Mariposa County Mental Health Services Act

- Three-Year Expenditure Plan 2020 – 2023
- Prevention and Early Intervention Report 2018-2019

Released for Public Comment: May 15th 2020

Public Hearing: June 16th 2020

 Adopted by Board of Supervisors: June 16th 2020
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Mariposa County Mental Health Services Act Three-Year Expenditure Plan 2020 – 2023
Executive Summary

Community Services and Supports (CSS)

- Full Service Partnerships (FSP): There are no changes from the past year, Mariposa County Behavioral Health and Recovery Services (MCBHRS) plans to continue providing mental health services to SMI/SED populations.

- General System Development (GSD): There is one new change with this component, after several years of being unable to fill the system navigator position, MCBHRS has decided to remove this program, however the other Peer Support position assigned to the Wellness Center will still continue.

Prevention and Early Intervention (PEI)

- Access and Linkage to Treatment: One of the changes from previous years is the removal of Crisis/TRAC team listed above as a PEI program. The Crisis/TRAC team will continue to operate but be funded under a different funding stream. All PEI programs must ensure access and linkage to services. As such, Mariposa County Behavioral Health and Recovery Services has decided to opt out of the access and linkage component. The reporting requirements for this component require more training and staff time than a very small county has the capacity to implement. MCBHRS is open to all stakeholder feedback.

- Timely Access to Services: The Drop in Center in past years was funded through MHSA through the timely access to services category. This is an optional category, that comes with heavy reporting requirements creating a burden on the providers. MCBHRS changed strategies this year to ensure a streamline in services by shifting the focus to early intervention services also focused on increasing access to services. MCBHRS issued a Request for Proposal (RFP) and the Drop in Center submitted an RFP with a focus on substance abuse. The Drop in Center will continue to be funded through a different funding stream and not MHSA.

- The other change is how school services will be implemented; stakeholders overwhelmingly identified school aged youth as an underserved population, as such MCBHRS issued a Request for Proposals (RFP) for early intervention services to be provided to school aged youth. Historically school services have been pieced out between three different providers. While those services were successful, the services were too siloed. The approach for the next three years is to award all of the funding allocated for school services to one entity.

- Suicide Prevention: Stakeholders, during the stakeholder process for the three year planning, identified school aged youth as the most underserved population
and suicide prevention as the most needed service in the community. MCBHRS decided to fund a program to provide suicide prevention for school aged youth.

**Innovation (INN)**

- MCBHRS does not have any current innovation plans, once MCBHRS begins the process of drafting a new one, stakeholders will be identified.
MHSA Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County/City: Mariposa

☑ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

<table>
<thead>
<tr>
<th>Local Mental Health Director</th>
<th>County Auditor-Controller / City Financial Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Chevon Kothari</td>
<td>Name: Luis Mercado</td>
</tr>
<tr>
<td>Telephone Number: 209-742-0862</td>
<td>Telephone Number: 209-966-1310</td>
</tr>
<tr>
<td>E-mail: <a href="mailto:ckothari@mariposahsc.org">ckothari@mariposahsc.org</a></td>
<td>E-mail: <a href="mailto:lmercado@mariposaccounty.org">lmercado@mariposaccounty.org</a></td>
</tr>
</tbody>
</table>

Local Mental Health Mailing Address:
Mariposa County Health and Human Services Agency
P.O. Box 99
Mariposa, CA 95338

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3402 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Chevon Kothari
Local Mental Health Director (PRINT) [Signature] [Date]

I hereby certify that for the fiscal year ended June 30, 2019, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County’s/City’s financial statements are audited annually by an independent auditor and the most recent audit report is dated 3/14/20 for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 2019, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Luis Mercado
County Auditor Controller / City Financial Officer (PRINT) [Signature] [Date]

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1 Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and PER Certification (07/22/2013)
MHSA COUNTY COMPLIANCE CERTIFICATION

County: Mariposa

Local Mental Health Director
Name: Chevon Kothari
Telephone Number: 209-742-0892
E-mail: ckothari@mariposahsc.org

Program Lead
Name: Laura Glenn (interim)
Telephone Number: 209-742-0823
E-mail: lglenn@mariposahsc.org

County Mental Health Mailing Address:
Mariposa County Health and Human Services Agency
P.O. Box 99
Mariposa, CA 95338

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interest and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on __________.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Chevon Kothari
Local Mental Health Director/Designee (PRINT)

Signature:  
Date: 5/21/20

County: Mariposa

Date: ____________________________
What is the purpose of this document?
This document serves as a blueprint and description of the programs proposed and funded by the Mental Health Services Act.

What is the Mental Health Services Act (MHSA)?
California voters passed the Mental Health Services Act (MHSA) in 2004; the Act imposes a 1% tax on personal income in excess of one million dollars. Local County Mental Health Programs receive this money to operate an MHSA program.

MHSA Programs are intended to increase access and services for underserved and unserved populations. MHSA includes five main components: Community Services and Supports (CSS); Prevention and Early Intervention (PEI); Innovation (INN); Workforce, Education and Training (WET); Capital Facilities & Technological Needs (CFTN).

Community Services and Supports (CSS) overarching purpose is to ensure that seriously mentally ill individuals have access to all necessary mental health services. This is provided through outreach and direct services for children, transitional aged youth, adults and older adults with a serious mental illness.

Prevention and Early intervention (PEI) programs are partially intended to prevent a serious mental illness by promoting strategies that reduce risk factors. Additionally, PEI programs are to be designed to improve timely access to services and a better understanding of recognizing early signs of mental illness.

Innovation (INN) projects are to be designed to find new approaches to improve mental health services, delivery of services, quality of services, or improve outcomes by promoting interagency collaboration.

Workforce, Education and Training (WET) is the component of MHSA that aims to reduce the workforce shortages of qualified staff in the mental health field, by supporting, building, retaining and training.

Capital Facilities & Technological Needs (CFTN) is designed to address the infrastructure needs to support the implementation of technological needs in order to improve mental health services.

MHSA incorporates standard principles that are to be integrated throughout the mental health programs, services and supports.
What are the MHSA Standard Principles?

Community Collaboration – A process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill shared visions and goals.

Cultural Competence – Working to achieve the desired goals, while incorporating the community’s diverse beliefs, racial/ethnic, cultural, and linguistic systems into Mariposa County’s policies, program planning, and service delivery.

Client and Family Driven – Adult clients and families of children have the primary decision-making role in identifying his or her needs, preferences and strengths. A shared decision-making role in determining services, enhances the supports that are most effective for him or her.

Wellness, Recovery, and Resilience Focused – A health system that is focused on promoting wellness, recovery and resilience by people participating fully in their community.

Integrated Service Experiences for Clients and their Families – The client, and/or family accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner.

Mariposa County continues to promote all of the standard principles that are fundamental to each of the MHSA programs.

What is a Three Year Plan and an Annual Update?

MHSA regulation require that counties prepare a three-year plan outlining programs and services that will be funded for the next three years. Counties are also required to provide subsequent annual updates to the three year plan during that timeframe to address each of the components listed above, and any changes in programs. A three-year plan or an annual update requires community stakeholders to participate in a community planning process that allows stakeholders an opportunity to provide feedback on the programs and services counties offer through the MHSA funding.
County Demographics

Mariposa is a small, rural county nestled in the Sierra Nevada foothills and is home to approximately 17,700 residents. As in other rural counties, Mariposa is characterized by the sparse number of young people under the age of 18, a characteristic which is maintained and propelled by a lack of job opportunities which pushes young families out of the county in search of gainful employment.

Aging Population

Mariposa has historically had a higher proportion of retirement-aged residents and a lower proportion of youth and young adults. Relative to the state of California, Mariposa county has a higher concentration of persons aged 60 and older (36% in the county, compared to 19% in the state overall). According to the US Census Bureau, Approximately 4.2 % are under the age of five. Approximately 15.5 % of the population is between the ages of 5 and 19 years. The county also has proportionally fewer young adults of working age (20-44 years old) (24% in the county, compared to the state 36%).

While the population in Mariposa has been steadily growing over the past several decades, a closer look at age distribution shows a steady decline of the population between the ages of 45 – 64, coupled with the increase in the elderly population, particularly in recent years.

The figure below depicts the number of individual who are Medi-Cal eligible in the county of Mariposa broken down into age groups for FY 18/19.

This graph illustrates the disparity in age groups amongst Mariposa County Medi-Cal residents. This graph also confirms the low population of 18 – 24 year olds, and reaffirms a larger population of 55 – 64 year olds. In addition, nearly 12% of the population under the age of 65 has a disability, as compared to less than 7% in the state overall.
**Ethnicity**
Mariposa County has a predominantly White population. Although limited in its racial/ethnic diversity, the County does have a Native American population as well as a small Hispanic population. Census data indicates that the county is approximately 89% White, 11% Hispanic (of any race), 3% Native American, and less than 3% of “other” groups.

In the figure below, you will see the number of individuals who are Medi-Cal eligible in the county of Mariposa broken down by ethnicity for the FY 18/19. As you can see in figure two there is a large White population within Mariposa County, and a considerable separation between the second largest population of Hispanics.

![Medi-Cal Ethnicity Distribution](image)

**Economic Landscape**
Mariposa County has a wide variety of recreational opportunities available that makes the county one of California’s most popular year-round vacation destinations, with Yosemite National Park annually drawing nearly four million tourists from all over the world. As such, tourism is this rural county’s main industry. Yosemite National Park and its affiliates are amongst the areas’ largest employers.

Mariposa’s population is supported by approximately 6,000 wage and salary jobs primarily in the local government and leisure industry. The unemployment rate in Mariposa County is typically higher than the rate state-wide, and currently stands at 5.8%, compared to the California rate of 4.2%. The lack of available jobs leads to higher unemployment, lower median household incomes, and a higher proportion of the population living below poverty, as compared to the state overall. The median household income in Mariposa is $51,385 as compared to $67,169 in the state overall. In such economically challenging conditions, the wellbeing of the County must be
protected against the myriad of negative consequences of poverty. In Mariposa County, 15% of residents live below the poverty level, while 41% live on the edge of poverty.

**Geographic Isolation**
The county spans approximately 1,450 square miles and residences tend to be spread out. All services are provided in the unincorporated township of Mariposa, with some agencies, including the Health & Human Services Agency, providing limited services to those communities that are geographically removed from the town of Mariposa. The sparse population of the County in relation to its geographic size, coupled with a lack of public transportation infrastructure, results in considerable social isolation.

Coupled with a lack of opportunity, the isolation of the County’s residents creates an environment ripe for depression, anxiety, and other mental and behavioral health disorders, and also provides an environment conducive for illegal activities and substance abuse. Additionally, those in need of services face multiple barriers accessing them.

**Housing**
The 2019 Mariposa County Needs Assessment estimated that 33.5% of homeowners in Mariposa County are “housing burdened”, in that they spend 35% or more of household income on housing costs, while renters are spending 38.5%. Furthermore, fair market rent prices have steadily increased over the years for all rental-housing sizes.

Additionally, the population struggles with housing, food security, access to healthcare and transportation –without basic needs, individuals and families can easily fall into bouts of cyclical poverty. Given the challenging landscape of this County, the wellbeing of our residents must be safeguarded, and opportunities to excel must be maximized.
Community Planning

What is a Stakeholder?
A stakeholder is defined by Title 9 as “An individual or entity with an interest in mental health services in the state of California, including but not limited to: an individual with serious mental illness and/or emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families.”

Three-Year Planning Process:

Planning/Development stage
(July - September)
- Begin developing a robust list of stakeholders
- Develop extensive stakeholder survey
- Begin planning for stakeholder meetings

Stakeholder Input / Feedback
(October - November)
- Conduct stakeholder meetings
- Receive feedback
- Begin gathering data

Draft Three-Year Plan
(December - February)
- Continue to receive stakeholder feedback
- Evaluate all stakeholder feedback
- Plan and execute draft MHSA plan

Public Review
(March)
- Take draft MHSA plan to Behavioral Health Board
- Post draft MHSA plan for 30 days
- Continue to receive feedback/input

Public Hearing
(April)
- Behavioral Health Board hosts public hearing
- Stakeholders provide final feedback
- Make edits/additions etc. to draft MHSA Plan

Approval
(May - June 30th)
- Submit MHSA 3yr plan to Board of Sups for approval
- Submit approved MHSA 3yr plan to DHCS within 30 days
- Submit approved MHSA 3yr plan to MHSOAC within 30 days
Local Review

**Stakeholder Input / Feedback:**
Feedback was gathered beginning in October 2019 and continued through December 2019. MCBHRS attended 20 different stakeholder groups to provide education and garner feedback. A total of 396 surveys were completed over the three month period. The surveys were also posted on our Facebook page, and available in all Behavioral Health lobbies.

**30 Day Public Comment:**
The Draft MHSA 3-Year Program and Expenditure Plan for Fiscal Year 20/21 through Fiscal Year 22/23 was posted for a 30 day public review and comment period from May 15th 2020 through June 16th 2020.

**Circulation Methods:**
The Draft MHSA Plan was posted throughout the community for 30 days. The plan was posted to the Mariposa County Behavioral Health website, the post office, and the Mariposa County Health & Human Services Facebook page, on May 15th 2020.

**Public Hearing:**
After the 30 day public review and comment period, a Public Hearing was held by the Behavioral Health Board on June 16th 2020. A notification of a Public Hearing was incorporated in this Draft MHSA 3-Year Plan, as well as being posted in the local newspaper and on our county website during the 30 day public review and comment period.

- Data for ethnicity breakdown based on penetration data for the fiscal year 17/18, was corrected post public hearing after an error was identified on the draft at the public hearing. The penetration rate for the ‘white’ category and the ‘other’ category were transposed.

**Board of Supervisors Approval:**
The Draft MHSA 3-Year Program and Expenditure Plan for Fiscal Year 20/21 through Fiscal Year 22/23 was presented to the Board of Supervisors for approval on June 16th. Board of Supervisors Approved Plan on June 16th, 2020.
Notice of Public Hearing

NOTICE IS HEREBY GIVEN that the County of Mariposa will conduct a Public Hearing at the meeting of the Mariposa County Behavioral Health Board on June 16th 2020 at 1:00pm or as soon thereafter as the item can be heard. The “Mariposa County Mental Health Services Act (MHSA) Three-Year plan (2020 – 2023)” will be reviewed during this meeting. The meeting will be held virtually, please join the meeting from your computer, tablet or smartphone by clicking on this link - https://www.gotomeet.me/VirtualRoom11

You can also dial in using your phone: 1 (646) 749-3112
Access Code: 148-692-197

Mariposa County Behavioral Health and Recovery Services (MCBHRS) invites any and all interested persons to attend virtually and review the proposed “Mariposa County Mental Health Services Act (MHSA) Three-Year plan (2020 – 2023)” and to make comments or suggestions.

A draft copy will be available as of May 15th, 2020. The draft of the Mariposa County Mental Health Services Act (MHSA) Three-Year plan (2020 – 2023) can be obtained at the Mariposa County Public Library and on the bulletin board outside the assessor-recorder’s office at the County Hall of Records.

An electronic copy is available for viewing and printing on the Mariposa County website at www.mariposacounty.org under the Health & Human Services Department, - Behavioral Health & Recovery Services, - “Mental Health Services Act Information.” An electronic copy can be sent via email upon request. Please phone Donya Evans at (209) 966-2000 to request a copy.

We welcome your full participation in the public review process. We encourage interested persons to review and comment upon the proposed plan.

If you have any questions, please phone Donya Evans at (209) 966-2000.

The purpose of the Public Hearing is to provide citizens an opportunity to comment on the proposed activities. If you are unable to attend the Public Hearing, you may direct written comments to Mariposa County Behavioral Health and Recovery Services, P.O. Box 99, Mariposa, CA 95338, or you may telephone (209) 966-2000.

