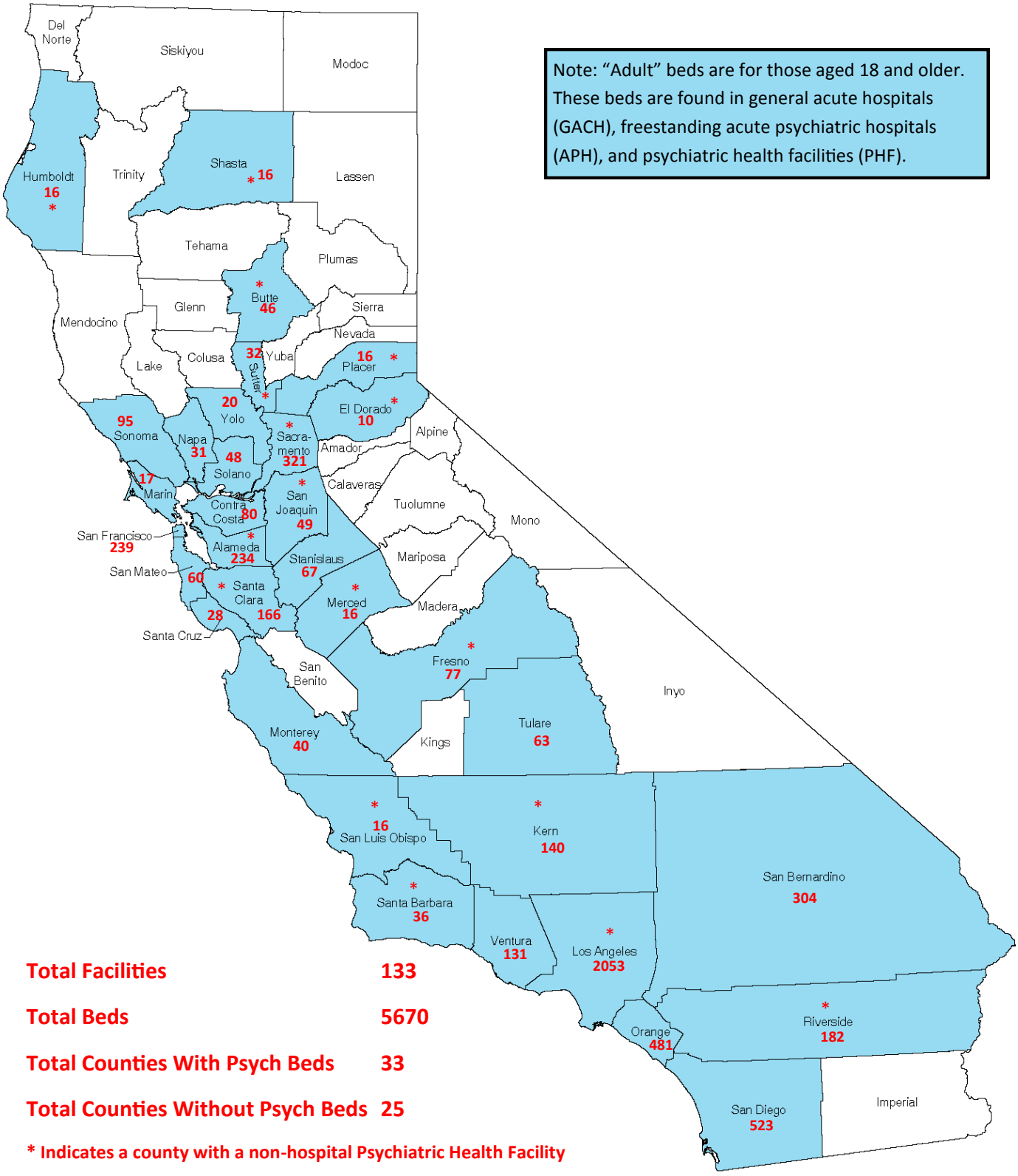
This document is updated annually, typically in September or October.

The current version can be found at www.calhospital.or/PsychBedData

Acute Care Inpatient Psychiatric Bed Distribution

Counties with Psychiatric Inpatient Beds for Adults

Note: "Adult" beds are for those aged 18 and older. These beds are found in general acute hospitals (GACH), freestanding acute psychiatric hospitals (APH), and psychiatric health facilities (PHF).



