

# **CONSIDERATIONS FOR THE DEVELOPMENT OF A SYSTEM TO DISTRIBUTE TAX REVENUES EARMARKED FOR BEHAVIORAL HEALTH IN BERNALILLO COUNTY**

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## Executive Summary and Background

The Robert Wood Johnson Foundation Center for Health Policy at the University of New Mexico (UNM), on behalf of Bernalillo County, has conducted this study in an effort to better understand: 1) the ways governmental entities (counties and states) have developed dedicated revenue streams for behavioral health services provided and/or funded by these entities, and 2) how these entities administer the distribution of these funds and provide accountability for their use. This research is intended to inform Bernalillo County as it designs a system to administer and distribute the revenue generated from the 1/8 of a cent addition to the gross receipts tax collected in the County.

This report relies on information gathered from 14 counties, in 5 states, that have implemented a tax, the proceeds from which are earmarked for behavioral health services. As such, an examination of the ways in which these counties have developed systems to receive and distribute these revenues and plan and identify priorities for the use of these funds can inform Bernalillo County as it develops such a system. Specifically, this report examines how the behavioral health boards<sup>1</sup> in these counties are structured and operate, how these boards conduct needs assessments or engage in other planning processes to determine behavioral health priorities, and the infrastructure required to support the activities of these boards.

High-level findings from this study are presented here. These findings indicate that Bernalillo County may want to consider:

- the County's population when determining the size of its behavioral health board and consider creating a behavioral health board with between 12 and 17 members, understanding that there is precedent for creating behavioral health boards with fewer members
- whether the County's behavioral health board has an even or odd number of members based on County-specific criteria and not on precedent created in the counties examined in this study
- staggering the terms of initial appointees to its behavioral health board and making appointments for terms of either 3 years or 4 years
- diversifying the types of board members the County would like to have on its behavioral health board and identify possible requirements and/or specific affiliations for board members
- including representation from consumers, family members and/or advocates, and determine the number, or percentage, of board members from these groups on its behavioral health board
- including county officials and/or representatives from county-affiliates on its behavioral health board.

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<sup>1</sup> The boards that oversee the distribution of, and accountability for tax revenues that are earmarked for behavioral health are referred to differently by the different governmental entities that establish them. Throughout this report, when referring to these boards generically, we refer to them as "behavioral health boards."

- giving the authority to appoint behavioral health board members to the Bernalillo County Commission exclusively, in which case the County will also need to determine what, if any, additional authority should be granted to the Chairperson of the County Commission
- how best to conduct needs assessments and whether needs assessments and other planning processes will be conducted by the County and/or by an outside entity(ies)
- gathering primary data for planning purposes using one or more of the following methods – surveys, focus groups, public forums, stakeholder planning sessions, telephone interviews, and/or presentations to the board
- using contracted teams for short periods of time and/or a Behavioral Health Strategic Planning Team to assist Bernalillo County’s behavioral health board undertake specific, discreet planning activities
- convening a large community forum(s) to identify behavioral health priorities in the County prior to distributing any revenues
- employing a rigorous program evaluation process that can determine which funded programs are effective and should be considered for additional funding, and to inform the County more generally about the types of programs that positively impact behavioral health in the County and should be replicated or expanded
- seeking grant funding to support data collection and analysis and needs assessment or other planning processes
- which secondary data sources the County’s behavioral health board should have access to and review to inform board priorities
- using the Youth Risk and Resiliency Survey (and other regular administered surveys) to identify priorities and to measure progress
- the periodicity of needs assessments and planning processes that its behavioral health board undertakes
- an iterative process for developing the infrastructure to support behavioral health board activities. Specifically, the County may want to consider engaging in a process to determine which board-related activities can be supported by current County staff and, simultaneously, hire an initial core team to support the board and initial board-directed activities. Once the volume of board-related activities becomes clearer, the County can hire additional staff as needed
- using behavioral health tax revenues to fund some or all of the FTE effort that supports the activities of the County’s behavioral health board
- how much funding, if any, would be earmarked to support County-administered behavioral health programs

It is hoped that the information provided in this study will guide the County as it develops the best and most informed system for managing and distributing the revenues generated from this tax and distributed towards improving behavioral health in the County.

## **Methodology**

This study was conducted by Dr. Sam Howarth (Department of Economics and Senior Fellow), and Janelle Johnson (MA, Department of Political Science) at the Robert Wood Johnson Foundation Center for Health Policy at the University of New Mexico, with assistance from Anna Marie Dinallo (Health Policy Fellow and PhD candidate in the Department of Education) (researchers).

### *Review and Case Selection: States and Counties*

Researchers selected states and counties that met the following criteria: First, researchers identified states that levy and/or allow counties within those states to levy a tax, the revenues from which are then used expressly to fund behavioral health services and programs. Then researchers considered the availability of relevant information on states and the counties within those states focusing primarily on: 1) the ways counties and/or cities can levy taxes for behavioral health, 2) how the behavioral health boards that determine the use of these revenues are structured, and 3) how these boards conduct needs assessments or engage in other planning processes to determine behavioral health priorities. Lastly, researchers considered variations between states and, where applicable, between counties within those states. The states included in this study provide different, statutorily-defined environments in which counties operate. The five states ultimately selected for this study are: Washington, Illinois, Ohio, Missouri, and California.