If you plan to attend the virtual Public Hearing and need a special accommodation because of a sensory or mobility impairment/disability, or have a need for an interpreter, please contact Donya Evans at (209) 966-2000 to arrange for those accommodations.

The County makes all programs available to all persons regardless of age, race, color, religion, sex, national origin, sexual preference, marital status, or disability.
Stakeholder Input & Feedback

Local Stakeholder Process:
Mariposa County Behavioral Health and Recovery Services (MCBHRS) engaged in a robust stakeholder process, providing education and receiving input and feedback from stakeholders on the next three years of MHSA.

MCBHRS relies on stakeholders to inform and direct the MHSA programs. Below you will find a comprehensive list of stakeholders. Participants were presented with an informative presentation regarding the MHSA and feedback was gathered on perceived gaps in mental health services available in the county.

Surveys with educational information and questions were also posted on the MCBHRS Facebook page to engage more individuals, and to ensure that those who want to have a voice have an opportunity to express it.

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Date</th>
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<tbody>
<tr>
<td>Mariposa County Behavioral Health Board</td>
<td>10/02/2019</td>
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<tr>
<td>MCBHRS – All Staff meeting</td>
<td>10/03/2019</td>
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<tr>
<td>Connections Homeless Shelter</td>
<td>10/09/2019</td>
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<tr>
<td>Mariposa County Sheriff’s Office (Commanders only)</td>
<td>10/30/2019</td>
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<tr>
<td>Men’s Bible Study</td>
<td>11/04/2019</td>
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<tr>
<td>Wellness Center</td>
<td>11/04/2019</td>
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<tr>
<td>Sheriff’s Department (Deputies)</td>
<td>11/06/2019</td>
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<tr>
<td>HHSA Eligibility Unit</td>
<td>11/06/2019</td>
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<tr>
<td>Veterans Fair</td>
<td>11/06/2019</td>
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<tr>
<td>Mercy Ambulance</td>
<td>11/12/2019</td>
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<tr>
<td>Area 12 Agency on Aging</td>
<td>11/12/2019</td>
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<tr>
<td>Ethos</td>
<td>11/13/2019</td>
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<tr>
<td>Senior Center</td>
<td>11/14/2019</td>
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<tr>
<td>School Board</td>
<td>11/14/2019</td>
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<tr>
<td>Community Corrections Partnerships</td>
<td>11/15/2019</td>
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<tr>
<td>School District</td>
<td>11/20/2019</td>
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<tr>
<td>Living Free Initiative</td>
<td>11/21/2019</td>
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<td>John C. Fremont Hospital (Senior Staff)</td>
<td>11/26/2019</td>
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<tr>
<td>Yosemite National Park Leadership</td>
<td>12/04/2019</td>
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<tr>
<td>Local Area Child Care Planning Council</td>
<td>12/09/2019</td>
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<tr>
<td>Posted to our Facebook Page</td>
<td>10/15/2019</td>
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<tr>
<td>Posted to our agencies intranet</td>
<td>10/16/2019</td>
</tr>
<tr>
<td>Surveys available at all HHSA lobbies and MCBHRS website</td>
<td>10/1/19 - 12/13/19</td>
</tr>
</tbody>
</table>
**Stakeholder Description:**
There was a total of 396 respondents to the stakeholder survey, below reflects some demographic information of the respondents. The majority of respondents were either between the 26-59 age group or in the 60+ age group. Thirty-one percent of respondents identified as male, while 69% identified as female.

In addition to the demographic information listed below, an overwhelming amount of respondents identified their primary language as being English, and 83% of respondents identified their ethnicity as being White or Caucasian similarly mirroring the county demographics.

It appears that the largest stakeholder group was comprised of educators / teachers, with 31%. Consumer / Consumer Family Member’s represented 19%, and Community Based Organization / Advocates represented 19%.
**Stakeholder Results:**

Stakeholders were asked which behavioral health services had been the most helpful to the community. Among the seven PEI programs currently funded, the school-based counseling program was found to be the most helpful, by 71% of the respondents. In addition, over half the respondents (53%) indicated the Crisis/TRAC team was helpful, followed closely with 45% of respondents finding the suicide prevention hotline the most helpful.

Stakeholders were asked what age groups are underserved in the community when it comes to mental health services. Fifty-Seven percent of respondents identified the 0 – 15 age group as the most underserved in the community, followed second with 53% of respondents identifying the 16-25 year age group as underserved. Thirty-six percent of respondents felt that the 26-59 year age group remains underserved, and 48% of respondents felt that the 60+ age group is underserved in the community.

Additionally, stakeholders were asked to identify some obstacles or barriers that make it challenging to receive mental health services in the community. While all the barriers listed in the survey received considerable endorsement from respondents, the most common obstacle or barrier that the survey respondents reported was transportation (72%), followed by lack of awareness (64%), lack of insurance/money (62%), stigma (52%), and lack of resources (50%). Relatively fewer respondents reported lack of parental or family support (44%) or lack of communication between agencies (41%) as barriers against receiving mental health. Note: The sum of percentages are bigger than 100% as respondents were allowed to choose multiple answers.
Stakeholders were then asked what type of mental health related activities, programs, or services are most needed in the community. The top three services that were identified as a greatest need in the community were: increased access to mental health treatment for underserved populations (67%); 64% indicated a need for more information on mental health and increasing awareness; and 62% indicated a need for more mental health services in schools. *Note: The sum of percentages are bigger than 100% as respondents were allowed to choose multiple answers.*

**Programs most needed in the community**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing incarceration of mentally ill adults</td>
<td>26%</td>
</tr>
<tr>
<td>More culturally aware treatment</td>
<td>28%</td>
</tr>
<tr>
<td>More services/supports of foster parents</td>
<td>30%</td>
</tr>
<tr>
<td>Consumer wellness and recovery</td>
<td>35%</td>
</tr>
<tr>
<td>More appropriate levels of care</td>
<td>44%</td>
</tr>
<tr>
<td>More MH treatment in schools</td>
<td>64%</td>
</tr>
<tr>
<td>Increasing awareness</td>
<td>67%</td>
</tr>
<tr>
<td>Increased access for underserved populations</td>
<td></td>
</tr>
</tbody>
</table>

Next, the respondents were asked to rank the services listed below by the most to least important. In the figure below, the average of the rankings was calculated and presented by service. On average, suicide prevention was considered the most important, followed closely by preventative services. Obtaining education about mental health and peer support were considered relatively less important than others on average.

**Average ranking of the following services (1 being the least important and 6 the most important)**

- Suicide prevention: 4.0
- Preventive services: 3.7
- Outreach for recognition of early signs: 3.5
- Reducing stigma and discrimination: 3.4
- Peer support: 3.3
- Obtaining education about MH: 3.2
Finally, stakeholders were asked to rank the following as either not needed, somewhat needed, neutral, or very needed. Stakeholders were asked to rank the following statements:

1. Individuals released from jail need increased access to mental health service.
2. Increasing access to mental health services for underserved populations.
3. Promoting inter-agency collaboration, in terms of mental health service.
4. Increase the quality of mental health services, including measurable outcomes.
5. More integrated mental health and physical healthcare services.

The following graph summarizes the percentages of respondents who indicated each activity as very needed. Over all the majority of statements were indicated to be very important with all ranking more than 50%. Seventy-one percent of respondents felt that increased access for underserved population was the most needed, followed by 68% of respondents indicating that integration with physical healthcare is much needed. Note: The sum of percentages are bigger than 100% as respondents were allowed to choose multiple answers.

<table>
<thead>
<tr>
<th>Services</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased access for underserved</td>
<td>71%</td>
</tr>
<tr>
<td>Integrate with physical healthcare</td>
<td>68%</td>
</tr>
<tr>
<td>Increase quality of services</td>
<td>63%</td>
</tr>
<tr>
<td>Promoting Inter-agency collaboration</td>
<td>63%</td>
</tr>
<tr>
<td>Increase access for people from jail</td>
<td>58%</td>
</tr>
</tbody>
</table>

Substantive Comments:

- “More mental health first aid at the apartments in town. Important for everyone to know this information.”
- “More information on services the county has for dementia.”
- “More services for the homeless”
- “More secure areas at the hospital for reducing homeless exposure. Homeless showing up to admit to the hospitals at night.”
- “A North County Wellness Center.”
“More outreach to Yosemite Park including Aramark.”
“Expand services to park employees.”
“Improve med clinic services in Yosemite.”
“Wellness Center opportunities in Yosemite.”
“Transportation.”
MHSA 2020 – 2023 Overview

This document presents the three-year MHSA plan for Mariposa County. Mariposa County received our first MHSA funds in 2005, and we have continued to cultivate and refine these programs since. Mariposa County Behavioral Health and Recovery Service’s goal is to support clients in achieving wellness in as many life domains as possible. Below you will find a list of programs that are aimed at targeting community needs identified through the stakeholder process.

Community Services and Supports (CSS):
- Full Service Partnerships (FSP)
  - Adult’s and Children’s’ Services
- General System Development (GSD)
  - Wellness Center
  - Peer Support – Wellness Center

Prevention and Early Intervention (PEI):
- Prevention Component
  - Yosemite National Park Counselor
- Early Intervention Components
  - School Services
- Stigma Discrimination & Reduction Component
  - Mariposa Minds Matter
- Outreach for increasing recognition
  - Mental Health First Aid
- Suicide Prevention
  - Central Valley Suicide Prevention Hotline
  - School Suicide Prevention
- Access and Linkage Component
  - Small County - OPT Out

Innovation (INN):
- No current INN projects

Workforce, Education, and Training (WET):
- No current WET projects

Capital Facilities / Technology (CFTN):
- No current CFTN projects
Assessment of Mental Health Needs:
A survey, conducted as part of the 2019 Community Health Needs Assessment indicated that community members had greatest health concerns around access to care, jobs, behavioral/mental health, substance use, and housing.

Throughout the stakeholder process, stakeholders overwhelmingly identified a need for increased access to mental health services for the underserved populations, more information about increasing awareness and more mental health treatment in the school systems. This three-year plan has programs that support the needs identified by the community.

Identification of Issues:
Mariposa County ranks 42 out of 58 counties in Health outcomes, representing how healthy counties are within the state, with the healthiest ranked at #1. Rankings are based on two types of measures: how long people live and how healthy people feel while alive.

As part of the county wide 2019 needs assessment, respondents were asked to indicate on a 4 point scale the degree to which a series of issues was an unmet need in their community. Answer choices were as follows: (1) not a need in the community, (2) This is a need in the community, (3) This is an important need in the community, (4) this is a very important need within the community. Children’s mental health services was ranked over all at a 3, indicating that this remains an important need within the community. This is also reflected throughout the stakeholder process as school aged youth was identified as the most underserved population in the county.

Mariposa County’s Community Health Improvement Plan states that “without appropriate interventions, behavioral health concerns and addictions can rob individuals of quality of life, with ripple effects for families and across generations.” Coupled with the stakeholder feedback through the three year community planning process for 2020-2023 MHSA plan, indicates a multitude of barriers to receiving services, like lack of transportation, lack of awareness of programs, stigma, and lack of money and/or insurance suggests there are still efforts that need to be made to promote wellness within the community.

Mariposa County’s 2019 Community Health Assessment asserts, “Specific behaviors – whether or not people use tobacco, eat a healthy diet, are physically active, use drugs and alcohol, or have unprotected sex – can have a profound effect on health outcomes. Helping individuals avoid addictive behaviors, promoting healthy behaviors and habits, and advocating for policies that make healthier behaviors easier and more accessible are all ways that Mariposa County can improve health outcomes for its residents.” Accessibility was also identified through the three-year community planning process for
2020 -2023 MHSA plan, with 71% identifying an increase in access for underserved populations as being “very needed.”

A lack of mental health services and supports, can often times lead to an increase in: suicide among youth, violence in schools and communities, bullying and harassment, recidivism of victimization, self-harm behavior, family dysfunction and stigma, drug use for self-medication, while at the same time lead to a decrease in: reporting child abuse and neglect, self-regulation, advocacy in the home, legal and school environment, and a lack of accessing other community resources.

Untreated mental illness does not go away on its own; without treatment it is likely some may feel isolation, which can often times lead to instability in activities of daily living, making it difficult to live independently. When unable to live independently, the need for a higher level of care, such as a licensed 24 hour care facility, acute psychiatric hospitalization or an Institution for Mental Diseases (IMD), increases. The three main areas of concern of untreated mental illness are homelessness, hospitalization, and incarceration.

**Utilization Breakdown:**
Mariposa County Behavioral Health and Recovery Services strives to make an effort to reach individuals of all ages, ethnicities, and languages. Of the total Medi-Cal population in Mariposa County, the number of people accessing services for FY 18/19 hovered around 12.5%.

This penetration data shows what percentage of the Medi-Cal eligible population received services. The data represented below is based on Mariposa County Penetration Rates for the past three fiscal years: FY 18/19, FY 17/18, and FY 16/17.

**Age** - Mariposa County penetration rates for fiscal year 2018/2019 demonstrates in the graph below that two lowest penetration rates are for children aged 0 – 5 and for adults over the age of 65.
**Ethnicity** - The graph below depicts the penetration rates for the last three fiscal years. White and Hispanic populations are the most prevalent in our county, coupled with the lowest penetration rates for FY 18/19, illustrated in the graph below, indicates these individuals are underserved.

![Ethnicity Penetration Rates](image)

**Gender** - The graph below shows that there is a slight discrepancy in the number of males reached versus women over the last three fiscal years.

![Gender Penetration Rates](image)
**Language** - The graph below indicates that the penetration rate for the Spanish speaking population remains low across three fiscal years.

![Language Penetration Rates](image)

<table>
<thead>
<tr>
<th>Language</th>
<th>FY 18/19</th>
<th>FY 17/18</th>
<th>FY 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>13%</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>Spanish</td>
<td>3%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Other Language</td>
<td>20%</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Unknown</td>
<td>6%</td>
<td>9%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Community Services and Supports (CSS)

Fiscal Year 2020 – 2021 | Fiscal Year 2021 – 2022 | Fiscal Year 2022 – 2023
---|---|---
$ 1,405,829 | $ 1,405,829 | $ 1,405,829

What is Community Services and Supports?
Community Services and Supports (CSS) overarching purpose is to ensure seriously mental ill individuals have access to all necessary mental health services. This is provided through outreach and direct services for children, transitional aged youth, adults and older adults with a serious mental illness.

Proposed Programs within Community Services and Supports (CSS):
- **Full Service Partnerships (FSP’s)**
  - Adult Services
  - Children Services
- **General Systems Development (GSD)**
  - Wellness Center
  - Peer Support at the Wellness Center

County’s Capacity to Implement:
Based on the recent Workforce, Education, and Training (WET) assessment, several ethnic groups are appropriately represented by the current workforce, however, it appears more effort needs to be made in recruiting staff that identify as Native American, as zero percent are currently represented in current staffing. Mariposa County Behavioral Health Services (MCBHRS) contracts with the American Indian Council to provide mental health services to the Native American population. These contract providers were not included in workforce data listed above. More work needs to be done to determine what other races or ethnicities are being served that fall into the Multi/Race or Other category.

Although there is not a large number of staff members proficient in other languages, the majority of consumers are proficient in English, with only the occasional need for Spanish and ASL interpretation. MCBHRS accommodates this need by contracting with a certified ASL interpreter and a tele-interpreter language line. MCBHRS has available to all participants the tele-interpreter service that includes all languages, and staff participate in an annual training to utilize this service.

The MCBHRS Cultural Competence Committee, consisting of MCBHRS employees and community partners brings awareness of different cultures as well as identify barriers or gaps to receiving services.
One of the strengths of MCBHRS, is the career ladder within behavioral health division. A client may enter services and become employed as a Peer Support, moving on to the position of a Mental Health Assistant III through time and experience.