Total Facilities	**133**
Total Beds	**5670**
Total Counties With Psych Beds	**33**
Total Counties Without Psych Beds	**25**

*** Indicates a county with a non-hospital Psychiatric Health Facility**

Source: OSHPD 2013 data

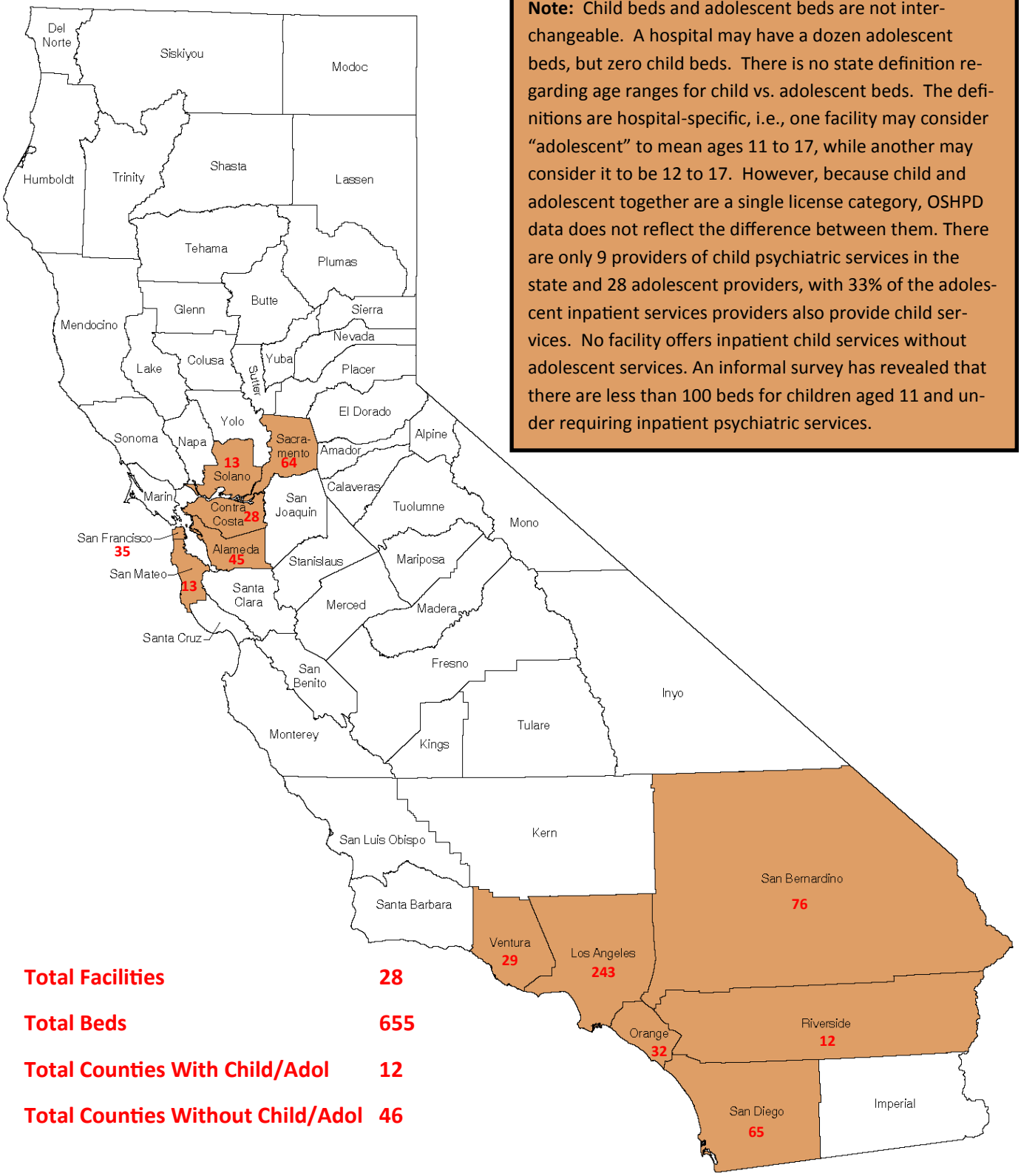
Updated October 29, 2015

This document is updated annually, typically in September or October.