There is significant variation among the five states selected in terms of their overall prescriptiveness, involvement in, and administration of local behavioral health services. For example, Washington State statute provides the most permissive environment of any state examined in this study, allowing counties to impose local tax levies (or not), create local behavioral health boards, and locally provide behavioral health services as they deem appropriate. In this respect, counties in Washington are the most like Bernalillo County. (For this reason, we include 4 Washington State counties in this study, the most counties from a given state.) State statutes in Illinois and Missouri are slightly more prescriptive in terms of local board creation and composition, and the subsequent provision of behavioral health services; however, state departments in these states are generally uninvolved in overseeing the activities of behavioral boards in their counties. In contrast, Ohio state statute explicitly lays out how taxes shall be levied, how boards are created, their composition, and ultimately, what and how services are provided with tax revenues earmarked for behavioral health services. Additionally, county activities related to the oversight and use of these funds are reported annually to the state of Ohio for approval, making for greater state involvement in the overall process of providing behavioral health services at the local level. Lastly, the state of California is the most prescriptive. State statute in California expressly prescribes the imposition of a tax, defines the creation and composition of local boards, and dictates the provision of local behavioral health services. All activities associated with the counties must be reported to the state for approval. While California statute dictates the local administration of services, there is some variation among California counties in terms of what the funds are used for, board size, and how various services are defined. Thus, California is relevant

and informative to this study. Given this prescriptive environment, however, we only include 2 California counties in this study.

We then selected counties within these 5 states that met similar criteria: the quality and availability of relevant information, and variance, where possible, between counties within a given state, focusing specifically on county population, differences in board structures (where applicable), and differences in how counties conduct needs assessments or other planning processes to inform priorities. The 14 counties that met these criteria and are included in this study are: Snohomish (WA), Kitsap (WA), Whatcom (WA), Lewis (WA), Jo Daviess (IL), DeWitt (IL), Kane (IL), Summit (OH), Hamilton (OH), Lorain (OH), Jackson (MO), St. Louis (MO), Sacramento (CA), and San Francisco (CA). In later sections of this study we focus particular attention on the five counties with populations most similar to the population of Bernalillo County (for benchmarking purposes), and we provide a discreet analysis of the counties within Washington State given that these counties are the most like Bernalillo County, having the most flexibility to develop systems to determine and oversee the distribution of tax revenues for behavioral health.

#### Survey and Interview Methodology

Having already located state statutes, county ordinances and other relevant documents as part of the process of selecting states and counties, researchers then developed a survey instrument that could be administered by phone or through email. County officials and administrators were then contacted by phone and/or email and, using the survey tool, asked to provide information about their systems, specifically, 1) the governance structure overseeing collection and distribution of revenues earmarked for behavioral health, 2) the number of appointed board members and their affiliations, if any, 3) appointing authority, or who makes appointments to behavioral health boards, 4) the degree of flexibility the governing body has in determining how funds will be spent, 5) the amount of funding administered, 6) how funding is distributed, 7) if the behavioral health board or other county officials engaged in a needs assessment or other planning processes to inform the distribution of funds and the nature of these processes, and 8) county population size and demographics in relation to board structure.

Telephone interviews have been used extensively in quantitative research<sup>1</sup> but relatively less so in qualitative studies.<sup>2</sup> The telephone interview is an accepted approach for data collection and is a principal survey method<sup>3</sup>; qualitative telephone data have been assessed to be rich, detailed, and of high quality.<sup>4</sup> Compared to in-person interviews, the advantages of telephone interviews include decreased costs<sup>5</sup>, increased access to geographically disparate subjects<sup>6</sup>, the ability to take notes unobtrusively<sup>7</sup>, and increased privacy and rapport.<sup>8</sup> In all cases, researchers sought to conduct phone interviews; however, in several cases representatives preferred to communicate only by email.

### Snowball Sampling

Researchers used a snowball sampling method to take advantage of the social networks of identified respondents to create a larger participant network.<sup>9 10</sup> Snowball sampling is a practical tool used in research studies that are primarily explorative, qualitative and descriptive.<sup>11</sup> Using this process, initial interviewees were asked to provide researchers with the names and contact information for other individuals who could provide additional information or other perspectives. In this fashion, researchers identified and surveyed administrators and/or board members overseeing, or affiliated with, organized behavioral health governance structures in the counties and states selected for study.

Information obtained from survey responses, interviews, statutes and ordinances, and reviews of other relevant documents was then entered into an Excel database for analysis.

### Study Limitations

Researchers attempted to include a southwestern state, other than California, in this study for a more regional comparison. Colorado, Arizona, and Texas, were investigated through online county website and other searches but their county-level structures did not fall within the study parameters and/or there was a lack of available information to indicate that they might have county-level behavioral health tax and revenue distribution systems. Researchers also explored the possibility of including eastern states in this study and examined Florida, New Jersey, New York, Wisconsin and Pennsylvania as possibilities. However, the states examined did not meet study criteria. Additionally, while other states and counties could have met the study criteria, time did not permit a more exhaustive review. Lastly, and unfortunately, we were unable to find any other states or counties that precisely mirror the situation in Bernalillo County – where state statute is silent on a county’s ability to impose a county tax to fund behavioral health and, in which, a lone county has elected to do so.

With this said, we believe that the sample size for this study and the diversity of, variance between states and counties examined in this study provide rich information to inform Bernalillo County’s deliberations as the County develops a system to administer the 1/8 of a cent increase to the gross receipts tax earmarked for behavioral health services in the County.