There are limitations to the county workforce as turnover has been an issue, in part due to the housing shortage in the county. This has created barriers to implementing services. The county has been working to support affordable housing development.

Additionally, as in all helping professions, burnout can be an issue. Providing secondary trauma trainings & self-care trainings is one way Health and Human Services Agency (HHSA) has attempted to address this.

Mariposa HHSA has also increased pay for positions through the WET funding that have been identified as hard to fill. Several MCBHRS supervisors hosted a booth at the California Marriage and Family Therapist (CMFT) training and in San Francisco in an effort to recruit more licensed staff members. One major effort MCBHRS has made is to become identified as a student loan forgiveness site to aid staff in applying for student loan forgiveness, if employed by MCBHRS.

Another barrier to implementing the proposed programs and services continues to be the lack of client transportation in the county and the lack of stable housing. To address these issues, HHSA will be hiring staff to provide transportation to assist clients in getting to their appointments. This is also being addressed with the implementation of tele-health services to more effectively meet the need of the clients. MCBHRS will continue to look into all possibilities to promote more affordable housing for the community.

The stigma within the community is also a barrier to individuals reaching out for support and assistance. The Mariposa Minds Matter Committee (funded out of PEI) was formed within the community to address reducing the stigma within the community.
Program Description:
Mariposa County Behavioral Health and Recovery Services (MCHRS) has been building the infrastructure of the Children’s Unit and Adult’s Unit since the original plan was adopted in 2005. Strides have been made in fully implementing the Recovery Model through support and training for staff. The goal is to continue to provide best practice services for our clients by supporting ongoing staff development.

The Full Services Partnership (FSP) program assures that clients and their families receive individualized, intensive services and supports. All ages will be served with client and family driven FSP’s that are culturally responsive. The program includes the team approach for all FSP clients, brought about by the successful Innovation project on team meetings.

The Children’s Unit provides mental health services aimed to reduce functional impairments in children and youth to increase a sense of empowerment, well-being, and optimism. The FSP program for youth is individually designed to fully wrap the youth in services. Therapeutic Behavioral Sciences (TBS) can be provided for short-term intensive targeted behavior modification. This is an addition to the intensive programs and if determined through the teaming approach.

A Personal Care Coordinator, (Mental Health Assistant III) will be assigned to the case and will be the youth’s point of contact throughout the duration of the FSP program. The Mental Health Assistants are trained to facilitate team meetings to identify the needs, concerns, and identify supports through a collaborative approach to development of an action plan with measurable goals.

The Adult Unit will provide a variety of services to meet the needs of the clients and their families. The Adult Unit will continue to use the Adult Team Meeting (ATM) model with monthly meetings for all adult and older adult FSP clients. Strengths assessments and personal recovery plans will be developed during the ATM’s to support client in reaching their goals. During these meetings, family members, when appropriate and endorsed by the client, will be invited to attend to support clients in meeting their personal recovery goals. This will allow for psycho-education, awareness of mental health symptoms and how to best support loved ones.

Transitional Housing will continue to support three to five clients a year allowing them to gain valuable skills to live independently. Skills to be obtained through Transitional Housing are basic adult living skills and household budgeting. Case Management will support clients learning about and obtaining employment or volunteer opportunities to gain independent living skills.
Proposed Activities:
All youth and transitional aged youth FSP participants will be provided with the array of services to best fit each child’s needs, including but not limited to: In Home Based Services to redirect participants in school, home and community settings; Intensive Care Coordination; Case Management to provide linkage to services and access to resources; Individual rehab to teach skills for daily living; Individual therapy to focus on symptom reduction and improvement of functional impairments; and Family Therapy to improve family dynamics, based on individuals need and family voice and choice.

All adult and other adult FSP participants will be provided with ATM’s and a variety of other services tailored to the need of the individual. These services include: intensive case management, individual rehabilitation, medication services, individual and group therapy.

ATM’s will increase the coordination, direction, and organization of client service. These meetings will allow for family members and significant others to learn effective ways to support the clients. Case management services will increase clients’ abilities to obtain needed services and resources to reduce their mental illness and increase their access to care. Individual rehabilitation will assist clients in learning skills to remain or gain independent living skills. Medication services will increase clients’ understanding of the risk and benefits of medication in order to make informed decisions about their care. Individual and group therapy will encourage clients in developing strategies to reduce the impacts of mental illness on their functioning.

Individuals Served:
The FSP program is expected to serve up to 30 individuals annually and this number is expected to maintain the same over the next three fiscal years.

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percentage Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children aged (0 – 15)</td>
<td>13%</td>
</tr>
<tr>
<td>Transitional aged youth (16 – 25)</td>
<td>15%</td>
</tr>
<tr>
<td>Adults aged (26 – 59)</td>
<td>57%</td>
</tr>
<tr>
<td>Older adults aged (60+)</td>
<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>58%</td>
</tr>
<tr>
<td>Female</td>
<td>42%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuban</td>
<td>0%</td>
</tr>
<tr>
<td>Mexican / Mexican American</td>
<td>4%</td>
</tr>
<tr>
<td>Not Hispanic</td>
<td>92%</td>
</tr>
<tr>
<td>Other Hispanic / Latino</td>
<td>4%</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>0%</td>
</tr>
</tbody>
</table>

*** Due to the extremely small numbers, the estimated numbers served in each age group, gender and ethnicity are presented as percentages.
**Budget:**
Children’s Services is estimated to spend $436,149.00 per fiscal year. This number is estimated to remain the same over the next three fiscal years. This is funded with both MHSA funds and Medi-Cal reimbursement funds.

Adult’s Services is estimated is spend $926,816.00 per fiscal year. This number is estimated to remain the same over the next three fiscal years. This is funded with both MHSA funds and Medi-Cal reimbursements funds.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.*
**General System Development (GSD)**

**Wellness Center**

**Program Description:**
The Mariposa Wellness Center aims to improve the mental health and overall wellness of Community Members. The Wellness Center provides a supportive and safe environment where participants who are 18 years and older can engage in activities provided by the Mariposa County Behavioral Health and Recovery Services (MCBHRS).

The Center provides social engagement as well as skill building activities to address daily living, job skills, budgeting, and creative expressions. Members have the opportunity to receive support, take classes, or teach a class (with permission and supervision), while meeting others on the path to improving the quality of their lives.

Members will have the opportunity to engage in structured programming including, but not limited to the following:
- Creative Expression
- Psycho-Education Classes
- Relaxation and Stress Management
- Job Readiness Skills
- Employment Development Assistance
- Financial/Budgeting/Saving
- Resource connection & referrals
- Peer Support
- Shared Life Experiences
- Volunteer Program
- Socialization
- Recreation and Exercise
- Community Activities
- Skill Building
- Health/Nutrition/Hygiene

The Mariposa Wellness Center operates by empowering members and providing support by forming meaningful relationships. The Center is aimed at facilitating personal growth.

The Wellness Center is staffed by one full time Mental Health Aid with lived experience regarding mental health and wellness to serve as a role model and mentor.

**Proposed Activities:**
Activities of the Wellness Center include daily living activities, including but not limited to: cooking, food shopping, budgeting, job training, job searching, stress management, communication skills, relaxation techniques, yoga, art classes and crafting, creative writing, and others which help to expand and enhance learning and expressive opportunities for those who may not have had such opportunities. The Wellness Center
also provides an environment where individuals can receive support and validation in an open and nonjudgmental manner.

**Individuals Served:**
The Wellness Center currently serves an average of 8 individuals per day and is open Mondays, Tuesdays, and Wednesday from 1pm to 5pm. The Wellness Center has the capacity to serve 12 individuals per day.

**Budget:**
MCBHRS estimates spending $7,500.00 on the Wellness Center each fiscal year. This number is expected to remain the same over the next three fiscal years.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.*
Program Description:
The Mariposa Wellness Center activities are developed and implemented by a Peer Support Partner. The Peer Support also facilitates and co-facilitates groups. As relationships build, the Peer Support can then provide support in FSP services as needed. This program was initially funded through the Workforce, Education, and Training (WET) component, and with its continued success, will continue to be funded through CSS. This has proven to be a successful venture as our Peer Supports were able to take over much of the operations of the Wellness Center and established a core group of consumers.

As part of Mariposa County’s overall MHSA strategy to establish and incorporate a Peer Support team, we will encourage peers to pursue the National Mental Health America certification.

The Wellness Center is a program that serves all community members regardless of participation in mental health. The Wellness Center is open to anyone over the age of 18. The peer support aid that runs the Wellness Center can provide a wealth of knowledge and information about county mental health, facilitating referrals to mental health when necessary. This program allows for improved access to services for those who make the step toward recovery by first starting at the Wellness Center, then being encouraged to seek services at MCBHRS if needed.

Forty-two percent of respondents during the most recent (2020-2023) three year plan stakeholder surveys, found the wellness center and peer supports to be helpful to the community. MCBHRS proposes continuing this program into the next three years 2020 – 2023.

Individuals Served:
This staff member is expected to serve up to 12 individuals daily during the operation of the wellness center. The peer support position is allocated for one individual at 60% full-time equivalent.

Budget:
MCBHRS estimates spending $35,364.00 on the Peer Support position each fiscal year. This number is expected to remain the same over the next three fiscal years.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.*
Prevention and Early Intervention

<table>
<thead>
<tr>
<th>Fiscal Year 2020 – 2021</th>
<th>Fiscal Year 2021 – 2022</th>
<th>Fiscal Year 2022 – 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 374,000</td>
<td>$ 374,000</td>
<td>$ 374,000</td>
</tr>
</tbody>
</table>

What is Prevention and Early Intervention?
Prevention and Early Intervention (PEI) programs are partially intended to prevent a serious mental illness by promoting strategies that reduce risk factors. Additionally PEI programs are designed to improve timely access to services and to provide a better understanding of recognizing early signs of mental illness. The PEI programs are made up of six components. Title 9 of the California Code of Regulations defines these six components below.

**Early Intervention:** “Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.”

**Prevention:** “A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this program is to bring about mental health including reduction of negative outcomes as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and as applicable, their parents, caregiver, and other family members.”

**Outreach for Increasing Recognition of Early Signs of Mental Illness:** “A process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.”

**Access and Linkage to Treatment:** “A set of related activities to connect children with severe mental illness, and adults and seniors with severe mental illness, as early in the onset of these conditions, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.”

**Stigma and Discrimination Reduction:** “The County’s direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.”
Suicide Prevention: “Organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.”

Proposed Programs within Prevention and Early Intervention (PEI):

Early Intervention:
School Services

Prevention:
Yosemite National Park Counselor

Outreach for Increasing Recognition of Early Signs of Mental Illness:
Mental Health First Aid

Stigma and Discrimination Reduction:
Mariposa Minds Matter Task Force

Suicide Prevention:
Central Valley Suicide Prevention Hotline (CVSPH)
School Suicide Prevention

Access and Linkage to Treatment:
Small County – Opt Out

PEI Community Planning Process:
The community planning process for the PEI component was included in the three-year plan stakeholder process. This section of the MHSA three-year plan includes information on what PEI means and the components that fall under PEI. This document should also serve to inform stakeholders of the requirements of PEI.

Stakeholders will be involved in all phases of the PEI programs from planning, implementing, and evaluation. Stakeholders will also be presented with outcome data once they become available, to ensure they are well informed and involved in the monitoring stage of projects.

All programs funded by PEI will reflect and be consistent with all applicable Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.
Program Description:
MCBHRS proposes to fund early intervention services in the schools intended to bring about mental wellness aimed at measuring the reduction of prolonged suffering through the following programs:

After School Peer Mentoring Program – Implementation of an After-School Peer Mentoring Program aimed at educating at risk high school youth grades 10 -12 on the fundamentals of psychology and psychotherapy, then have them act as peer mentors for at risk youth grades 7-9. This peer mentoring model will aim to empower and decrease symptoms of the upper-grade level at risk youth by having them first learn the material, then take a leadership role in teaching it to the lower-grade level youth. Lower-grade level youth will benefit from this model as well, due to the fact that they will not internalize it as potentially another lecture from an authority figure, but rather from someone like them, that they can connect and relate to.

Lunch Program – Provider will offer a Lunch-Time program that would take place 2x per week. This program would include active participation and engagement through physical activities and games geared toward mental health. Staff will also help to increase awareness on the effectiveness of engagement in physical activities by inviting participants to rate their mood before and after each activity. Activities may include but are not limited to: sports (volleyball, softball, kickball), arts and crafts, board games, group games/activities.

Teacher Training – Provider will also offer teacher/staff training 4x per year. These trainings would aim to educate staff on the implementation of conflict resolution in the classroom. The goal of this training series would be identify at risk youth and surround them with support in the classroom, decreasing the number of students being sent out of class. Staff would be trained on identifying and eliminating current shame-based discipline within the classroom setting in order to decrease the frequency and intensity if emotional/behavioral symptoms in the classroom. Staff would be trained on health conflict resolution by increasing knowledge of conflict resolution skills and engaging in the training activities outlined in Hacking School Discipline: 9 Ways to Create a Culture of Empathy & Responsibility Using Restorative Justice by Nathan Maynard and Brad Weinsten. This part of the program would be geared towards teachers who do end up kicking students out of class, and would help to provide health conflict resolution and reintegration into the classroom.

Individuals Served:
The target population are students between the ages of 13-18 who have a family history of neurological, behavioral, socioeconomic and environmental challenges. Staff will
work to identify students that fall into the high-risk category. The expected number to be served for each program are listed below.

- **After School Peer Mentoring Program** – 50 individuals each fiscal year
- **Lunch Program** – 100 individuals each fiscal year
- **Teacher Training** – 15 to 30 individuals each fiscal year

**Outcomes and Indicators:**
Targeted negative outcomes include, but are not limited to: anxiety, depression, ADHD, ODD, conduct disorder, anger, suicidal/homicidal ideation, and stress resulting in negative behaviors at school.

These programs will include these evidence based practices: cognitive behavioral therapy, dialectical behavioral therapy, mindfulness based stress reduction, emotional freedom technique, and non-violent communications.

**After School Peer Mentoring Program and Lunch Program** - The objectives of the program include, but are not limited to: learning and practicing positive ways of coping as seen by increasing knowledge of positive coping skills by 3 (from baseline); practicing journaling as seen by increasing engagement in mindful journaling engagement by 1x per week for 10 minutes (from baseline); learning and practicing relaxation techniques as seen by increasing engagement in Mindfulness Based Stress Reduction exercises by 15 minutes 1x per week (from baseline); identifying and challenging irrational thoughts and patterns of symptoms/behaviors as seen by increasing psycho-education on CBT/DBT and engaging in CBT/DBT based exercises by 20 minutes 1x per week (from baseline); learning and practicing healthy communication skills as seen by increasing psycho-education in non-violent communications (NVC) and engaging in NVC exercises by 10 minutes 1x per week (from baseline); learning and practicing self-monitoring as seen by increasing psycho-education on mindfulness based stress reduction and the mind/body connection and engaging in related exercise by 15 minutes 1x per week (from baseline); and reducing the frequency and intensity of symptoms as seen by decreasing student participant PHQ-9 and GAD-7 symptom severity scores by 1 degree in each category (from baseline) from program start date. If student participant initial reports having little to no interest in doing things nearly every day, services would aim to get their response to decrease 1 degree, shifting it to more than half the days weekly, by the next evaluation.