The current version can be found at www.calhospital.or/PsychBedData

Acute Care Inpatient Psychiatric Bed Distribution
Counties with Inpatient Beds for Children/Adolescents

Note: Child beds and adolescent beds are not interchangeable. A hospital may have a dozen adolescent beds, but zero child beds. There is no state definition regarding age ranges for child vs. adolescent beds. The definitions are hospital-specific, i.e., one facility may consider "adolescent" to mean ages 11 to 17, while another may consider it to be 12 to 17. However, because child and adolescent together are a single license category, OSHPD data does not reflect the difference between them. There are only 9 providers of child psychiatric services in the state and 28 adolescent providers, with 33% of the adolescent inpatient services providers also provide child services. No facility offers inpatient child services without adolescent services. An informal survey has revealed that there are less than 100 beds for children aged 11 and under requiring inpatient psychiatric services.



Total Facilities	**28**
Total Beds	**655**
Total Counties With Child/Adol	**12**
Total Counties Without Child/Adol	**46**

Source: OSHPD 2013 data

Updated October 29, 2015

This document is updated annually, typically in September or October.

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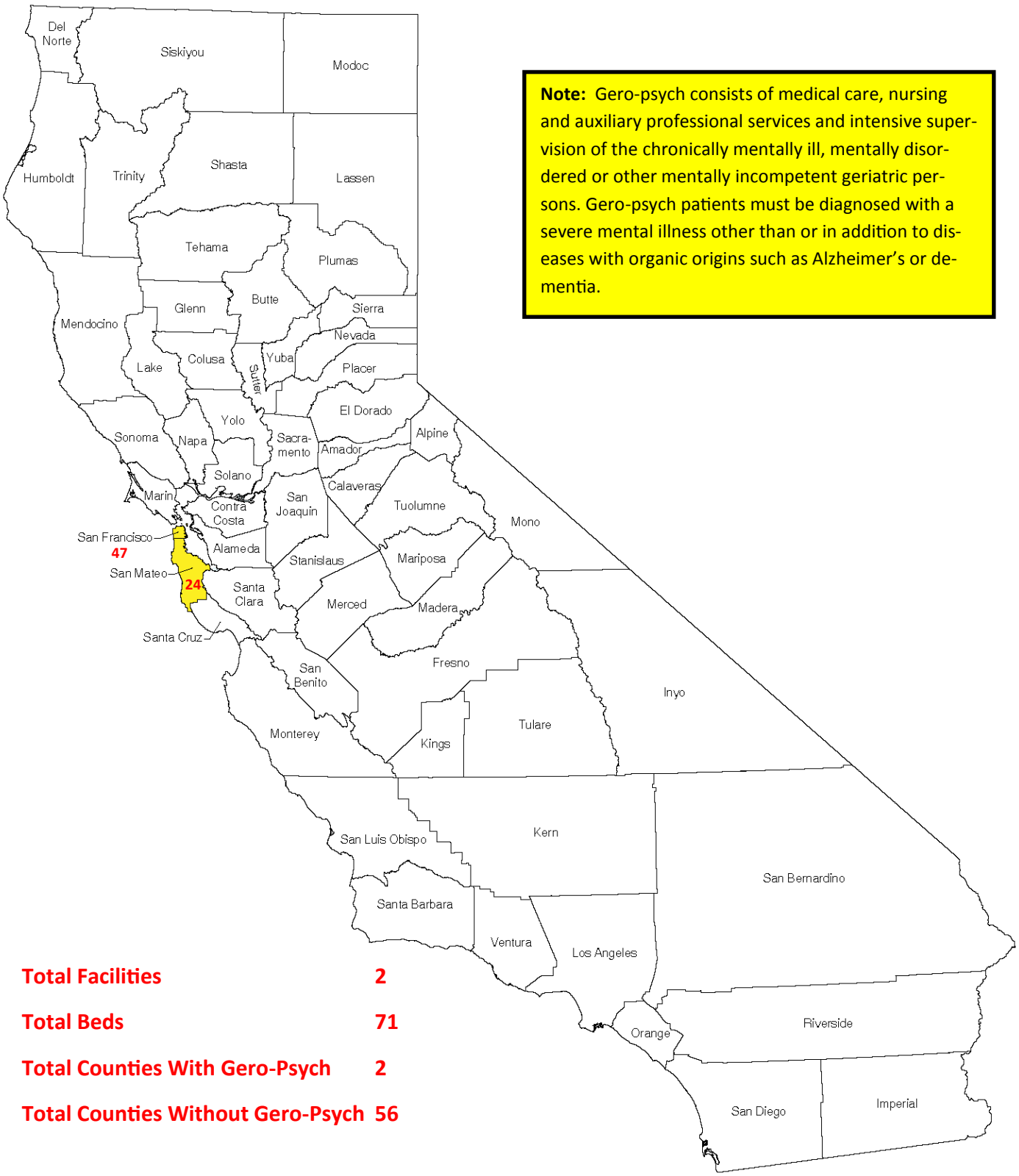
Acute Care Inpatient Psychiatric Bed Distribution
Counties with Inpatient Beds for Gero-Psych