## **Findings**

### Organization of Findings

Study findings are organized as follows. The first section, *State Findings*, presents information on each of the five states, describing the context within which counties operate and the limitations and requirements that states do and don’t place on counties as they create systems to distribute tax revenues earmarked to fund behavioral health services and programs. This information provides a backdrop against which the behavior and decisions of counties can then be better understood. The second section, *Behavioral*

*Health Boards*, presents information learned from each of the counties represented in this study related to their behavioral health boards. The next section, *County Needs Assessments or Other Planning Processes to Inform the Distribution of Tax Revenues for Behavioral Health*, provides findings from this study related to the ways in which counties conduct needs assessments or engage in other planning processes to inform their behavioral health priorities. In the last section, *Final Considerations*, we provide some additional findings related to how counties actually provide funding to contracted partners and we present an overview of the types of services these counties have decided to fund.

### State Findings

As indicated prior, counties in Washington State, Illinois, Ohio, Missouri, and California are included in this study. This section provides a brief overview of the “regulatory environment” defined by statute in each of these states. This is important because the behaviors of all of the counties in this study are impacted by the regulatory environment created by the states in which they operate. This is not the case for Bernalillo County as there is not a similar New Mexico state statute(s) that would define or impact how Bernalillo County collects, oversees and distributes a locally generated tax revenue to fund behavioral health.

### *Washington State*

Counties in Washington State are most like Bernalillo County. In 2005, Washington State passed the Omnibus Mental Health and Substance Abuse Act (E2SSB-5763) that allows counties to raise their local gross receipts tax by one-tenth of one percent to augment state funding to counties for mental health, chemical dependency or therapeutic court services.<sup>12</sup> This Act also allows cities with populations of 40,000 or greater to levy a tax for this purpose, if the county in which the city is located chooses not to do so. The Act allows these revenues to be used for services including, but not limited to, treatment, case management, housing that serves as a component of a coordinated chemical dependency or mental health treatment program or service, and for the operation or delivery of therapeutic court programs or services.<sup>13</sup> Additionally, all or part of the revenues collected from this tax may be transferred to the State of Washington’s Department of Social and Health Services to obtain federal matching funds to provide and coordinate community services.<sup>14</sup>

As stated above, Washington State is the most permissive of the states analyzed here, allowing counties to design systems to generate, administer and distribute tax revenues to fund behavioral health. Thus, Washington counties demonstrate considerable variability in board size, appointment, and composition. For example, in Snohomish County, the board consists of 13 members, while there are 11 board members in Kitsap County, 10 in Whatcom County, and 9 in Lewis County. Commonalities do emerge among these counties, however. Members serve three-year terms in all 4 counties. Board size in all of these Washington State counties more closely mirrors population size than it does in the counties in any of the other states examined. Additionally, there is strong county-affiliated official representation on behavioral health boards in these counties. For example, 7 out of 13 board members in Snohomish County are affiliated with boards,

commissions, or agencies associated with the county, and 3 of those 13 are county officials representing the county jail, the superior court, and local law enforcement. County official representation is similar in the other 3 Washington State counties. Finally, and quite interestingly, in the absence of statutory mandate(s) by the state, Washington counties have more leeway and are able to be more exact in selecting who comprises their local boards, for how long, and according to whom. Ultimately, these counties have more latitude to determine how funds are distributed and how needs and services are defined.

### *Illinois*

The passage of the 1967 Community Mental Health Act<sup>15</sup> by the state of Illinois permitted local units of government (townships, municipalities or counties) to pass a local referendum to allow for an annual tax levy “not to exceed .15% upon all of the taxable property in such governmental units at the value thereof, as assessed by the Department of Revenue.”<sup>16</sup> The Act requires local units of government electing to raise such taxes to create seven to nine member Community Mental Health Boards (appointed by the chairman of that county’s governmental body) to determine how these tax revenues will be distributed before the tax is actually levied.<sup>17</sup> These members are required to be residents of that county and should “represent interested groups” within the community.<sup>18</sup> Members of the Community Mental Health Board serve staggered, four-year terms and no member serving on the board can receive compensation, but may be reimbursed for expenses incurred while serving in their board capacity.<sup>19</sup>

When collected, tax revenues are paid into a “Community Mental Health Fund” which is administered by Community Mental Health Boards.<sup>20</sup> Revenues collected are then to be used to fund “mental health, developmental disability and substance abuse services” at the local level. While the Illinois Community Mental Health Act requires that funds be used for “mental health, developmental disability and substance abuse services,” it allows the local boards administering the Act to define “mental health,” “developmental disability,” and “substance abuse.” As such, the types of services funded vary by local township, municipality, and county. This allows for significant local control over which services are funded to address local issues within each community.

### *Ohio*

Between 1968 and today, Ohio has passed a series of laws that define the ways counties can raise and distribute revenues to fund behavioral health services. The state tax code stipulates that counties can impose a mill levy to generate revenue for mental health services.<sup>21</sup> Those funds are then placed in the care of the county Auditor, who also serves as the fiscal officer of the county’s Mental Health Service District (MHSD). According to the Summit County board director, “In total, these levies generate about \$330 million annually [statewide] to support the provision of mental health and addiction services.”