The program goal will be to stabilize emotional/behavioral functioning in student participants. Program activities may include, but are not limited to: psycho-education therapeutic techniques (building rapport, active listening, reflecting, holding space), psycho-education on therapeutic theory (CBT, DBT, mindfulness Based Stress Reduction, Non-Violent Communication, and Emotional Freedom Technique, psycho-education on coping skills that aim to reduce stress (mindfulness, journaling, breathing techniques, healthy communication, emotional freedom technique), interactive games related to mental health, and peer mentoring processing sessions.
The PHQ-9 and GAD-7 assessments will be administered to each program participant in the after school program 4x per year to assess for potential risk, as well as progress being made. A decrease in severity of symptoms between survey 1-2 and 2-3 and 3-4. These self-report assessments will demonstrate program effectiveness. The after-school program clinical team will meet upon completion of the survey collection to analyze data and measure effectiveness of program resources.

**Teacher Training** - The objectives of this training program includes decreasing frequency and intensity of emotional behavioral symptoms in the classroom by decreasing ineffective disciplinary action and replacing them with healthy conflict resolution skills. Objectives of this training would also include, learning and practicing healthy conflict resolution as seen by increasing knowledge of conflict resolution skills by 5 (from baseline).

**Budget:**
MCBHRS estimates spending $151,000.00 on the school services each fiscal year. This number is expected to remain the same over the next three fiscal years.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.*
Program Description:
Yosemite National Park (YNP) lies within the boundaries of Mariposa County. In 2017 the National Park Service (NPS) employed 1,200 individuals in the summer and 800 individuals in the winter. The concessionaire within YNP employs a significant number of employees both seasonally and annually. YNP is geographically isolated and remote and has little resources in the way of mental health services. This large population remains underserved. It is worth mentioning that in 2016, there were 5,217,144 visitors to Yosemite, a slight decline occurred in subsequent years due to wildfires.

MCBHRS proposes to provide a Clinician onsite to address and promote recovery within the unique community that is Yosemite. Interventions and services will include: crisis response, first responder stress, mental health issues, and groups.

This community based prevention program will provide services and interventions in an effort to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The overall services provided include, but are not limited to: group therapy, therapeutic interventions, crisis response, emotional support/wellness groups, educational series, and psycho-education to those working and living in Yosemite National Park.

Proposed activities that are intended to reduce the negative outcomes listed in WIC include: wellness coaching/educational drop in hours (short term need), crisis and support groups, psycho-educational series (e.g. Mindfulness, emotional intelligence), employer/employee consultations regarding mental health, training opportunities for facilitated dialogues (Allies for Inclusion) offered on different topics and park stressors, linkage to community resources (counseling, cal fresh, Health and Human Services Community Assistance Programs, psychiatry), and monthly/quarterly newsletter addressing emotional wellness and links to resources.

Yosemite National Park is an hour and a half from the township of Mariposa, where the majority of mental health services are available. This creates a burdensome access to the mental health system. Providing services and activities within the boundaries of YNP greatly enhances access and availability to services that would reduce negative outcomes that may result from untreated mental illness.

As individuals or their families are identified as being in need of further mental health services, the Clinician will provide direct access and linkage to MCBHRS or other appropriate services. This program facilitates timely access to services for this underserved population by virtue of their accessibility in the community setting. The program is designed and will be implemented in the community setting to reduce stigma by talking openly about mental wellness.
The intended settings of these services will be within the YNP boundaries in an effort to strengthen and elevate access for this underserved population. This creates a less burdensome access to mental health services. Community members would otherwise face a lack of long drive times and a lack of transportation.

**Individuals Served:**
This program is designed to target remote, rural, underserved, and high risk residents and employees of YNP. An estimate of 75 – 350 people will be served each fiscal year.

**Outcomes and Indicators:**
This program expects to decrease: staff suicide rates, unemployment, prolonged suffering, and homelessness (specifically by keeping individuals employed and connected to employee housing and their current community), by providing therapeutic and educational interventions.

The program will utilize the following evidence based practices:
- mindfulness and meditation
- non-violent communication trainings
- therapeutic modalities
  - Internal Family Systems
  - Emotional Focused Therapy
  - Cognitive Behavioral Therapy
  - Somatic Practices
  - Peer Support and Education

All individuals served by this program will be accounted for through quarterly stats. Pre/post surveys will be given to analyze the duration of symptoms.

The goal of this prevention program is to provide behavioral health interventions and education to increase emotional wellness and resilience. The program is also aimed at reducing the need for longer term counseling services, hospitalizations, or significant impairments to activities of daily living (including the ability to maintain regular employment and housing).

**Budget:**
MCBHRS estimates spending $50,000.00 on the YNP services each fiscal year. This number is expected to remain the same over the next three fiscal years.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.*
Program Description:
Mental Health First Aid (MHFA) is an evidence based program that MCBHRS implemented in 2014 after stakeholders identified this as need within the community. This program engages and trains first responders to recognize and respond effectively to early signs of mental illness. MCBHRS staff that have been trained as trainers will facilitate these classes.

The objective of this training is to bring awareness of the prevalence and negative impact mental illness can have on an individual, family, and friends. The goal is to share information and resources so that the person leaves the training with an understanding of how to connect someone to mental health resources. The training can also shed some myths of mental illness and increase a sense of compassion for those suffering with untreated mental illness.

Each training informs responders on how to access, and link individuals, to treatment. Trained responders may interface with unserved or underserved populations. Responders are trained in assisting individuals seeking treatment and promoting timely access to services. MHFA has been identified as being a helpful educational tool that respondents can use to: notice the early signs of mental health problems, empower respondents to feel confident in being able to help someone experiencing a mental health problem, and reduce stigma surrounding mental illness in the community and nearby surrounding areas.

The design and implementation of these trainings are intended to reduce stigma and discrimination attached to seeking or receiving services by talking freely about mental wellness.

Trainings are scheduled at various locations across the county to encourage more participation at a location that is convenient for responders. An increase in the number of participants should help facilitate access to services by training more individuals to recognize signs of mental illness.

MCBHRS has two mental health assistants certified to train MHFA that make up the training team.

MCBHRS proposes that this program continue to be funded as stakeholders have expressed how important this program is to our community.

Individuals Served:
MHFA instructors plan to engage with members of the community and nearby surrounding communities in order to train and educate those individuals on the signs and symptoms of mental illness. Respondents of the MHFA trainings includes, but are
not limited to: first responders (law enforcement, EMS, crisis workers, ER staff etc…), health care workers (including those with a background in mental health), school staff, community members, local businesses including owners and employees, and community youth.

MCBHRS strives to hold 10 training sessions each year; with a minimum of 6 training sessions in a combination of courses specific to youth, adults, first responders, and specific course target populations. MCBHRS estimates that each training will have 10 participants, but require a minimum of five people for the training to take place. MCBHRS estimate serving at least 30 individuals a year.

MCBHRS will hold trainings at various locations so that more individuals are reached in a community and environment they are comfortable in.

**Outcomes and Indicators:**
MHFA is listed in the Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practice.

The expected outcomes of MHFA is a comprehensive training program that increases an individual’s knowledge of signs, symptoms, risk factors, protective factors, and confidence to assist someone who may be struggling.

The MHFA program uses pre/post surveys to gather information regarding comprehension, interest, and other comments for improvement. In addition, data collection will be rendered at the completion of the course identifying age, gender, ethnicity, recruitment, and lived experience. The course evaluation was developed by the MHFA training programs.

Pre/post surveys will be utilized to check in with potential responders during the training. The training team will use interactive activities during the training to answer questions and establish rapport. Staff will measure if potential responders feel more confident in recognizing signs and symptoms of mental illness at the completion of the course.

The effectiveness of this program will be demonstrated through the pre/post surveys. Effectiveness will be evident if potential respondents felt more confident responding to a mental health crisis after each training. An increase in the number of participants that are renewing their certification every three years will also indicate the effectiveness of the program. For reference, in the last fiscal year 43 out of 44 participants felt more confident in being able to respond to someone experiencing a crisis.

**Budget:**
MCBHRS estimates spending $10,000.00 on MHFA each fiscal year. This number is expected to remain the same over the next three fiscal years.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.*
**Program Description:**

Mariposa Minds Matter (MMM) is an integral part of the Behavioral Health Board (BHB). MMM is made up of members of the BHB, consumers, community based partners, and staff. Activities held throughout the year are designed to reduce stigma in our unique rural community. In 2018, the Committee renamed themselves from the ‘Stigma Reduction Committee’ to the ‘Mariposa Minds Matter Task Force’. This program is designed to welcome community member’s participation in the development of stigma and discrimination reducing activities.

MMM is a program specifically targeted to reduce stigma and discrimination by increasing awareness through: education, resources, quizzes, games, demonstrations of sound baths and aromatherapy. This program is expected to increase acceptance, dignity, and inclusion for individuals with mental illness. The intention of the program is to also encourage self-acceptance for those that may be struggling.

MMM is a project based task force, participating in several events throughout the county ranging from the annual county fair to the local farmers market. The task force will have a booth at several festivals throughout the year in an effort to generate conversations about the stigma and discrimination around mental health. Conversations about stigma (personal, social, and institutional) is a key component to reducing negative feelings, attitudes, beliefs, perceptions, stereotypes, and discrimination related to being diagnosed with a mental illness or receiving services for a mental illness. The booths will provide both verbal and written educational materials on mental health and stigma reduction. Materials will include, but not limited to: an emotion wheel, children’s drawing boards and mental health screenings.

Twice yearly, MMM will host community video events to feature a specific mental health diagnosis. These videos will also include a lived experience speaker and handouts.

MMM also plans to provide one booth annually in a heavily trafficked area. This booth will provide information on mental illness, mental health and stigma reduction.

While this program will mainly consist of one-touch encounters, MMM will strive to provide access and linkage, and timely access to services as appropriate for individuals attending events.

The program is designed to be fluid, as far as where the outreach is directed. The objective is to reach as many individuals as possible; in a rural community reaching individuals can often be a challenge. The ability to reach more individuals is enhanced by participating in events that are expected to bring folks to one area, (e.g. the county fair).
**Individuals Served:**
300 people are expected to be served through the community events; the local fair and the farmers markets. In addition, 50 participants are expected to be served through the video presentations.

This is mainly a one-touch encounter strategy, however, give-a-ways will be offered to entice participation.

**Outcomes and Indicators:**
The expected outcomes is a reduction in negative feelings, attitudes, beliefs, perceptions, stereotypes, and discrimination related to being diagnosed with mental illness. The program is also expected to increase acceptance, dignity, and inclusion for individuals with mental illness and their families. It is also expected to encourage self-acceptance for members of the committee.

MMM will collect data at all community events using pre/post surveys to determine the effectiveness in changing attitudes, knowledge, and/or behavioral regarding being diagnosis with mental illness, having a mental illness, and/or receiving mental health services. The MMM will use the data to drive the direction and target of future campaigns.

Pre/post surveys will demonstrate if the stigma reduction interventions effective in bringing about a the desired outcomes listed above.

**Budget:**
MCBHRS estimates spending $2,500.00 on the stigma reduction program each fiscal year. This number is expected to remain the same over the next three fiscal years.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.*
Suicide Prevention
Central Valley Suicide Prevention Hotline

Program Description:
The Central Valley Suicide Prevention Hotline (CVSPH) took their first call on January 17, 2013. The hotline operated on a limited basis five days a week for twelve hours each day. In July 2013, CVSPH expanded operations to 24 hours per day, seven days per week, and 365 days per year.

CVSPH is a program administered through CalMHSA on behalf of counties that are participating in the program. It serves as the counties primary suicide prevention hotline. CVSPH operates a 24/7 suicide prevention hotline accredited by the American Association of Suicidology, and will continue to answer calls through its participation in the national suicide prevention lifeline which provides interpreters for 150 different languages.

CVSPH serves a culturally diverse group of seven counties in California’s Central Valley: Fresno, Tulare, Kings, Madera, Mariposa, Merced and Stanislaus. The Hotline is operated by staff utilizing volunteers to minimize cost and maximize efficiency.

The Hotline assists individuals who are looking for resources and education regarding a loved one or friend; provides support for those in crisis and keeps people safe who have suicidal ideation or that are in the process of killing themselves.

The program is designed to help improve access to services by linking callers to the appropriate services. The accessibility of a local hotline providing callers with information and resources ensures that the program is non-stigmatizing and nondiscriminatory.

Individuals Served:
The program is expected to serve 50 individuals per fiscal year.

Outcomes and Indicators:
The expected outcome of this evidence-based practice is to reduce suicide by the accessibility of a local hotline providing timely access to services. The number of callers will be used to indicate a change in attitude and behavior to prevent mental illness-related suicide.

The CVSPH uses the Columbia Suicide Severity Rating scale to screen their callers with the intention of preventing suicide for Mariposa County.

Budget:
MCBHRS estimates spending $7,411.00 on the CVSPH each fiscal year. This number depends on the price charged by the vendor according to our share of the call volume, but is expected to remain the same over the next three fiscal years.
*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.
Program Description:
School aged youth was identified as one of the most underserved population in Mariposa County. Suicide prevention was identified as one of the most needed programs through the three year planning and stakeholder process.

MCBHRS proposes funding a school based suicide prevention program that targets school aged youth. This program is intended to provide youth with education on the signs and symptoms of suicide and to provide crisis intervention if and when necessary.

This program will primarily consist of educational groups on suicide prevention, however a more targeted intervention may be utilized on a case by case basis.

Individuals Served:
This program is expected to serve approximate 50 individuals per fiscal year.

Outcomes and Indicators:
The expected outcome of this program is to engage youth in conversations about suicide in an effort to provide education and information. The program will be targeted educational groups held in the school setting.

The program will measure a change in attitude, beliefs, behaviors and knowledge about suicide in several manners. For educational groups a pre/post survey or screening will be utilized to assess for any changes in beliefs or knowledge after the groups. For more targeted crisis interventions a screening tool will be utilized to measure the number of individuals that were successfully de-escalated after intervention as opposed to those that required a higher level of care or hospitalization.

Budget:
MCBHRS estimates spending $40,000 on the school based suicide prevention program each fiscal year. This number is expected to remain the same over the next three fiscal years.

*The above amounts are budget estimates based on MHSA revenue projections. The actual expenditures may be lower or higher depending on the actual MHSA revenue received in these future years.
Access and Linkage

Opt Out

Each project listed above in the PEI component facilitate and ensure access and linkage to services. As such, MCBHRS has decided to opt out of the access and linkage component. The reporting requirements for this component requires more training and staff time than a very small county has the capacity to implement.
Innovation

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<tr>
<th>Fiscal Year 2020 – 2021</th>
<th>Fiscal Year 2021 – 2022</th>
<th>Fiscal Year 2022 – 2023</th>
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**What is Innovation?**
Innovation (INN) projects are designed to find new approaches to improve mental health services, delivery of services, quality of services, or improve outcomes by promoting interagency collaboration.

**Proposed Programs within Innovation (INN):**
- *None – Projects are currently in draft*

**Community Planning Process:**
MCBHRS currently does not have any active Innovation Projects.

MCBHRS is currently working on utilizing stakeholder results from this three year plan to draft a proposal for an Innovative Project. The proposal will then be posted for a 30 day public review, and approved by the local mental health board. Once approved, MCBHRS will take the proposal to the Mariposa County Board of Supervisors for approval.

**Three-Year Plan (2020 – 2023):**
MCBHRS Innovation plan will be finalized in the 20/21 fiscal year. The selected primary purpose and the reasons that the primary purpose is the priority of the county will be included in the innovation plan prior to submission.

MCBHRS will submit the final Innovation Plan and budget to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for final approval in the 20/21 fiscal year.

If the plan is approved by the MHSOAC, MCBHRS will ensure that all phases of the Innovation project includes meaningful stakeholder involvement. Stakeholders will also be included in the evaluation of the Innovation project, and the decision regarding whether to continue the Innovation project, or elements of the project without Innovation funds.