Note: Gero-psych consists of medical care, nursing and auxiliary professional services and intensive supervision of the chronically mentally ill, mentally disordered or other mentally incompetent geriatric persons. Gero-psych patients must be diagnosed with a severe mental illness other than or in addition to diseases with organic origins such as Alzheimer's or dementia.

Total Facilities	**2**
Total Beds	**71**
Total Counties With Gero-Psych	**2**
Total Counties Without Gero-Psych	**56**

Source: OSHPD 2013 data

Updated October 29, 2015

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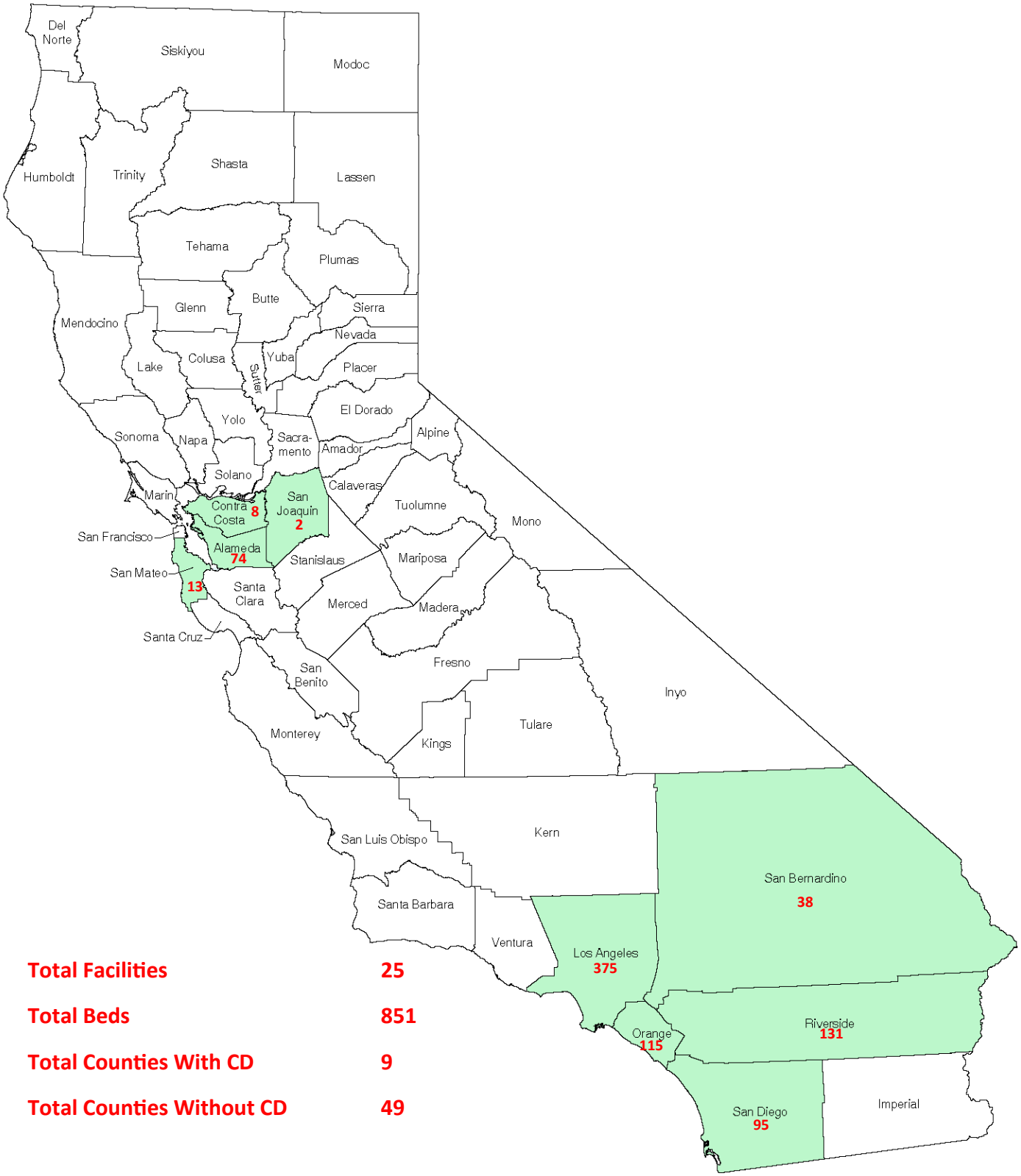
Acute Care Inpatient Psychiatric Bed Distribution
Counties with Hospital-Based Chemical Dependency Beds