Section 14(a) of Chapter 5119 of the Ohio Revised Code outlines the roles and responsibilities of the State of Ohio’s Department of Mental Health and Addiction Services (DMHAS); it indicates that the DMHAS shall maintain, operate, manage, and govern state institutions as it relates to state provision of mental healthcare.<sup>22</sup> This

department is responsible for dividing the state into Mental Health Service Districts (MHSD) for the purpose of providing mental health services.<sup>23</sup> A board district may cover one or more counties depending on the population size. The Act then requires that local boards be established for these Mental Health Service Districts, and be responsible for planning, funding, and evaluating outpatient mental health services.<sup>24</sup> These boards are to consist of either 14 or 18 members, upon the decision of the local governing body. For boards consisting of 18 members, the Director of DMHAS is responsible for appointing 8 members and the local Board of County Commissioners appoints the remaining 10 members.<sup>25</sup> The Director must also make sure that at least one member of the appointed board is a medical clinician with experience in the delivery of mental health or addiction services, that one member is an individual who receives (or has done so in the past) mental health or addiction services, and that one member is the parent or relative of such a person.<sup>26</sup> These board members serve without compensation, but are reimbursed for actual or necessary expenses incurred in the fulfillment of their official duties.<sup>27</sup> The revised code further stipulates that all board members attend in-service training sessions provided by the DMHAS annually.<sup>28</sup>

In 1989, separate Boards of Alcohol and Drug Addictions Services (ADAS) and Mental Health, evolved into what are now known as Mental Health and Recovery Services Boards (MHRSB). The MHRSBs must assess community needs to address addiction and mental health treatment, prevention, and recovery supports, put forward funding to address community needs and must “monitor the services that are funded to insure that they are appropriate and cost effective” as delineated in the state’s Revised Code 340. These boards also are responsible for seeing that the rights of consumers are protected and investigating allegations of abuse or neglect. They also operate as overseeing agents.<sup>29</sup> Lastly, according to representatives in Lorain County, local boards in Ohio generally do not provide direct services, except in very rare emergency circumstances. Rather, the boards accomplish their mission by contracting with state certified community mental health centers.

### *Missouri*

In 1969, the Missouri General Assembly passed revised statute 205.976 stipulating that the State Department of Mental Health would establish service areas where mental health services would be administered according to the most recent state plan of the department.<sup>30</sup> Additionally, the statute allowed counties, by a majority vote of registered voters, to levy taxes to be used to “develop and maintain local programs for mental health and development disabilities.”<sup>31</sup> Such county levies are not to exceed 40 cents per \$100 of assessed valuation upon all taxable property within the county and tax revenues generated in this fashion are then to be deposited into a “Community Mental Health Fund.”<sup>32</sup> Boards of Trustees are responsible for depositing tax funds into and maintaining the Community Health Fund to establish and operate mental health centers and services in the community.<sup>33</sup> Revenues overseen by these boards are then used to fund the following activities: “1) Provide necessary funds to establish, operate and maintain community mental health clinics, 2) Provide funds to supplement existing funds for the operation and maintenance of mental health centers, services or clinics, 3) Purchasing mental health services from community mental health centers or clinics or

other public facilities or not-for profit corporations.”<sup>34</sup> According to a Jackson County representative, only 13 out of 114 counties voluntarily tax themselves to develop and maintain mental health services.

Section 984 of Missouri Revised Statute Chapter 205 provides for the establishment of these Boards of Trustees in designated service areas.<sup>35</sup> Boards of Trustees must have no less than nine members and board members are appointed by the county’s governing body, serving staggered three-year terms. No more than one third of those members can represent public or private entities involved in the provision of psychiatric services; at least one third of the members should be consumers of psychiatric services, or families of such consumers; at least one member should be a licensed physician, and at least half of the body should be made up of individuals who do not directly provide health care. This section of statute also stipulates that the board should be representative of the service area’s population, based on employment, sex, age, race, and demographic characteristics.

### *California*

In 2004, California passed the Mental Health Services Act (MHSA), colloquially known as Prop 63. This Act enabled the California Department of Mental Health (DMH) to provide increased funding, personnel and other mental health resources to support county mental health programs, and conduct needs assessments and evaluations.<sup>36</sup> Revenue to fund these initiatives is generated through the imposition of a 1% increase to the income tax on personal incomes in excess of \$1 million.<sup>37</sup> These revenues are then placed in the Mental Health Services Fund of the State Treasury<sup>38</sup> and the State Controller disburses the monies to Local Mental Health Services Funds according to approved county plans<sup>39</sup> to support the activities outlined in those approved plans. The Act authorizes that funding can be allocated to support a broad spectrum of community needs for children, transition age youth, adults, geriatrics and families. Funding streams are directed to specific areas of community mental health services, including intervention, education and infrastructure.<sup>40</sup>

Statewide, the tax was projected to generate approximately \$254 million in fiscal year 2004-05, \$683 million in 2005-06 and increasing amounts thereafter. It was recently reported that the Mental Health Services Act has generated over \$13 billion in revenues since its enactment.<sup>41</sup>

The Act requires that each county establish a local mental health board. State statute requires county mental health boards to have between 10 and 15 members,<sup>42</sup> unless, as is the case for the two counties in this study, two or more local agencies jointly establish a mental health service area, in which case the mental health board for the community mental health service area shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.”<sup>43</sup> Sacramento County works with the City of Sacramento (and surrounding areas) to provide behavioral health services and San Francisco County works with the City of San Francisco (and surrounding areas) to provide these services. By working with these cities (agencies) both counties are required to add 2 additional board members. As such, Sacramento County’s mental health board

has 16 members and San Francisco County's mental health board has 17 members. In California, county mental health boards may have between 10 and 17 or more members.

These boards, with input from constituents and local stakeholders (including individuals with mental illness, families of such individuals, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care professionals, and other important interests) are to develop 3 year plans outlining various programs, needs, evaluations, and the provision of services; counties are directed to develop these programs with meaningful stakeholder involvement on mental health policy, program planning and implementation, monitoring, quality control, evaluation, and budget allocations.<sup>44</sup> The program plan is prepared and circulated for review and comment for at least 30 days and then sent to the state's Mental Health Services Oversight and Accountability Commission for approval.<sup>45</sup> A representative from San Francisco County indicated that all of this local activity is done in conjunction with other supplemental outcome and public health data generated by various state-affiliated agencies; thus, overall needs assessments and evaluation of services are done locally but with significant input and direction from the state Department of Health Services.