Any Innovation projects will be consistent with all relevant MHSA regulations and standards.
What is Workforce, Education and Training?
Workforce, Education and Training (WET) is the component of MHSA that aims to reduce the workforce shortages of qualified staff in the mental health field, by supporting, building, retaining and training.

Proposed Programs within Workforce, Education and Training (WET):
- There is currently no funding for WET

Workforce Needs Assessment:
*(See full WET Assessment – Appendix)*

MCBHRS conducted a WET assessment in January 2020 to determine current workforce shortages and identify hard to fill positions. Staff were asked to complete a short survey identifying their licensure/position, their ethnicity and any language proficiencies. It should be noted that 18% of the current workforce did not respond to the information requested.

Comparability of workforce, by ethnicity, to population receiving public mental health services:

<table>
<thead>
<tr>
<th></th>
<th>White / Cauc.</th>
<th>Hispanic / Latino</th>
<th>African-American / Black</th>
<th>Asian / Pacific Islander</th>
<th>Native American</th>
<th>Multi Race / Other (Includes unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Served</td>
<td>70%</td>
<td>11%</td>
<td>2%</td>
<td>&gt;1%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>MCBHRS Workforce</td>
<td>62%</td>
<td>12.3%</td>
<td>1.6%</td>
<td>1.6%</td>
<td>0%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Several ethnic groups were identified as being appropriately represented by the current workforce, however, it appears more work needs to be done to recruit staff that identify as Native American, with zero percent staffing represented. MCBHRS contracts with the American Indian Council to provide mental health services to the Native American population. These contract providers were not included in workforce data listed above.
More work needs to be done to determine what other races or ethnicities are being served that fall into the Multi/Race or Other category.

**Language Proficiency:**
Three staff members self-identified as being proficient in Spanish, and one staff indicted they were proficient in French. Although there is not a large number of staff members proficient in other languages, the majority of consumers are proficient in English, with only the occasional need for Spanish and ASL interpreter. MCBHRS offsets this need by contracting with a certified ASL interpreter and a tele-interpreter language line. Staff are trained annually on the usage of the language line to ensure, when the need arises, staff have access to multiple languages. One area that warrants further exploration is whether Non-English speaking communities are not seeking out the services they need because of perceived language barriers. Further exploration may be necessary to determine if the need is great enough to offer an incentive for direct service hires with ASL or Spanish language proficiency, or training for current employees in these languages.

**Positions designated for individuals with consumer experience:**
Currently there are two positions designed for individuals with consumer experience. The Wellness Center has a Mental Health Aide, Peer Support position. Mariposa County also has a position for a Peer System Navigator. This position has not formally been filled, historically staff have entered this position, and then moved on to promotional opportunities before this program has had the opportunity to be fully developed. These positions provide an opportunity for consumers and family members to enter the mental health profession, and potentially be promoted through the Mental Health Assistant (I – III) career ladder.

**Other, Miscellaneous:**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-15 Years</th>
<th>6-11 Years</th>
<th>12-17 Years</th>
<th>18-20 Years</th>
<th>21-24 Years</th>
<th>25-34 Years</th>
<th>35-44 Years</th>
<th>45-54 Years</th>
<th>55-64 Years</th>
<th>65+ Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Served</td>
<td>5%</td>
<td>14%</td>
<td>30%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>14%</td>
<td>15%</td>
<td>12%</td>
<td>6%</td>
</tr>
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</table>

It is notable that Mariposa County’s 65+ age group makes up 27% of the population, and yet the penetration rate for this group is 6%. Forty-eight percent of stakeholders identified the 60+ age range as an underserved population in the community. This could be indicative of the county’s lack of Medicare providers. The older adult age group remains an underserved population for MCBHRS.
### Capital Facilities and Technology Needs (CFTN)

<table>
<thead>
<tr>
<th>Fiscal Year 2020 – 2021</th>
<th>Fiscal Year 2021 – 2022</th>
<th>Fiscal Year 2022 – 2023</th>
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<tr>
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**Proposed Programs within Capital Facilities and Technology Needs (CFTN):**

- MCBHRS expended all of these one-time funds.
### Expenditure Plan

#### Funding Summary

| County: Mariposa | Date: 4/21/20 |

<table>
<thead>
<tr>
<th>A. Estimated FY 2020/21 Funding</th>
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<tbody>
<tr>
<td>1. Estimated Unspent Funds from Prior Fiscal Years</td>
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<tr>
<td>2. Estimated New FY2020/21 Funding</td>
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<tr>
<td>3. Transfer in FY2020/21</td>
</tr>
<tr>
<td>4. Access Local Prudent Reserve in FY2020/21</td>
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<tr>
<td>5. Estimated Available Funding for FY2020/21</td>
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<table>
<thead>
<tr>
<th>B. Estimated FY2020/21 MHSA Expenditures</th>
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<tbody>
<tr>
<td>1,405,829</td>
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<tr>
<th>C. Estimated FY2021/22 Funding</th>
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<tbody>
<tr>
<td>1. Estimated Unspent Funds from Prior Fiscal Years</td>
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<tr>
<td>2. Estimated New FY2021/22 Funding</td>
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<tr>
<td>3. Transfer in FY2021/22</td>
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<tr>
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<td>5. Estimated Available Funding for FY2021/22</td>
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<th>D. Estimated FY2021/22 Expenditures</th>
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<tr>
<td>1,405,829</td>
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<th>E. Estimated FY2022/23 Funding</th>
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<td>1. Estimated Unspent Funds from Prior Fiscal Years</td>
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<table>
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<tr>
<th>F. Estimated FY2022/23 Expenditures</th>
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<tr>
<td>1,405,829</td>
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<table>
<thead>
<tr>
<th>G. Estimated FY2022/23 Unspent Fund Balance</th>
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<tbody>
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<td>0</td>
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<table>
<thead>
<tr>
<th>H. Estimated Local Prudent Reserve Balance</th>
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</thead>
<tbody>
<tr>
<td>1. Estimated Local Prudent Reserve Balance on June 30, 2014</td>
</tr>
<tr>
<td>2. Contributions to the Local Prudent Reserve in FY 2020/21</td>
</tr>
<tr>
<td>3. Distributions from the Local Prudent Reserve in FY 2020/21</td>
</tr>
<tr>
<td>4. Estimated Local Prudent Reserve Balance on June 30, 2015</td>
</tr>
<tr>
<td>5. Contributions to the Local Prudent Reserve in FY 2021/22</td>
</tr>
<tr>
<td>6. Distributions from the Local Prudent Reserve in FY 2021/22</td>
</tr>
<tr>
<td>7. Estimated Local Prudent Reserve Balance on June 30, 2016</td>
</tr>
<tr>
<td>8. Contributions to the Local Prudent Reserve in FY 2022/23</td>
</tr>
<tr>
<td>9. Distributions from the Local Prudent Reserve in FY 2022/23</td>
</tr>
<tr>
<td>10. Estimated Local Prudent Reserve Balance on June 30, 2017</td>
</tr>
</tbody>
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*a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years."
## Community Services and Supports (CSS) Component Worksheet

### Fiscal Year 2020/21

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
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<th>D</th>
<th>E</th>
<th>F</th>
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<tbody>
<tr>
<td></td>
<td>Estimated Total Mental Health Expenditures</td>
<td>Estimated CSS Funding</td>
<td>Estimated Medi-Cal FFP</td>
<td>Estimated 1991 Realignment</td>
<td>Estimated Behavioral Health Subaccount</td>
</tr>
<tr>
<td>FSP Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Children</td>
<td>518,961</td>
<td>436,149</td>
<td>82,812</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Adult</td>
<td>1,066,315</td>
<td>926,816</td>
<td>139,498</td>
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<tr>
<td>Non-FSP Programs</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. Wellness Center - GSD</td>
<td>7,500</td>
<td>7,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Peer Support - Wellness Center - GSD</td>
<td>35,364</td>
<td>35,364</td>
<td></td>
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<tr>
<td>CSS Administration</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>CSS MHSA Housing Program Assigned Funds</td>
<td>0</td>
<td></td>
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<td></td>
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<tr>
<td>Total CSS Program Estimated Expenditures</td>
<td>1,628,139</td>
<td>1,405,829</td>
<td>222,311</td>
<td></td>
<td></td>
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<tr>
<td>FSP Programs as Percent of Total</td>
<td>112.8%</td>
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### Fiscal Year 2021/22

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**FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan**

**Innovations (INN) Component Worksheet**

| County: Mariposa | Date: 4/21/20 |

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### Workforce, Education and Training (WET) Component Worksheet

**County:** Mariposa  
**Date:** 4/21/20

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**Fiscal Year 2017/18**

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**CFTN Programs - Capital Facilities Projects**

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**CFTN Programs - Technological Needs Projects**

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2. 0 0 0 0 0
3. 0 0 0 0 0

**CFTN Administration**

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**Total CFTN Program Estimated Expenditures**

0 0 0 0 0

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**Fiscal Year 2018/19**

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**CFTN Programs - Capital Facilities Projects**

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2. 0 0 0 0 0
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**CFTN Programs - Technological Needs Projects**

1. 0 0 0 0 0
2. 0 0 0 0 0
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**CFTN Administration**

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**Total CFTN Program Estimated Expenditures**

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**Fiscal Year 2019/20**

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<td><strong>Estimated Total Mental Health Expenditures</strong></td>
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<td><strong>Estimated 1991 Realignment</strong></td>
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<td><strong>Estimated Behavioral Health Subaccount</strong></td>
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**CFTN Programs - Capital Facilities Projects**

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**CFTN Programs - Technological Needs Projects**

1. 0 0 0 0 0
2. 0 0 0 0 0
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**CFTN Administration**

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**Total CFTN Program Estimated Expenditures**

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PEI Report

Overview:
Mariposa County’s Behavioral Health and Recovery Services (MCBHRS) Prevention and Early Intervention (PEI) Annual Program and Evaluation Report presents summaries and analyses of the seven PEI projects active during the FY 18/19.

PEI is designed to engage individuals and prevent mental illness from becoming severe and disabling, and increase the timely access to services for underserved populations. The goal is to reduce adverse outcomes that may be a result of an untreated mental health illness. The following seven programs were constructed with stakeholder participation to address the aforementioned. Each program is designed to be non-stigmatizing and nondiscriminatory.

1. Yosemite National Park (YNP): This early intervention program was designed and implemented in 2018 when stakeholders, the National Park Services (NPS), and the Hospitality industry reached out for assistance with mental health services in YNP. A mental health clinician was funded to provide services and interventions, to address and promote recovery and related functional outcomes for mental illness in early emergence by providing counseling and support services. This program is designed to reduce stigma and discrimination by serving people in an environment that connects staff to resources in their workplace.

2. School Counselors: Stakeholders identified a need for additional counselors within the school system. School aged youth are identified as a disparity in our county leading to the direct approach of funding additional counselors for students in our county. School counselors provide youth to youth mentoring, social support groups, resilience curriculum, individual counseling, crisis intervention, conflict resolution, assistance and support with anti-bullying curriculum, and youth lead stigma reduction activities. The design and implementation of the activities is in the school setting thus reducing the stigma and discrimination attached to seeking or receiving services.

3. Drop In Center: Mariposa Heritage House (MHH) is a safe, healthy, clean and sober support center reaching out to adults and their families, seeking to change their lives. The Drop in Center was established for homeless and the underserved populations. MHH provides referrals and linkage to community supports and services as well as access to shower facilities, a kitchen, and group rooms seven days a week (8am – 7pm). This component reduces stigma and discrimination by serving people in an environment in which they are comfortable, such as the Drop In Center.
4. **Crisis/Triage Response Assess Crisis (TRAC) Team:** This team connects early in onset, children with emotional disturbance, and adult/older adults with serious mental illness, to medically necessary care and treatment. This is accomplished through the 24/7 TRAC team and a 5-day a week warm line. Additionally the team does outreach in the community including the local Drop in Center and schools. All of these activities touch the underserved populations in our community, especially those in generational poverty, a population identified in the 2015 Mariposa County Needs Assessments. The program reduces stigma and discrimination by serving people in an environment in which they are comfortable, such as the Wellness Center, the Drop-in Center, schools, and other community locations.

5. **Mental Health First Aid:** This evidence based program provides outreach for increasing recognition of early signs of mental illness and embodies the ideals set forth within PEI. This program engages and trains first responders to recognize and respond effectively to early signs of mental illness. The trainings are held in locations convenient for community members, community partners, consumers and family members. This program focuses on bringing about recovery, wellness, and resilience.

6. **Stigma Reduction Task Force:** The Stigma Reduction Task Force is an integral part of the Behavioral Health Board. The Task Force is made up of members, consumers, community-based partners, and staff. Activities are held throughout the year designed to reduce stigma in our unique rural community. In 2018, the Committee renamed themselves – Mariposa County Minds Matter Task Force. This component is designed to welcome community member's participation in the development of stigma and discrimination reducing activities.

7. **Central Valley Suicide Prevention Hotline (CVSPH):** In collaboration with this hotline, trainings are provided to MCBHRS staff and community. CVSPH is a means of suicide prevention for the community. The hotline assists individuals who are looking for resources and education regarding a loved one or friend, and provides support for those in crisis. Stigma and discrimination are reduced by the anonymity of each phone call. This evidence based practice reduces suicide by the accessibility of a local hotline, providing timely access to services, and access and linkages to treatment.

Results and analysis of all PEI programs include the perspective of diverse people with lived experience through our local Behavioral Health Board.

Unserved and underserved populations were identified through internal and external needs assessments within our county. Outcomes and indicators for each program were
selected as a result of stakeholder input on what would be the desired outcomes for those unserved and underserved populations. See appendixes for reporting forms and selected indicators for each program.
Yosemite National Park (YNP) lies within the boundaries of Mariposa County. In 2017, the National Park Service (NPS) employed 1,200 individuals in the summer and 800 individuals in the winter. The concessionaire within YNP employs a significant number of employees both seasonally and annually as well. This large population remains underserved. Geographically isolated and remote, YNP has limited resources in the way of mental health services. It is worth mentioning that in 2016, there were 5,217,144 visitors to Yosemite.

NPS and the concessionaire reached out to MCBHRS for assistance with mental health services within the YNP community as there was an increase in the employee suicide rate. MCBHRS provided a clinician onsite to address and promote recovery within the unique community that is YNP.

This community based Early Intervention Program will provide services and interventions to address and promote recovery and related functional outcomes for mental illness in early emergence by providing the following counseling and support activities:

- Individual Counseling
- Wellness Groups
- Crisis intervention
- Early intervention and Linkage to Services
- Education for Families and Employers

Yosemite National Park is an hour and a half from the township of Mariposa, where the majority of mental health services are available; creating a burdensome access to mental health system. Providing the above-mentioned services and activities within the boundaries of YNP, greatly enhances access and availability to services that would reduce negative outcomes that may result from untreated mental illness.

As individuals or their families are identified as being in need of further mental health services, the clinician will provide direct access and linkage to MCBHRS or other appropriate services. This program facilitates timely access to services for this underserved population by virtue of their accessibility in the community setting. By talking openly about mental wellness in the community setting, the program design reduces stigma.

**Method of Collection:** Pre and post surveys were administered through some wellness groups, and sign in sheets.
**Data Collection Period:** Quarterly reports were submitted on the last day of January, April, July, and October.