Total Facilities	**25**
Total Beds	**851**
Total Counties With CD	**9**
Total Counties Without CD	**49**

Source: OSHPD 2013 data

Updated September 18, 2015

This document is updated annually, typically in September or October.

The current version can be found at www.calhospital.or/PsychBedData

ATTACHMENT E

Mendocino County Mental Health Facility Literature Review

Presented by

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Introduction

The Sheriff of Mendocino County has proposed a sales tax increase to raise funding for the construction of a mental health facility. The Sheriff claims that the lack of such a facility has imposed a burden on the Sheriff's Department, which has been tasked with responding to individuals who require mental health services. There is disagreement, however, between what the County of Mendocino believes a mental health facility will cost versus what the Sheriff's Department can expect to generate through its proposed ballot initiative. It is possible that the Sheriff 's Department has underestimated the construction and potential ongoing costs the County will bear from the mental health facility being proposed.

This report will use existing literature to examine the costs of constructing and maintaining a mental health facility. The report will present a range of the potential costs for smaller facilities rather than a specific estimate, since actual costs will vary based on factors including amount and quality of amenities, design of patient rooms, treatment areas, communal areas, therapeutic space and offices, and types of treatments provided. The findings of this report will help the County of Mendocino illustrate how the proposed sales tax ballot initiative might (or might not) be able to meet the costs of a new facility.

Construction Costs

While construction costs would largely depend on the size of the building, an estimate of total project costs must take the following into account: 1) Construction of the building itself and related fees such as demolition costs, architectural fees, and construction manager fees; 2) Cost of the land and any necessary utility hookups; 3) Design fees and construction oversight expenses; and 4) Furnishing costs for patient rooms, treatment areas, common areas, and offices.

Table 1 provides a list of recently constructed mental health hospitals, their building costs, number of beds, and building size:

Table 1: Construction Data of Selected Recently Built Mental Health Facilities

Name (Year Opened)	Number of Beds	Construction Cost ($)	Building Size (sq. ft.)	Location
Horizon View (2015)	16	9,400,000	15,000	Ventura County, CA
Vermont Psychiatric Care Hospital (2014)	25	38,000,000	53,000	Berlin, VT
El Camino Hospital (est. 2017)	36	50,000,000	52,000	Mountain View, CA
DMH Psychiatric Hospital at Worcester (2012)	320	302,000,000	428,000	Worcester, MA

As the data in the table demonstrates, the scale of a mental health facility can vary widely. Generally, however, facilities contain fewer than 50 beds. In some cases, like Horizon View in Ventura County, there may be fewer than 20 beds. If square feet per bed is used as a metric for determining the building size—with the exception of Vermont Psychiatric Care Hospital (see Table 2 below), which is 2,120 square feet/bed—the facilities range from 900 to 1400 square feet/bed.

Table 2: Construction Cost per Bed, Construction Cost per Square Feet, and Facility Size per Bed for Selected Mental Health Facilities

Name	Cost/bed ($)	Cost/sq. ft. ($)	Size/bed
Horizon View	587,500	627	938
Vermont Psychiatric Care Hospital	1,520,000	717	2,120
El Camino Hospital	1,388,889	962	1,444
DMH Psychiatric Hospital at Worcester	943,750	706	1,338

The 900 to 1,400 square feet/bed range for these newly constructed facilities is slightly larger than the square feet per bed of older mental health facilities. In a discussion paper by the Montana Legislature, Sue O'Connell (2014) noted that the Montana State Hospital, built in 1877, is a 88,000 square foot building with 114 beds (772 square feet/bed); other facilities cited in the report ranged from 792 square feet/bed to 1,063 square feet/bed. Based on the square feet/bed of existing facilities, O'Connell suggested a more modest 800 to 1,000 square feet/bed as a ballpark estimate.