#### Summary of State Findings

Understanding how state actions and policies related to the generation of tax revenues earmarked for behavioral health by smaller governmental entities within those states is useful. These understandings provide a backdrop against which we can better understand the requirements and/or limitations placed on governmental entities (counties) within those states as they create systems to collect administer and distribute these revenues. The five states examined in this report operate differently in this respect. For example, the state of California provides funding that is generated from a 1% increase to the income tax on personal income in excess of \$1 million. This revenue is then provided to counties to use to address a broad spectrum of county mental health needs. California requires that all counties establish local mental health boards to oversee the use of these monies. As such, although counties in California have variable definitions of needs and services, the state is more involved in how counties form boards, and make decisions about funding behavioral health services. This is true for counties in Ohio, as well, though Ohio's statute(s) have slightly fewer specific mandates. In Illinois and Missouri, state legislatures enacted legislation that allows local governmental entities within these states (townships, municipalities or counties) to pass local referenda to increase property tax levies to raise revenues specifically to fund behavioral health services within those jurisdictions. But state involvement beyond this is limited.

Lastly, counties within the state of Washington have the least state involvement or direction in how they design systems to generate, administer and distribute tax revenues to fund behavioral health. Like the other states analyzed here, Washington passed legislation that allows counties to raise their local gross receipts tax - by 1/10 of 1% to augment state funding for behavioral health services in those counties. Local behavioral health boards in these counties have the most leeway, however, in determining their board structure, composition, roles and responsibilities, and identification of funding

priorities. This latitude is reflected in the considerable variation among the Washington counties analyzed here. Given the absence of state involvement, and limited mandate, counties in Washington are those most like Bernalillo County.

### **Behavioral Health Boards**

In this section findings related to behavioral health boards are discussed. Specifically, this chapter provides information on behavioral health board size, terms of appointments, board constituency representation, and authority to appoint board members.

It is important to note that all of the states in this study, with the exception of Washington State, dictate certain requirements related to county behavioral health board sizes, terms of appointments, board constituency representation, and board appointing authority. There is, however, variance in the prescribed requirements in these four states and some latitude granted to counties in some of these domains. As such, information from these four states, and Washington, is valuable to this study.

#### *Behavioral Health Board Size*

The table below provides information on state statutory requirements for behavioral health board size, if applicable, and the actual number of board members in each of the counties within these states and the ratio of board members to county population.

State/County	Statutory Requirement	Board size	County Population (2014) <sup>46</sup>	Ratio of Board Members to Population
Snohomish (WA)	Not Applicable	13	745,913	1:57,378
Kitsap (WA)	Not Applicable	11	253,968	1:23,088
Whatcom (WA)	Not Applicable	10	208,315	1:20,832
Lewis (WA)	Not Applicable	9	75,081	1:8,342
Jo Daviess (IL)	7 to 9 members	7	22,254	1:3,179
De Witt (IL)	7 to 9 members	7	16,284	1:2,326
Kane (IL)	7 to 9 members	7	527,306	1:75,329
Summit (OH)	14 or 18 members	14	541,943	1:38,710
Hamilton (OH)	14 or 18 members	14	806,631	1:57,617
Lorain (OH)	14 or 18 members	18	304,216	1:16,901
Jackson (MO)	No less than 9	15	683,191	1:45,546
St. Louis (MO)	No less than 9	12	1,001,876	1:83,490
Sacramento (CA)	10 to 15 members*	16*	1,482,026	1:92,627
San Francisco (CA)	10 to 15 members*	17*	852,469	1:50,145
<b>AVERAGES</b>		<b>12</b>	<b>537,248</b>	<b>1:41,108</b>

#### *A Little More About California*

State statute in California provides that county behavioral health boards must have between 10 and 15 members<sup>47</sup> and allows for exceptions in two cases. For counties with

populations less than 80,000, boards must have a “minimum of 5 members.”<sup>48</sup> The statute also allows for two or more “local agencies” (governmental entities) to jointly establish a mental health service area; in this case, the behavioral health board shall consist of an “additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.”<sup>49</sup> This is the case with the two California counties included in this study. Sacramento County has created a service area that includes the local agency of the City of Sacramento and San Francisco County has created a service area that includes the City of San Francisco. As such, in California, county behavioral health boards may have anywhere between 5 and 17 members, and possibly more if a number of local agencies come together to form a large service area. In fact, California state statute indicates, “Nothing in this section shall be construed to limit the ability of the governing body to increase the number of members above 15.”<sup>50</sup>

*Findings Related to Board Size*

The county behavioral health boards examined in this study ranged in size from 7 (Jo Daviess (IL), De Witt (IL) and Kane (IL) to 17 in San Francisco County (CA). The average board size for the counties in this study is 12.

*Findings Related to the Relationship of County Behavioral Health Board Size to County Population*

Intuitively, one might expect to see a strong correlation between board size and population, especially in counties where there is the opportunity to choose the size of the board. However, this is not the case here. In fact, in counties in the states of Ohio, Missouri and California, there is an inverse relationship between board membership and population, where the counties with the largest populations in these states have the fewest board members and the counties with smaller populations have more board members. As such, this finding does not assist Bernalillo County as the County considers what size board to establish.

In Ohio, each of the three counties represented have seven member boards regardless of county populations that range from very small (16,284 in De Witt County and 22,254 in Jo Daviess County) to significantly larger (527, 306 in Kane County). Again, this information indicating a significant variation does not help to inform Bernalillo County’s deliberations.