**Expected Outcomes:** Our expected outcome for this program was to provide early intervention to a remote population of individuals that often remain untreated. This program is also expected to promote timely access to services, access, and linkage by referring individuals when identified as having that need

**Outcomes:**

<table>
<thead>
<tr>
<th>Evaluation Indicators</th>
<th>Unduplicated Outcomes</th>
<th>Duplicate Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in prolonged suffering resulting from untreated mental illness – the number of individuals referred to mental health services.</td>
<td>18</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduction in prolonged suffering by improved mental, emotional, and relational functioning – The number of individuals supported with education for families or employers.</td>
<td>12</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduction in prolonged suffering by improved mental, emotional and relational functioning – the number of individuals receiving crisis intervention / conflict resolutions.</td>
<td>19</td>
<td>52</td>
</tr>
<tr>
<td>Reduction in prolonged suffering by improved mental, emotional, and relational functioning – The number of individuals served in wellness groups or workshops with improved recovery and related functioning outcomes as shown in pre/post surveys.</td>
<td>N/A</td>
<td>282</td>
</tr>
<tr>
<td>The number of individuals who received individual counseling.</td>
<td>93</td>
<td>604</td>
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</table>

**Results and Analysis:**

Yosemite National Park is an isolated area with limited resources when it comes to mental health. A Licensed Professional Clinical Counselor provided early interventions to a population that often remains untreated. Throughout the 2018/2019 fiscal year, the Clinician held two Fire Crisis Debrief sessions after several fires directly affected the employees and residents of the park. Due to the nature of these groups, sign in sheets were not captured during this emergency, so the unduplicated numbers could be misrepresented.

The park also suffered a few employee related suicides in the past fiscal year leading the Clinician to hold two employee suicide support groups to address and promote recovery within this isolated population.
YNP experienced a government shutdown during this fiscal year, leaving many employees without work. The shutdown, coupled with considerable isolation, led to the Clinician coordinating several government shutdown support groups to support employees during this time of heightened anxiety.

Among the groups listed above, the Clinician held the following interventions throughout the fiscal year:

- 4 Mindfulness trainings
- 1 Environmental Learning Collective Speaker
- 7 Emotional Intelligence Groups
- 1 Nature Bridge Resiliency Talk
- 1 NPS Mental Health Awareness Talk

The clinician provided a valuable and important service to the incredibly isolated YNP. Over 142 unduplicated individuals were served in any capacity and 18 individuals were identified as needing to be referred to ongoing mental health services. This is 18 individuals that may have remained underserved or unserved.

There were some overall challenges with the implementation of this program at the beginning, not all demographics and sign in sheets were captured. Overall demographic data could be misrepresented.
In 2014, MCBHRS explored how to increase our ability to prevent mental illness amongst children and youth. MCBHRS had conversations with the Mariposa Unified School District surrounding the lack of counseling/support capacity within the elementary schools. At that time the District had only one full-time counselor between 6 elementary schools. This limited capacity made it difficult for the District to detect early warning signs of mental illness and even more difficult to provide support for children and families.

Although data indicated an increase in all areas of service for elementary age children, it became evident from stakeholder feedback and discussions with the District that another counselor was needed in the elementary schools. One counselor was serving 4 schools that are geographically spread out; necessitating long commutes between sites and a decreased overall ability to serve children and families. The feedback and discussions indicated that this population age group is underserved.

Feedback from youth stakeholders and discussions with the School District indicated that a mental health counselor was needed to serve the high school-age population. The feedback and discussions indicated that this population age group was also underserved.

Early in the 2017/18 school year, the local charter school reached out to MCBHRS to request PEI services at their site. The school receives some support from the school district special education department, but their needs exceeded the support available. MCBHRS, with stakeholder agreement, began serving the school in the spring of 2018.

MCBHRS funded 5.5 FTE school counselors for school aged youth, to provide services and interventions to address and promote recovery and related functional outcomes for mental illness in early emergence along with reducing risk factors and building protective factors.

This fiscal year (2018/19), the school district implemented the ‘Signs of Suicide (SOS)’ program district wide. All 7th – 12th grade students were exposed to a classroom presentation provided by a counselor, helping students identify whether they or a friend were at risk for suicide or struggling with depression. Feedback from staff and students was overall positive. This program successfully allowed staff to identify at risk students and refer them for treatment.
New this fiscal year, and to be fully implemented next year, is the Ripple Effect Program. All counselors and administrators were trained in the spring to use this online program with students. This program is personalized, trauma informed, evidence based interventions. Ripple Effects can be used as part of any intervention.

**Method of Collection:** Sign in sheets, and data from electronic health record. MCBHRS will continue to encourage and support counselors to utilize pre and post surveys for groups, however this proved to be a challenge for schools with constant staff turnover. The school district has assured us that this will be overcome in the next reporting period. See appendixes for reporting forms for this program.

**Data Collection Period:** The school district reports at the end of each semester (twice annually)

**Expected Outcomes:** Increased access and linkage to services for school aged youth and family member

**Outcomes:**

<table>
<thead>
<tr>
<th>Evaluation Indicators</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>Reduction in prolonged suffering resulting from untreated mental illness – the number of individuals referred to mental health services.</td>
<td>57</td>
</tr>
<tr>
<td>Reduction in prolonged suffering by improved mental, emotional, and relational functioning – The number of students linked to SST, 504, IEP, SARB or other services such as foster youth/homelessness programs.</td>
<td>238</td>
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<tr>
<td>Reduction in prolonged suffering by improved mental, emotional and relational functioning – the number of students receiving crisis intervention / threat assessments</td>
<td>202</td>
</tr>
<tr>
<td>Reduction in prolonged suffering by improved mental, emotional, and relational functioning – The number of student with improved social-emotional functioning as indicated by participation in programs.</td>
<td>82</td>
</tr>
</tbody>
</table>

**Results and Analysis:**

The data above reflects a combination of data from the elementary school, the high school and the charter school.

The sheer volume of students that have been involved in this PEI program displays the continued successful efforts to build protective factor amongst Mariposa’s youth.

While the overall unduplicated amount of students served this fiscal year was on average lower than the previous years, the number of individuals that were linked to SST, 504, IEP, SARB and other services for youth has almost doubled from the previous year, speaking to the continued success of this program.
While the program is an overall success, one area of improvement that is needed, is in administering pre and post surveys for the groups offered. Next fiscal year, pre and post surveys will be one of the goals of the program.

Below is a list of groups offered within the school district:

- Girls Rock
- Friendship Group
- Boys Rule! Conflict Resolution
- Family Trauma
- Hospitalization of the Father
- Adolescent Girls Friendship Group
- Zone of Regulation Group
- School Anxiety
- Conflict Resolution
- Peer Mentor
- Healthy Relationships
- Classroom intervention on bullying
- Making Friends
- Communication
- Anger Management
- Self Esteem
- Anxiety Group
- Emotion Support Group
- Relaxation Group
- Social Skills Group
- Life Management
- Mindfulness
- Natural Helpers
- Stress Management
- Friends Rock
- Self-Control / Empathy
- Controlling emotions and impulses
- Protégés
- Life skill club
- Interpersonal relationships skills
- Intervention Group
- Peer relationships and anxiety
- School is a breeze group
- Time management
**Timely Access to Services for Underserved Populations**

**Drop in Center**

**Years Active:** 2015 – Current  

**Unduplicated Individuals Served:**

In 2015 MCBHRS contracted with the Alliance for Community Transformations, a Community Based Organization (CBO), to operate a Wellness Center partially funded through MHSA funds. Our community environment has changed along with the population served through this program. In conversation with Alliance and through feedback from our stakeholder’s process, we felt that outreach and engagement of our unserved and underserved population would be best served through shifting this program to a drop-in center. This has proven to be a good partnership as Alliance staff members are leads in our Stigma Reduction Task Force, Mariposa Minds Matter (MMM) and includes the region’s Access Ambassador. Staff are excellent at building relationships and outreach to unserved and underserved population.

**Method of Collection:** Sign in sheets and spreadsheets. See appendixes for reporting forms for this program.

**Data Collection Period:** Quarterly reports submitted on the last day of January, April, July, and October.

**Expected Outcomes:** Our expected outcome for this community based practice is improved timely access to services for underserved populations who need mental health services.

**Outcomes:**

<table>
<thead>
<tr>
<th>Evaluation Indicators</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>The number of individuals referred to treatment beyond early onset</td>
<td>56</td>
</tr>
<tr>
<td>The number of individuals that engaged</td>
<td>50</td>
</tr>
<tr>
<td>The average interval between referral and engagement</td>
<td>6.5 days</td>
</tr>
<tr>
<td>The number of homeless individuals served</td>
<td>164</td>
</tr>
</tbody>
</table>

**Results & Analysis:** This population of individuals has always been difficult for MCBHRS to engage in services. This program speaks to the success they have experienced in not only engaging this hard to reach population, but also encouraging and supporting these individual’s to seek mental health treatment. This is evident in the number of individuals that not only were referred to services, but also engaged in services after the referral.
Description of ways the program encouraged access to services and follow through on referrals: The program continues to adapt services to meet the needs of the consumers and encourages access through building relationships, offering incentives, case management, and matching need to services. The program continues to assess needs of clients through engagement and feedback, adapt or create groups to respond to the needs, provide incentives, conduct outreach and attend meetings to communicate services and encourage referrals. Staffing hours are used to encourage access as well as approaching our services from a trauma-informed perspective, and using incentives.

Challenges/Succesess/Lessons Learned and Relevant Examples: A huge challenge is overcoming barriers that are out of MCBHRS control, such as 'lack of treatment programs, affordable housing and employment opportunities'. The program’s success in these situations occur when we are able to assist individuals in identifying realistic goals and acting on what they have control over, this success can be attributed to our ability to respond to presenting needs in a timely and responsive way. The program found success in proving continued education to the community on the importance of peer work in the recovery setting. They have experienced an increase in service utilization and relate this to their accessibility, increased community awareness, and an increase in referrals from partners.
Access and Linkage to Treatment
Crisis / TRAC Team

**Years Active:** 2014 – Current  **Unduplicated Individuals Served:** 244

In 2014 we created a Crisis/Triage Team that was partially funded through the SB 82 grant. This team responds with law enforcement, to the jail, to community-based organizations, to schools and to our medical partners, not only during times of crisis, but to intervene in situations before they reach higher levels of crisis. At the end of the SB 82 grant, and with the positive feedback from stakeholders on the continued need for this program, PEI funds supplement the funding of this program, along with Medi-Cal billing.

**Method of Collection:** TRAC team members gathered data on the crisis forms and outreach forms to capture the required information. Mariposa County Behavioral Health & Recovery Services utilizes the electronic health record and the timeline to services spreadsheet to capture the referral information. See appendixes for reporting forms for this program.

**Data Collection Period:** Quarterly reports submitted on the last day of January, April, July, and October.

**Expected Outcomes:** Our expected outcome for this program is improved timely access to services for underserved populations who need mental health services.

**Outcomes:**

<table>
<thead>
<tr>
<th>Evaluation Indicators</th>
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</thead>
<tbody>
<tr>
<td>The number of individuals referred to Mental Health</td>
<td>73</td>
</tr>
<tr>
<td>The number of individuals that followed through and engaged in services</td>
<td>36</td>
</tr>
<tr>
<td>The average duration of untreated mental illness</td>
<td>N/A</td>
</tr>
<tr>
<td>Average interval between referral and engagement</td>
<td>7.36 days</td>
</tr>
</tbody>
</table>

**Results & Analysis:** During this reporting period, fiscal year 18/19, a total of 389 duplicated individuals were served. Of those 389 individuals, 226 were crisis and 163 were outreach/encounters. The total unduplicated number of individuals served was 244, there was a total of 114 unduplicated encounters, and a total of 160 unduplicated crisis services.
Of the 244 unduplicated individuals served, 73 individuals were referred to mental health services. Of the 73 individuals referred to mental health services, 36 of those engaged in services by at least attending one appointment. With 36 more people receiving services for their mental health, this indicates the overall success of the program.

During this reporting period, there was a period of time where this unit was severely understaffed and the demographic data was not captured in a way that Quality Assurance could reliably extract the data from the electronic health record. The demographic data on the last page reflects all PEI programs but the Crisis/TRAC team.

Although it is clear that the program is positively impacting those at risk of severe mental illness and additional analysis may be needed on the number of individuals that were interacted with and not referred.
Outreach for Increasing Recognition of Early Signs
Mental Health First Aid

**Years Active:** 2014 – Current  **Unduplicated Individuals Served:** 44

In 2014 we added the strategy of Mental Health First Aid (MHFA) as it has been shown to be a needed and an appreciated service to staff and community partners. Stakeholders indicated support for continuing the program. Also, stakeholders of the local homeless shelter suggest additional training such as MHFA would be beneficial.

We have continued Mental Health First Aid (MHFA) as it is an effective evidence-based program for Outreach for Increasing Recognition of Early Signs of Mental Illness. The Program engages and trains first responders to recognize and respond effectively to early signs of mental illness.

**Method of Collection:** Post surveys and sign in sheet. See appendixes for reporting forms for this program.

**Data Collection Period:** Reported at the end of each Mental Health First Aid Training (Around 6 Annually)

**Types of potential responders engaged:** Health and Human Services Staff, Community Based Partners, School Staff, Behavioral Health Board members, Hospital Staff, Sheriff’s Department Staff.

**Expected Outcomes:** Our expected outcome for this program is to provide outreach for increasing recognition of early signs of mental illness and well as promoting timely access to services.

**Outcomes:**

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<th>Evaluation Indicators</th>
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<tbody>
<tr>
<td>The number of participants that agree or strongly agree that as a result of the training they feel more confident that they can:</td>
<td>44 Total Responders</td>
</tr>
<tr>
<td>Recognize the signs that someone may be dealing with a mental health problem</td>
<td>43</td>
</tr>
<tr>
<td>Assist a person who may be dealing with a mental health crisis seek professional help</td>
<td>43</td>
</tr>
</tbody>
</table>

**Results & Analysis:** MCBHRS hosted 6 mental health first aid trainings in the 2018/2019 fiscal year, three Youth MHFA and three Adult MHFA. Each training informs responders on how to access and link individuals to treatment. Trained responders may interface with unserved or underserved populations and are trained in assisting an individual in seeking treatment. It is expected that this will promote timely access to services.
As evident by the post surveys after each training, all but one participants felt that they were more informed on how to recognize the signs of mental illness. All but one participant out of the 44 that attended the trainings over the 2018/2019 fiscal year, felt that they could assist a person who is dealing with mental health issues or seek help. This indicates the success of the MHFA program in increasing recognition of early signs and symptoms of mental health.
In 2016 MCBHRS began the Stigma Reduction Committee (SRC) as a Behavioral Health Board (BHB) task force. The committee was made up of consumers, community-based partners, BHB members and staff. The first project was a Mariposa Minds Matter event with a speaker from NAMI with about 50 participants and Mental Health Wellness event at the local farmers market with about 75 participants. Stemming from the Mariposa Minds Matter event were a Friends and Family peer-led group provided at the Alliance drop-in/wellness center. Also, there was interest in the development of a lived experience speaker’s bureau.

Interest in creating a speakers bureau has been tabled in 2018 as the task force has concentrated in other areas. Activities determined by the committee members are designed to reduce stigma in our unique rural community. Even though this program consists mainly of one touch encounters, the goal is to provide access and linkage and timely access to services as appropriate for individuals attending events.

The members of SRC have renamed themselves the Mariposa County Minds Matter Task Force.

The goal of this task force is to raise awareness and educate the public on mental illness, substance use myths and facts. Objectives that assist this task force in meeting this goal are as follows:

- Educate community on Myths and Facts about mental illness
- Allow self-exploration through the use of an online screening tool and wellness guides
- Engage children and families in conversation about mental illness and mental wellness
- Provide resources and materials
- Provide interactive activities to community to experience self-care through sound baths and aroma therapy

From July 1st, 2018 to June 30th, 2019 Mariposa County Minds Matter attended 2 events. The first event was the Mariposa County Fair, where the task force shared a booth with Mariposa County Human Services. Volunteer staff reported approximately 120 adults and children were engaged in conversations about stigma, discrimination and how to use language to change thinking. About 320 promotional items were handed out to visitors.