In terms of architectural and contractor fees, although there is no data specifically tied to mental health facilities, 2013 RSMeans data pegs architectural fees at 9% of total cost and contractor fees at 25% of total cost. The total cost ranges from $341/square foot to $354/square foot. In addition, the Architecture and Engineering Division of RSMeans estimates design fees to be 10% of the construction costs and furnishing expenses to be 30% to 35% of the construction costs. All costs together yield a range of $435.40/square foot to $513.30/square foot in 2013 dollars.

Clearly, the estimated range is considerably lower than the figures obtained in Table 2. There are other considerations that could account for the differences. First, the aforementioned estimated range includes only the basic costs of construction and does not take additional costs or unexpected costs into account. For example, in a discussion paper by the DMH Inpatient Study Commission (2009), the estimated "hard construction costs," which include demolition, site work, and Construction Manager/General Contractor costs, were estimated to be $259.4 million (or $606.07/square foot) in 2009 dollars. Since the DMH facility emphasized systemic efficiencies, it is likely that there were more upfront costs (construction costs), which would be offset by cost savings in the future (reduced operating costs). The original estimated cost for Horizon View at Camarillo Airport was $5.3 million ($353.33/square foot), $4 million lower than the final cost. Unexpected costs due to trouble finding a desired location, design revisions, other delays, and an overly optimistic budget contributed to the cost differential.

Operational Costs

While wages and salaries constitute a significant portion of the operating costs of a typical facility that provides care and treatment to individuals, there are several factors—such as number of staff, experience and salaries of the staff, utilities, medications, and supplies costs—that contribute to potential variations in operational costs. At a minimum, a relatively small 15-to-20-bed mental health facility should have at least one psychiatrist, one registered nurse supervisor, one medical director, and a number of staff.

Table 3 provides the annual operating costs based on figures obtained from the annual reports of several mental health facilities:

Table 3: Annual Operating Cost by Selected Mental Health Facilities

Name	Operating Cost per Year ($)	Number of Beds	Operating Cost per Bed per Year ($)
Vermont Psychiatric Care Hospital	11,656,000	25	466,240
DMH Psychiatric Hospital at Worcester	124,480,000	320	389,000
Division of Behavioral Health, Arizona Dept. of Health Services	69,028,146	260	265,493
Bridgewater State Hospital	38,340,960	227	168,903

Unlike construction costs, operational costs tend to be lower per bed for large facilities due to factors such as lower administrative costs per patient. The weighted average operating cost per bed per year using the sample above is $292,674. O'Connell (2014) found that the annual operating costs for a 16-bed mental health treatment facility in Minnesota could be $4 million to $5 million ($250,000/bed to $312,500/bed annually) and a 16-bed mental health treatment facility in Washington could be $4.7 million to $6.4 million ($293,750/bed to $400,000/bed annually). These potential annual operating costs per bed appear to be comparable to the figures in Table 3.

Finally, costs such as general medical care and mental health treatment could vary considerably from year to year due to the number of seriously and/or chronically ill patients admitted, the intensity of treatments provided, and the duration of stay per patient. Overall, based on previous studies and the data in Table 3, annual operating costs for a relatively small 15-to-20-bed facility, comparable to the scale expected for the County of Mendocino, could be at least $3 million to $4 million.

References

"Construction Cost Estimates for Hospital, 2-3 Story in National, US." (n.d.). RSMeans. Retrieved April 12, 2016.

Donato-Weinstein, N. (2014). “El Camino Hospital to Build New $50M Health Center.” Silicon Valley Business Journal. April 24, 2014. Retrieved April 12, 2016.

Gonzalez, H. (2015). “Mental Health Facility Cost is Almost Double the Estimate.” Camarillo Acorn. October 9, 2015. Retrieved April 12, 2016.

“New DMH Psychiatric Hospital (For Discussion Purposes Only).” DMH Inpatient Study Commission. May 13, 2009. Retrieved April 13, 2016.

O’Connell, S. (2014). “HJR 16: State-Operated Institutions Building and Operating a 16-Bed Inpatient Facility.” Agenda Item 4.c: HRJ 16 Study. May 2014. Retrieved April 13, 2016.

True, M. (2014). “New State Psychiatric Hospital Brings Care Into the 21st Century.” VTDigger. May 28, 2014. Retrieved April 12, 2016.

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