*Findings Related to the Relationship of County Behavioral Health Board Size to County Population In Washington State*

State/County	Board size	County Population (2014) <sup>51</sup>	Ratio of Board Members to Population
Snohomish (WA)	13	745,913	1:57,378
Kitsap (WA)	11	253,968	1:23,088
Whatcom (WA)	10	208,315	1:20,832
Lewis (WA)	9	75,081	1:8,342

In the four counties examined in Washington State (the state that allows counties complete flexibility in determining board size), board membership does correlate with county population. As demonstrated in the table above, the county with the largest population (Snohomish) has the largest board and the highest board member to population ratio. Lewis County has the smallest population, the smallest board, and the lowest board member to population ratio. Kitsap and Whatcom counties also follow this pattern. This suggests that in counties, like Bernalillo, where there is the unrestricted ability to determine the size of the board, that population and amount of tax revenue for behavioral health (which generally correlates to county population) should be considered. **As such, Bernalillo County may want to take into account the County’s population when determining the size of its behavioral health board.**

*Findings Related to Board Size in Counties with Populations Similar to the Population of Bernalillo County (between 490,000 and 860,000)*

An examination of counties with similar populations to the population of Bernalillo County provides another way of considering board size. Six counties in this study have populations between 490,000 and 860,000. Of these, Kane County is required by state statute to have a board with either 7 or 9 members (Kane County elected to create a 7-member board.) and therefore is excluded from this analysis. The remaining five counties have flexibility to determine the size of their boards and fit these criteria. See table below.

State/County	Statutory Requirement	Board size	County Population (2014) <sup>52</sup>	Ratio of Board Members to Population
Snohomish (WA)	Not Applicable	13	745,913	1:57,378
Kane (IL)	7 to 9 members	7	527,306	1:75,329
Summit (OH)	14 or 18 members	14	541,943	1:38,710
Hamilton (OH)	14 or 18 members	14	806,631	1:57,617
Jackson (MO)	No less than 9	15	683,191	1:45,546
San Francisco (CA)	10 to 15 members	17	852,469	1:50,145
<b>AVERAGES</b>		<b>14.6</b>	<b>717,029</b>	<b>1:49,879</b>

Of these remaining five counties, the board member to county populations ranged from 1:38,710 (Summit County, OH) to 1:57,617 (Hamilton County, OH). The average board member to county population ratio is 1:49,879. If we apply the lowest ratio, the highest ratio and the average ratio to this average ratio to the population of Bernalillo County, it would suggest that Bernalillo County would create a behavioral health board with 17 (17.45) members, 14 members (13.54) or 14 members (14.07) respectively.

The two counties with the populations closest in size to the population of Bernalillo County (population 675,551) are Jackson County (population 683,191) and Snohomish

County (population 745,913). The behavioral health board in Jackson County has 15 members and a board member to population ratio of 1:45,546; the board in Snohomish County has 13 members and a board member to population ratio of 1:57,378. Applying Jackson County’s board member to population ratio to the population of Bernalillo County would suggest that Bernalillo County might consider creating a behavioral health board with 15 (14.83) board members. If we apply the board member to population ratio of Snohomish County to the population of Bernalillo County we arrive at 11.77, suggesting that Bernalillo County may want to consider having 12 members on it behavioral health board.

These analyses suggest that **Bernalillo County may want to consider creating a behavioral health board with somewhere between 12 and 17 members. (However, there is also precedent for creating behavioral health boards with fewer members.)**

*Findings Related to Board Membership: Boards with an Odd or Even Number of Members*

Eight of the 14 (57%) counties examined in this study have an odd number of board members and 6 counties (43%) have an even number. This relatively small difference does not indicate a strong preference for boards with an odd number of members. These percentages stay the same when we remove the three counties in Ohio that must have an odd number of board members, either 7 or 9, and the three counties in Ohio that are required to have an even number of board members, 14 or 18. As such, **Bernalillo County may want to determine whether the County’s behavioral health board has an even or odd number of members based on County-specific criteria and not on precedent created in the counties examined in this study.**

*Behavioral Health Board Terms of Appointments*

In this section, we present findings related to terms of initial appointments and terms of ongoing appointments to behavioral health boards. Information presented here was gathered from interviews with county officials and reviews of board materials, and then matched to county ordinances or state statutes when possible.

State/County	Initial Terms of Appointment	Continuing Terms of Appointment
Snohomish (WA)	In original ordinance appointments were made for four year terms and staggered in this fashion: 5 members for 4 years 4 members for 3 years 4 members for 2 years	3 years *
Kitsap (WA)	3 members for 1 year 4 members for 2 years 4 members for 3 year	3 years
Whatcom (WA)	3 members for 1 year 3 members for 2 years 3 members for 3 years	3 years

	and the member of the County Council appointed for 3 a three-year term.	
Lewis (WA)	Staggered 3 year terms	3 years
Jo Daviess De Witt Kane (IL <sup>53</sup> )	2 members for 2 years 2 members for 3 years 3 members for 4 years	4 years
Summit (OH)	4 members for 2 years 5 members for 3 years 5 members for 4 years	4 years
Hamilton (OH)	4 members for 2 years 5 members for 3 years 5 members for 4 years	4 years
Lorrain (OH)	6 members for 2 years 6 members for 3 years 6 members for 4 years	4 years
St. Louis Jackson (MO <sup>54</sup> )	1/3 of members for 1 year 1/3 of members for 2 years 1/3 of members for 3 year	3 years
San Francisco Sacramento (CA)	Equitably staggered appointments, so that approximately 1/3 of appointments expire each year	3 years