The second event the task force attended was the Mariposa Butterfly Festival in May 2019, they were able to engage 465 adults and children in conversations about stigma, discrimination, and how to use language to change thinking. Estimated that over 500 individuals came by and received information on mental health.
**Method of Collection:** The Program mainly consists of one touch encounters. However, some pre/post surveys were administered at some of the large events. See appendixes for reporting forms for this program.

**Data Collection Period:** Data is reported at the end of each event.

**Expected Outcomes:** The outcomes for attendees of the speakers bureau and other activities is a reduction in negative feelings, attitudes, beliefs, perceptions, stereotypes, and discrimination related to being diagnosed with mental illness. The program is also expected to increase acceptance, dignity, and inclusion for individuals with mental illness and their families. It is also expected to encourage self-acceptance for members of the committee.

**Outcomes:**

<table>
<thead>
<tr>
<th>Evaluation Indicators:</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in attitudes</td>
<td>Both events in 2018/2019 were one-touch events with about 585 individuals that engaged in conversations regarding mental illness and mental wellness.</td>
</tr>
<tr>
<td>Changes in perception</td>
<td></td>
</tr>
<tr>
<td>Changes in acceptance</td>
<td></td>
</tr>
</tbody>
</table>

**Results & Analysis:** The County’s Stigma and Discrimination Reduction Program has grown and transformed from a county staff led program to a community task force. The community led task force showed great enthusiasm in striving to change attitudes, perception and acceptance and overall reduction of discrimination/stigma of those with mental illness. The task force excelled, taking on events that reached out to the community. The staff supported these efforts during Mental Health Awareness Month with social media blasts and green ribbon events. Together changes were accomplished as seen in the event attendance and lime green ribbons seen throughout the county indicating a community awareness.

**Success and Challenges:** The task force has found great success in the wheel of emotion, being a great way to engage youth in conversations, while the myth or fact quiz, was a great way of engaging adults in conversations about mental illness. The sounds bath continues to remain a major success in demonstrating some self-care.

This task force faces some challenges with member retention. While the overall program has been successful, retaining members has been difficult as this is a volunteer program that often demands a lot of work.
MCBHRS began working with the Central Valley Crisis Suicide Prevention Hotline in 2015.

The Central Valley Crisis and Suicide Prevention Hotline, CVSPH, took their first call on January 17, 2013. The Hotline operated on a limited basis five days a week for twelve hours each day. In July 2013, CVSPH expanded operation to 24 hours per day, seven days per week, and 365 days per year. In January 2014, CVSPH received National Accreditation being recognized as a best practices call center by the American Association of Suicidology. The Hotline is also a member of National Suicide Prevention Lifeline which provides interpreters for 150 different languages.

CVSPH serves California’s Central Valley, a culturally diverse group of seven counties: Fresno, Tulare, Kings, Madera, Mariposa, Merced and Stanislaus. The Hotline is operated by staff utilizing volunteers to minimize cost and maximize efficiency.

The Hotline assists individuals who are looking for resources and education regarding a loved one or friend, provides support for those in crisis and keeps people safe who have suicidal ideation or that are in the process of killing themselves.

**Method of Collection:** Tracking of the number of those that call the hotline. The hotline also provides the reason for the calls, demographic information and an evaluation of how many crisis calls were received, cost associated with those calls, and the cost savings of each call.

**Data Collection Period:** Quarterly reports submitted on the last day of January, April, July, and October.

**Expected Outcomes:** The expected outcome of this evidence-based practice is to reduce suicide by the accessibility of a local hotline providing timely access to services and access to linkage to treatment.

**Outcomes:**

<table>
<thead>
<tr>
<th>Evaluation Indicators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of Individuals that called</td>
<td>48 Calls</td>
</tr>
</tbody>
</table>

**Results & Analysis:**

Central Valley Suicide Hotline provides a valuable resource to those in need. CVSPH uses the Columbia Suicide Severity Rating Scale which has been adopted for the National Suicide Prevention Lifeline, to assess risk of callers, this is an evidence-based tool all members use in their assessment of callers.
Of the 48 calls to the crisis line, 37 of those were screened for suicidal ideation, intent and severity. 18 callers showed significant risk at the beginning of the call. 28 were offered additional resources, including instructions on self-coping skills such as breathing and mindfulness. Success was achieved by linking clients to timely access to services, by referring them to additional websites, warm lines, and direction to County Behavioral Health.

As our county has been consumed by fires and floods over the last fiscal year, this hotline as provided a significant wealth of support and information to residents.
### Aggregate Demographic Information for all PEI Components:

#### Age Totals

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<thead>
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<td>16 – 25</td>
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<tr>
<td>60+</td>
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#### Gender Totals

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<tr>
<td>Female</td>
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<td>Queer</td>
<td>Suppressed</td>
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<td>Black or African American</td>
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<td>More than one race</td>
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#### Ethnicity Totals

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<td>Asian Indian / South Asian</td>
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<tr>
<td>Cambodian</td>
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#### Veteran Status Totals

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#### Language Totals

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#### Disability Totals

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<table>
<thead>
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<table>
<thead>
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<table>
<thead>
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<th>Mental illness</th>
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<tbody>
<tr>
<td></td>
<td>50</td>
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</table>

<table>
<thead>
<tr>
<th>Physical/ Mobility Issues</th>
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</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Chronic Health Condition</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35</td>
</tr>
</tbody>
</table>
- It should be noted that the PEI demographic data reflected in this fiscal year report excludes demographic data for the TRAC/Crisis team. Due to a large number of staff turnover and inconsistent staffing, demographic data was not captured in a way that could be reliably extracted from our electronic health record.

- Mental Health First Aid only collect age, gender, and race.

- The schools only collect age and race.
Behavioral Health Board Minutes

BEHAVIORAL HEALTH BOARD
of Mariposa County
Post Office Box 99
Mariposa, California 95338
(209) 966-2000

MINUTES
June 16, 2020
1:00 to 2:00 pm
Mariposa County Board of Supervisors Chambers
5100 Bullion Street, Mariposa, CA 95338

Meeting was also conducted telephonically pursuant to the Governor’s Executive Order N-29-20,
which relaxed certain Brown Act provisions.

SPECIAL MEETING
Public Hearing to receive input, consider, and approve submission of the Mariposa County Mental
Health Services Act Three-Year Expenditure Plan 2020-2023 to the Department of Health Care
Services (DHCS)

Members Present: Paul Brickett, Olga Leonard, Rosemarie Smallcombe, Debbie Cook,
Ron Schmitz, Donald Mculley

Members Excused: Ellie McQuarrie

Members Absent: None

Guests: Pam Hawkins

Quorum: Yes

Staff Present: Chevon Kothari, Sheila Baker, Lynn Rumfelt, Laura Glenn

I. Meeting was called to order at 1:00 p.m. by Paul Brickett, Chair

II. Introductions: Roll call was performed

III. Purpose of Special Meeting: Chevon Kothari stated the purpose of the special meeting
today was to conduct a public hearing for presentation of the proposed MHSA 2020-2023 Plan
by Mariposa County Behavioral Health and Recovery Services (BHRs) to the public, and
adoption of the plan by the BHB to submit to the Board of Supervisors for their approval.

IV. Public Hearing Opened: Paul Brickett opened the Public Hearing

V. Presentation: Laura Glenn gave a presentation for the proposed MHSA Plan 2020-2023

VI. Feedback Session: Questions regarding the MHSA Plan were answered

VII. Adoption: The MHSA Plan 2020-2023 will be presented to the Board of Supervisors for their
approval today by Laura Glenn and Chevon Kothari
RESOLUTION - ACTION REQUESTED

MEETING: June 16, 2020

TO: The Board of Supervisors

FROM: Chevon Kothari, Health and Human Services Director

RE: Approval of MHSA 3-Year Plan for FY2021-2023

RECOMMENDATION AND JUSTIFICATION:
Approve Submission of the "Mariposa FY2021-2023 Mental Health Services Act (MHSA) 3-Year Plan" to the Department of Health Care Services (DHCS); Authorize the Human Services Director to Sign the Certifications and Any Subsequent Amendments with DHCS with Regard to the MHSA Plan (Subject to Review and Approval of County Counsel as to Legal Form); and Authorize the Human Services Director to Implement the Activities Within the "Mariposa FY2021-2023 Mental Health Services Act (MHSA) 3-Year Plan" Upon DHCS Approval.

This proposed plan is the result of a six month planning process that included facilitating 20 stakeholder meetings throughout the county in an attempt to gather input and support from stakeholders where they felt most comfortable. Each presentation included information/training about the mental health services act and the Community Program Planning Process. In addition, surveys were provided and collected at each convening. The lengthy planning process is described in detail on pages 14-22 of the attached Draft Plan, the MHSA Survey Results are also attached.

Human Services requests Board approval of the three-year Mental Health Services Act (MHSA) Plan for Mariposa County for FY2020-21 through FY2022-23. Mariposa County received its first MHSA funds in 2005 and began developing the Adult and Children's Systems of Care Program. We have continued to cultivate and refine these programs implementing the Recovery Model. Our goal is to support our clients in achieving wellness in as many life domains as possible. We propose to continue these proven programs.

Note: The Certification forms are found on pages 7 and 8 of the attached Plan document. A copy of the Notice of Public Hearing is on page 16.

BACKGROUND AND HISTORY OF BOARD ACTIONS:
The Board approved the previous 17/20 MHSA Plan Update on June 20, 2017 by Resolution 2017-406.

The Board approved the previous 14/17 MHSA Plan Update on April 22, 2014 by Resolution 2014-169.

ALTERNATIVES AND CONSEQUENCES OF NEGATIVE ACTION:
The MHSA Three-Year Plan with stakeholder and Board approval of the MHSA plan are required in order to receive MHSA funding. If this plan is not approved by the Board, Mariposa County Behavioral Health will lose a primary revenue source. This would result in the discontinuance of successful MHSA programs.
MENTAL HEALTH SERVICES ACT (MHSA) INFORMATION

NOTICE OF PUBLIC HEARING
NOTICE IS HEREBY GIVEN that the County of Mariposa will conduct a Public Hearing at the meeting of the Mariposa County Behavioral Health Board on June 18th, 2020 at 7:00 pm or as soon thereafter as the same can be heard. The Mariposa County Mental Health Services Act (MHSA) Three-Year Plan (2020-2023) will be reviewed during this meeting (see info below). The meeting will be held virtually, please review the full Notice of Public Hearing for more information.

REVIEW DRAFT MHSA THREE-YEAR PLAN
Please review the Draft MHSA Plan on the proposed mental health programs for the next three years. Please feel free to reach out to Laura Ellen at lellen@mariposacounty.org or at 209-742-2933 to provide any feedback on the proposed programs before June 18th.

MENTAL HEALTH SERVICES 2019-2020 ANNUAL PLAN UPDATE
2019-2020 Mental Health Services Act FY 2019-2020 Annual Plan Update

MENTAL HEALTH SERVICES ACT PLAN FOR FY 2017 TO 2020
Click on the links below to view the components of the FY 2017 to 2020 MHSA Plan:

Mariposa Mental Health Services Act Plan 2017 to 2020 (PDF)

MHSA Survey Results and Demonstration (PDF)

Public Hearing Notice MHSA FY 2017-20 Plan Update (PDF)

Mariposa FY 2017-18 through FY 2019-20 Three Year MHSA Expenditure Plan (PDF)

Mariposa FY 2018 to 2020 Mental Health Services Act Annual Plan Update (PDF)
Appendix

Appendix A: Stakeholder Survey (4 pages)
Appendix B: Stakeholder PPT (1 page)
Appendix C: Workforce, Education, and Training Assessment (9 pages)
Appendix A: Stakeholder Survey (Page 1 of 4)

Mariposa County Behavioral Health and Recovery Services – Mental Health Services Act (MHSA) Stakeholder Survey

What is the Mental Health Services Act (MHSA)?
- Proposition 63 was passed in November 2004, this act imposes a 1% tax on personal income in excess of $1 million.
- MHSA’s goal is to reduce the long-term impact on individuals and families resulting from untreated serious mental illness.
- MHSA provides funding to support county mental health programs for families, children, and transition age youth, adults and older adults.

What is a Stakeholder?
- A stakeholder is an individual or entity with an interest in mental health services.
  The stakeholder process includes education, input and feedback. We value your input, as we look forward to our three year MHSA Plan.
- Please review the current programs and give us your input.

What is Mariposa County doing with MHSA?
- Adult System of Care
- Wellness Center & Peer Supports
- Children System of Care
- School Based Counseling
- Drop in Center at Heritage House
- Mental Health First Aid Training
- Stigma Reduction Task Force
- Crisis/Triage Team
- Suicide Prevention Hotline
- Yosemite National Park Counselor

Please Tell Us About Yourself

Which of the following best describes you:

☐ Consumer
☐ Consumer family member
☐ Educator / Teacher
☐ Advocate
☐ Medical Provider
☐ Law enforcement
☐ Student

☐ Veteran
☐ Homeless
☐ Other
☐ Decline to answer
☐ Community based organization
☐ Faith based organization
## Appendix A: Stakeholder Survey (Page 2 of 4)

### Health & Human Services Agency

### Age
- 0 – 15
- 16 – 25
- 26 – 59
- 60+
- Decline

### Language
- English
- Spanish
- Other
- Decline

### Veteran
- Yes
- No
- Decline

### Disability
- Difficulty Seeing
- Difficulty Hearing
- Other
- Mental illness
- Physical/ Mobility Issues
- Chronic Health Condition

### Sexual Orientation
- Gay or Lesbian
- Hetero or Straight
- Bisexual
- Questioning or Unsure
- Queer
- Another Sexual Orient.
- Decline

### Race
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other
- More than one race
- Decline to answer

### Ethnicity

<table>
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<tr>
<th>Hispanic or Latino:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caribbean</td>
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<td>Central American</td>
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<td>Puerto Rican</td>
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<td>South American</td>
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<tr>
<td>Other Hispanic or Latino</td>
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<table>
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<tr>
<th>Non-Hispanic or Latino:</th>
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<tr>
<td>African</td>
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</tr>
<tr>
<td>Vietnamese</td>
</tr>
<tr>
<td>Other Non-Hispanic or Latino</td>
</tr>
<tr>
<td>Decline</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>More than One Ethnicity</td>
</tr>
</tbody>
</table>

### Gender
- Assigned at Birth
  - Male
  - Female
  - Decline

- Current Gender Identity
  - Male
  - Female
  - Transgender
  - Queer
  - Questioning or Unsure
  - Another Gender Identity
  - Decline
Appendix A: Stakeholder Survey (Page 3 of 4)

1. Which behavioral health services have you found are helpful to our community? (Mark all that apply)
   - Wellness Center & Peer Supports
   - School Based Counseling
   - Drop in Center at Heritage House
   - Mental Health First Aid Training
   - Crisis/TRAC Team
   - Mariposa Minds Matter Taskforce
   - Suicide Prevention Hotline
   - Yosemite National Park Counselor

2. What age groups do you feel are underserved in our community when it comes to mental health services? (Mark all that apply)
   - 0 – 15 years old
   - 16 – 25 years old
   - 26 – 59 years old
   - 60 +

3. What are some obstacles or barriers that make it challenging to receive mental health services in our community? (Mark all that apply)
   - Transportation
   - Stigma
   - Lack of resources
   - Lack of awareness
   - Lack of parental or family support
   - Lack of insurance/money
   - Lack of communication between agencies

4. What types of mental health related activities, programs or services are most needed in your community or culture? (Mark all that apply)
   - Consumer wellness and recovery
   - Increased access to mental health treatment for underserved populations
   - Reducing incarceration of mentally ill adults
   - More information on mental health services and increasing awareness
   - More services and supports for foster parents
   - More mental health treatment in schools
   - More culturally aware treatment
   - More appropriate levels of care
5. PEI - Rank the following (1 being the least important and 6 being the most important)?
   ______ Peer support
   ______ Obtaining education about mental health
   ______ Suicide prevention
   ______ Reducing stigma and discrimination related to mental health
   ______ Outreach for recognition of early signs of mental illness
   ______ Preventative services

6. INN – How do you rate the following:
   a. Individuals released from jail need increased access to Mental Health Services.
      □ Very needed □ Neutral □ Not needed
      □ Somewhat needed □ Not needed
   b. Increasing access to mental health services for underserved populations
      □ Very needed □ Neutral □ Not needed
      □ Somewhat needed □ Not needed
   c. Promote inter-agency collaboration - in terms of mental health services
      □ Very Needed □ Neutral □ Not needed
      □ Somewhat needed □ Not needed
   d. Increase the quality of mental health services, including measurable outcomes
      □ Very needed □ Neutral □ Not needed
      □ Somewhat needed □ Not needed
   e. More integrated mental health and physical healthcare services
      □ Very needed □ Neutral □ Not needed
      □ Somewhat needed □ Not needed

7. Please provide feedback on any gaps in mental health services in our community.
Appendix B: Stakeholder PPT

Mental Health Services Act (MHSA)

MHSA OVERVIEW
- Prop. 63 was passed by California voters in November 2004 – known as the Mental Health Services Act (MHSA)
- Impose a 1% tax on personal income in excess of one million dollars.
- MHSA provides funding to support county mental health programs for families, children, transitional aged, youth, adults, and other adults.
- MHSA goal is to reduce the long-term impact on individuals and families resulting from untreated serious mental illness.

MHSA REQUIREMENTS
- What is a stakeholder?
  - An individual or entity with an interest in mental health services
- MHSA programs must include stakeholder involvement at every stage of the process
  - Developing
  - Implementing
  - Evaluating
- The stakeholder process must include education, input, and feedback

STAKEHOLDER PROCESS

COMMUNITY PLANNING PROCESS

SURVEY FEEDBACK

As we plan for the next three years – we need your feedback on the current programs, and identify where we can improve the communities overall mental wellness.

MARIPOSA CURRENT MHSA STRATEGIES
- Adult System of Care
- Children System of Care
- Wellness Center
- Peer Support Services
- School Based Counselors
- Mariposa Heritage House Drop-in Center
- Mental Health First Aid
- Stigma Reduction Task Force
- Crisis Team
- Suicide Prevention Hotline
- Yosemite National Park Counselor
Mariposa County Workforce, Education, and Training Assessment 2020
Appendix C: WET Assessment (Page 2 of 9)

EXHIBIT 1: WORKFORCE FACE SHEET

Mariposa County Mental Health Services Act (MHSA) Workforce Education and Training Component – Workforce Assessment

**County:** Mariposa

**Date:** February 28th, 2020

This County’s Workforce, Education and Training component of the Three Year Program and Expenditure Plan will address, when fully implemented, the shortage of qualified individuals who provide services in this County’s Public Mental Health System. This includes community based organizations and individuals in solo or small group practices who provide publicly funded mental health services to the degree they comprise this County’s Public Mental Health System workforce.

Mariposa County’s Workforce Education and Training (WET) Plan will be consistent with and supportive of the vision, values, mission, goals, objectives and proposed actions of California’s MHSA Workforce Education and Training Five-Year Strategic Plan (Five-Year Plan).

Funds do not supplant existing workforce development and/or education and training activities. Funding will also be used to modify and/or expand existing programs and services to fully meet the fundamental principles contained in the Act.

All proposed programs and activities contribute to developing and maintaining a culturally competent workforce, to include individuals with client and family member experience who are capable of providing client and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes.

The WET Plan will be developed with stakeholders and public participation. Progress and outcomes of education and training programs will be reported and shared on an annual basis with stakeholders.

**County Mental Health Director**

**Printed Name:** Chevon Kothari

**Signature:** ________________________________

**Phone:** 209-966-2000

**Email:** okothari@mariposahsc.org

**Address:** PO Box 99, Mariposa, CA 95338

Contact Person: Laura Glenn   ----   Phone: 209-742-0823   ----   Email: lglenn@mariposahsc.org
All of Mariposa County’s MHSA planning processes are designed to facilitate a meaningful participation from stakeholders, including underserved and un-served populations. Below represents the planning structure created for MHSA three-year plans and annual updates. The 2020 WET assessment is incorporated with the three-year planning process for the 2020-2023 MHSA three-year plan. The draft plan will be posted for 30 – day public review beginning on 05/08/2020. Hard copies of the plan will be made available to the public at various locations throughout the community.

After a 30 day public review, a Public Hearing will be held on 06/09/2020 by the Behavioral Health Board. A notification of a Public Hearing will be incorporated in the draft MHSA plan, as well as being posted in the local newspaper and on the County website.

The final draft MHSA plan will be presented to the Board of Supervisors on June 9th, 2020. The WET assessment will reviewed and used to develop a workforce-training plan to address our workforce needs.
### EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

#### I. Workforce Needs Assessment by Occupational Category:

<table>
<thead>
<tr>
<th>Est. # FTE</th>
<th>Pos. Hard to fill?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 = Yes 2 = No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Addt # of FTE required to meet the need</th>
<th>White/ Cau</th>
<th>Hispanic/ Latino</th>
<th>African American/ Black</th>
<th>Asian/ Pacific Islander</th>
<th>Native American</th>
<th>Multi Race / Other</th>
<th>Total Ethnicities by Category</th>
</tr>
</thead>
</table>

#### A. Licensed Mental Health Staff who provide direct services to clients

<table>
<thead>
<tr>
<th>County Employees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>License Clinical Social Worker (LCSW)</td>
<td>1</td>
</tr>
<tr>
<td>Licensed Marriage and Family (LMFT)</td>
<td>1</td>
</tr>
<tr>
<td>Licensed Professional Counselor (LPCC)</td>
<td>0</td>
</tr>
<tr>
<td>Associate Marriage and Family Therapist</td>
<td>5.8</td>
</tr>
<tr>
<td>Associate Clinical Social Worker</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>0.25</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>0.25</td>
</tr>
</tbody>
</table>

**Subtotals:** 9.3 2 3 7.05 .25 |

**Total A (Licensed Staff):** 18.3

**Missing one staff member**

<table>
<thead>
<tr>
<th>Contract Providers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Clinical Social Worker (LCSW)</td>
<td>1</td>
</tr>
<tr>
<td>Licensed Marriage and Family (LMFT)</td>
<td>0</td>
</tr>
<tr>
<td>Licensed Professional Counselor (LPCC)</td>
<td>2</td>
</tr>
<tr>
<td>Associate Marriage and Family Therapist</td>
<td>3</td>
</tr>
<tr>
<td>Associate Clinical Social Worker</td>
<td>2</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1</td>
</tr>
</tbody>
</table>

**Subtotals:** 9 5 1 |

**Total A (Licensed Staff):** 14.3

**Missing three staff members – Two clinicians and one psychiatrist.**
### B. Unlicensed Mental Health Staff who provide direct services to clients

<table>
<thead>
<tr>
<th>County Employees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager (MHA I/II/III)</td>
<td>10</td>
</tr>
<tr>
<td>Peer Support – Client Recovery (MH Aid)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Subtotals</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contract Providers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager (MHA I/II/III)</td>
<td>2</td>
</tr>
<tr>
<td>Rehabilitation Specialist</td>
<td>2</td>
</tr>
<tr>
<td>After Hours- Crisis Worker</td>
<td>3</td>
</tr>
<tr>
<td><strong>Subtotals</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

| Total B (Unlicensed Staff) | **18** |

### C. Other health care providers that provide direct services to clients

<table>
<thead>
<tr>
<th>County Employees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Vocational Nurse</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td><strong>Subtotals</strong></td>
<td><strong>1.5</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contract Providers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Vocational Nurse</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td><strong>Subtotals</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

| Total C (Other direct services staff) | **1.5** |

### D. Managerial and Supervisory

<table>
<thead>
<tr>
<th>County Employees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO or manager above direct Supervisor</td>
<td>2</td>
</tr>
<tr>
<td>Licensed Supervising Clinician</td>
<td>5</td>
</tr>
<tr>
<td>Other Managers and Supervisors</td>
<td>3</td>
</tr>
<tr>
<td><strong>Subtotals</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

| **Total D (Managerial and Supervisory)** | **9** |
### Appendix C: WET Assessment (Page 6 of 9)

#### Contract Providers

<table>
<thead>
<tr>
<th>Role</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO or manager above direct Supervisor</td>
<td>2</td>
</tr>
<tr>
<td>Licensed Supervising Clinician</td>
<td>1</td>
</tr>
<tr>
<td>Other Managers and Supervisors</td>
<td>0</td>
</tr>
</tbody>
</table>

**Subtotals**

<table>
<thead>
<tr>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

**Total D (Managerial & Supervisors)**: 13

#### E. Support Staff (non-direct service)

##### County Employees

<table>
<thead>
<tr>
<th>Role</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyst, tech support, quality assurance</td>
<td>4.5</td>
</tr>
<tr>
<td>Clerical, secretary, administrative assistants</td>
<td>6.5</td>
</tr>
<tr>
<td>Other support staff</td>
<td>0</td>
</tr>
</tbody>
</table>

**Subtotals**

<table>
<thead>
<tr>
<th>FTE</th>
<th>Addtl # of FTE required to meet the need</th>
<th>White/Cauc</th>
<th>Hispanic/ Latino</th>
<th>African American/ Black</th>
<th>Asian/ Pacific Islander</th>
<th>Native American</th>
<th>Multi Race / Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td></td>
<td>8.5</td>
<td>1.5</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

##### Contract Providers

<table>
<thead>
<tr>
<th>Role</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyst, tech support, quality assurance</td>
<td>1</td>
</tr>
<tr>
<td>Clerical, secretary, administrative assistants</td>
<td>1</td>
</tr>
<tr>
<td>Other support staff</td>
<td></td>
</tr>
</tbody>
</table>

**Subtotals**

<table>
<thead>
<tr>
<th>FTE</th>
<th>Addtl # of FTE required to meet the need</th>
<th>White/Cauc</th>
<th>Hispanic/ Latino</th>
<th>African American/ Black</th>
<th>Asian/ Pacific Islander</th>
<th>Native American</th>
<th>Multi Race / Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**Total E (Support Staff)**: 12

#### Total FTE

<table>
<thead>
<tr>
<th>Role</th>
<th>Est. # FTE</th>
<th>Pos. Hard to fill?</th>
<th>Addtl # of FTE required to meet the need</th>
<th>White/Cauc</th>
<th>Hispanic/ Latino</th>
<th>African American/ Black</th>
<th>Asian/ Pacific Islander</th>
<th>Native American</th>
<th>Multi Race / Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Employees</td>
<td>42.8</td>
<td>5</td>
<td>6</td>
<td>28.55</td>
<td>6.75</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Contract Providers</td>
<td>20</td>
<td></td>
<td>0</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total Workforce</strong></td>
<td><strong>62.8</strong></td>
<td></td>
<td><strong>6</strong></td>
<td><strong>39.55</strong></td>
<td><strong>7.75</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
<td><strong>0</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

*18% of the workforce did not respond to the information requested.*
II. **Total Public Mental Health Population Served**

<table>
<thead>
<tr>
<th>White / Caucasian</th>
<th>Hispanic / Latino</th>
<th>African-American / Black</th>
<th>Asian / Pacific Islander</th>
<th>Native American</th>
<th>Multi Race / Other (Includes unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70%</td>
<td>11%</td>
<td>2%</td>
<td>&gt;1%</td>
<td>4%</td>
<td>12%</td>
</tr>
</tbody>
</table>

III. **Shortages by Occupational Category**

There are three categories with staffing shortages:

I. Licensed clinical staff, nurse practitioners, and psychiatrists.

Barriers Identified:

II. One major barrier is that housing remains an issues in Mariposa County. The county of Mariposa is a small rural county which typically draws retirees as there is minimal industry and wages are not competitive with larger surrounding counties.

How are we addressing these needs:

III. Mariposa County has done several things to try and combat the barriers listed above, recently increased the pay for the nurse practitioner, and the psychiatrists, also began contracting with a psychiatrist who provides tele-health to reduce the need for housing in our already strapped housing market in Mariposa County. Mariposa County Behavioral Health and Recovery Services (MCBHRS) also began the process of applying for a loan repayment program to benefit licensed clinical staff in partaking in the loan forgiveness program. MCBHRS supervisors also attended the Addressing the Art and Science of Psychotherapy 2019, a CAMFT Training held a booth at a school in San Francisco to try and recruit more licensed staff.
Appendix C: WET Assessment (Page 8 of 9)

IV. Comparability of workforce, by ethnicity, to target population receiving public mental health services:

<table>
<thead>
<tr>
<th></th>
<th>White / Caucasian</th>
<th>Hispanic / Latino</th>
<th>African-American / Black</th>
<th>Asian / Pacific Islander</th>
<th>Native American</th>
<th>Multi Race / Other (Includes unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Served</td>
<td>70%</td>
<td>11%</td>
<td>2%</td>
<td>&gt;1%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>MCBHRS Workforce</td>
<td>62%</td>
<td>12.3%</td>
<td>1.6%</td>
<td>1.6%</td>
<td>0%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Several ethnic groups are appropriately represented by the current workforce, however, it appears more work needs to be done to recruit staff that identify as Native American, with zero percent staffing represented. Mariposa County Behavioral Health Services does contract with the American Indian Council to provide mental health services to the Native American population, as a note, those contract providers were not included in workforce data listed above. More work needs to be done to determine what other races or ethnicities are being served that fall into the Multi/Race or Other category.

V. Language proficiency:

<table>
<thead>
<tr>
<th>Language, other than English</th>
<th>Number who are proficient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Staff</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td></td>
</tr>
<tr>
<td>French</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Staff</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td></td>
</tr>
</tbody>
</table>

Although there is not a large number of staff members proficient in other languages, the majority of consumers are proficient in English, with only the occasional need for Spanish and ASL interpreter. MCBHRS offsets this need by contracting with a certified ASL interpreter and a tele-interpreter language line. Staff are trained annually on the usage of the language line to ensure when the need arises staff have access to multiple languages. One area that warrants further exploration is whether non-English speaking communities are not seeking out the services they need because of perceived language barriers. Further exploration may be necessary to determine if the need is great enough to offer an incentive for future direct service hires with ASL or Spanish language proficiency, or training for current employees in these languages.
IV. Positions designated for individuals with consumer experience:

Currently there are two positions designed for individuals with consumer experience. The Wellness Center has a Mental Health Aide, Peer Support position. Mariposa County also has a position for a Peer System Navigator. This position has not formally been filled, historically staff have entered this position, and then moved on to promotional opportunities before this program has had the opportunity to be fully developed. These positions provide an opportunity for consumers and family members to enter the mental health profession, and potentially be promoted through the Mental Health Assistant (I – III) career ladder.

V. Other, Miscellaneous:

It is notable that Mariposa County’s 65+ age group makes up 27% of the population, and yet the penetration rate for this group is 6%. 48% of stakeholders identified the 60+ age range as an underserved population in the community. This could be indicative of the county’s lack of Medicare providers. The older adult age group remains an underserved population for MCBHRS.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-15 Years</th>
<th>6-11 Years</th>
<th>12-17 Years</th>
<th>18-20 Years</th>
<th>21-24 Years</th>
<th>25-34 Years</th>
<th>35-44 Years</th>
<th>45-54 Years</th>
<th>55-64 Years</th>
<th>65+ Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Served</td>
<td>5%</td>
<td>14%</td>
<td>30%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>14%</td>
<td>15%</td>
<td>12%</td>
<td>6%</td>
</tr>
</tbody>
</table>
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