\* Originally, Snohomish County ordinance dictated that board member appointments would be for 4 years. However, in 2010, Snohomish County passed an amendment to their ordinance making their board members' terms 3 (instead of four) years.<sup>55</sup>

*Behavioral Health Board Initial Terms of Appointment and Ongoing Terms of Appointment*

As presented in the table above, all the counties in this study stagger initial appointments to their behavioral health boards. Counties that ultimately want appointees to have 3-year terms, stagger initial appointments appointing some board members to 1-, 2- and 3-year appointments. The number or percentage of appointments to each of these terms varies slightly between the boards and is, in part, based on the total number of board members to be selected. Counties that ultimately want appointees to have 4-year terms, stagger initial appointments appointing some board members to 2-, 3- and 4-year appointments. Again, the number or percentage of appointments to each of these terms varies slightly between the boards and is, in part, based on the total number of board members to be selected. Given the uniformity found across all counties in this study, **Bernalillo County may want to consider staggering the terms of appointees to its behavioral health board.**

As represented in the table above, all of the counties in this study, ultimately, appoint members for 3- or 4-year terms. All of the counties examined in this study in Washington, Missouri and California appoint board members to 3-year terms (8 counties) while all of the counties in Illinois and Ohio appoint members to 4-year terms (6 counties). The terms of appointment in Illinois, Ohio, Missouri, and California are

dictated by statute. In Washington State, counties determine terms of appointment. **Given these findings, Bernalillo County may want to consider making appointments for terms of either 3 years or 4 years.**

*Behavioral Health Board Constituency Representation*

In this section findings related to which constituency groups or entities are required to be represented on behavioral health boards are provided. Again, information presented here was gathered from interviews with county officials and review of board materials and then matched to county ordinances or state statutes when possible.

State/County	Board Member Constituency Representation
Snohomish (WA)	2 members of the Community Mental Health Program Advisory Board 2 members from Alcohol and Drug Abuse Administrative Board 1 member of the Snohomish County Council on Aging 1 member of the Children’s Commission 1 member of the Veterans’ Assistance Fund Executive Board 1 member representing the county jail, 1 member representing the superior court 1 member who personally provides chemical or drug dependency or mental health services to individual clients 1 member representing law enforcement 2 members, appointed at-large
Kitsap (WA)*	1 member from the Peninsula Regional Support Network Advisory Board 1 member from the Kitsap County Substance Abuse Advisory Board 1 member from the Commission on Children and Youth 1 member from the Area Agency on Aging 1 member from Law and Justice 5 at-large members representing a broad spectrum of community members whose background and expertise will enhance the function and effectiveness of the “Behavioral Health Advisory Board” in fulfilling their responsibilities 1 member appointed by the County Counsel
Whatcom (WA)	1 member representing PeaceHealth Hospital 1 member representing the judicial branch of Whatcom County government 1 member, the Whatcom County Sheriff or his/her designee 1 member, the Chief of Corrections or his/her designee 1 member, the Whatcom County Public Health Director or his/her designee 1 member representing the Whatcom County Behavioral Health Advisory Board (This body oversees other local, state and federal resources used to support behavioral health services.)

	<p>2 members that represent mental health advocacy</p> <p>2 members that represent drug recovery advocacy</p>
Lewis (WA)	<p>1 member, The Public Health and Social Services Director of Lewis County</p> <p>1 member, a representative of the Lewis County therapeutic courts</p> <p>1 member, a Certified Mental Health professional</p> <p>1 member, a Certified Chemical Dependency Treatment professional</p> <p>1 member, a representative of the Lewis County Board of Health Advisory committee</p> <p>1 member, a representative of the Lewis County Affordable Housing Network</p> <p>1 member, a representative of the Lewis County Community Health Partnership (An organization that is made up of executives engaged in health and community building efforts)</p> <p>1 member, a representative from law enforcement, The sheriff or his/her designee</p> <p>1 member, a citizen of Lewis County appointed at-large</p>
Jo Daviess De Witt Kane (IL <sup>56</sup> )	<p>Only 1 member shall be a member of the county governing body</p> <p>“Members of the community mental health board shall be residents of the government unit and, as nearly as possible, be representative of interested groups of the community such as local health departments, medical societies, local comprehensive health planning agencies, hospital boards, lay associations concerned with mental health, developmental disabilities and substance abuse, as well as the general public.”</p>
Summit Hamilton Lorrain (OH <sup>57</sup> )	<p>At least 1 member is a clinician with experience in the delivery of mental health services</p> <p>At least one member is a person who has received or is receiving mental health services</p> <p>At least one member is a parent or other relative of such a person</p> <p>At least one member of the board is a clinician with experience in the delivery of addiction services</p> <p>At least one member of the board is a person who has received or is receiving addiction services</p> <p>At least one member of the board is a parent or other relative of such a person.</p> <p>Also, all members shall be residents of the service district. The membership shall, as nearly as possible, reflect the composition of the population of the service district as to race and sex.<sup>58</sup></p>
Jackson St. Louis (MO)	<p>No more than 1/3 of members shall represent public or private entities involved in the provision of services</p> <p>At least 1/3 of members shall represent consumers of psychiatric services or the families of such consumers.</p>

	<p>At least 1 member shall be a licensed physician At least ½ of members shall be individuals who are not providers of health care.<sup>59</sup> Composition of board shall be “representative of the residents of the county...taking into consideration their employment, age, sex, and place of residence and other demographic characteristics of the area.”<sup>60</sup></p>
<p>Sacramento San Francisco (CA<sup>61</sup>)</p>	<p>Fifty (50) percent of board shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least twenty (20) percent of the total membership shall be consumers, and at least twenty (20) percent shall be families of consumers. In counties with populations under 80,000, at least one [additional] member shall be a consumer, and at least one member shall be a family member of a consumer. One member of the board shall be a member of the local governing body The statute also allows for two or more “local agencies” (governmental entities) to jointly establish a mental health service area; in this case, the behavioral health board shall consist of an “additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.” (5604.03 (c)) (This is the case for Sacramento County.) Also, counties are encouraged to appoint individuals who have experience and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county.</p>

As is represented in the table above, state statute dictates board constituency representation in Illinois, Ohio, Missouri and California. These statutes, while limiting in some respects, do provide counties within these states various degrees of latitude in making specific board appointments as long as appointees represent the types of entities, providers of service or consumers indicated in statute.

For example, in California, statute demonstrates a commitment to consumer and family member representation on behavioral health boards, requiring that at least 50% of board members “consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services,” with at least 20% of members being consumers and 20% being family members. The only other requirement in California statute provides that county behavioral health boards must also have one member from the local, county, governing body. Otherwise the statute is silent, allowing counties significant flexibility in making other appointments.

Illinois statute also provides a significant amount of local, county discretion in making board appointments. Statute provides that only one member can represent the county governing body and that other members be “residents of the government unit and, as nearly as possible, be representative of interested groups of the community such as local health departments, medical societies, local comprehensive health planning agencies, hospital boards, lay associations concerned with mental health, developmental disabilities and substance abuse, as well as the general public.”

Ohio state statute is very prescriptive in terms of the types of individuals who must be on county behavioral health boards, but leaves the actual appointees that represent these types up to the counties. In Ohio, county mental health boards must include at least one member representing each of these types: a clinician with experience in the delivery of mental health services, a person who has received or is receiving mental health services, a parent or other relative of such a person, a clinician with experience in the delivery of addiction services, a person who has received or is receiving addiction services and a parent or other relative of such a person. However, this represents only 6 appointments to boards that are to have either 14 or 18 members.

Similarly, in Missouri, state statute outlines the types of individuals who must be on county behavioral health boards, but allows counties to select board members that meet the following criteria: No more than 1/3 of members shall represent public or private entities involved in the provision of services; at least 1/3 of members shall represent consumers of psychiatric services or the families of such consumers; at least 1 member shall be a licensed physician; at least 1/2 of members shall be individuals who are not providers of health care.<sup>62</sup> And composition of board shall be “representative of the residents of the county...taking into consideration their employment, age, sex, and place of residence and other demographic characteristics of the area.”<sup>63</sup>

As such, counties in these states have a fair amount of latitude to select individual board members as long as appointees fit within these broad requirements. In contrast, the counties in Washington State examined for this study are very prescriptive when defining the types of individuals that sit on their behavioral health boards. This difference is very likely due to the difference in origin of the statute or ordinance that defines board membership – States, through statute, very likely chose to provide broad parameters to counties to act within, while counties, through ordinance or bylaw, create more precise or defined requirements for affiliations for board members. It is assumed that this is because counties are much more aware of the types of individuals and types of affiliations they would want represented on their boards to best represent the interests of consumers, families and providers in their counties. As such, **Bernalillo County may want to consider both the types of members they would like to have on its behavioral health board and identify possible requirements and/or specific affiliations for board members.**

#### *Consumer, Family Member and Advocate Participation on Behavioral Health Boards*

Three of the states examined in this study have strong state statutory requirements that require strong consumer and family membership on the behavioral health boards in

counties in those states. In Ohio, “at least” 4 of the 14 or 18 board members, as required by state statute, are to be people who has received or is receiving mental health or addiction services and parents or other relatives of such a person. In Missouri, at least 1/3 of county behavioral health board members must represent consumers of psychiatric services or family members. And in California at least 50% of the membership of a county behavioral health board must be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services; at least 20% of the total membership must be consumers, and at least 20% must be families of consumers. Additionally, as is the case for the two California counties examined in this study, when two or more governmental entities jointly establish a mental health service area, the behavioral health board shall consist of an “additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.” (5604.03 (c))

In Illinois, state statute does not specifically require consumer, family member or advocate representation on county behavioral health boards; however, statute would clearly allow for such membership. Interestingly, in the counties examined for this study in Washington State, where board member affiliation is the most precisely defined, not one of the four counties examined here requires consumer or family members to be on their behavioral health boards. Whatcom County does require that 4 members be advocates, 2 representing mental health and 2 representing drug recovery. Snohomish County allows for 2 at-large appointees, Kitsap County allows for 5 at-large appointees; and Lewis County allows for 1 at-large appointee. Clearly, these appointees could be consumers, family members and/or advocates. **As such, Bernalillo County may wish to consider requiring that its behavioral health board include representation from consumers, family members and/or advocates, and determine the number, or percentage, of board members from these groups.**

#### County Official or County-Affiliated Official Representation on County Behavioral Health Boards

In Washington State, there is strong county-affiliated official representation on the behavioral health boards examined for this study. For example, In Snohomish County, 7 of 13 board members are affiliated with boards, commissions or agencies administered in the county, and 3 of 13 are county officials representing the county jail, the superior court and law enforcement. In Whatcom County, 1 of 10 board members are affiliated with boards, commissions or agencies administered in the county and 4 of 10 members are county officials representing the judicial branch, the sheriff’s office, the chief of corrections and the Whatcom County Public Health Director. And 1 of 10 represents the only hospital in the county. In Kitsap County, 5 of 11 board members are affiliated with boards, commissions or agencies administered in the county. In Lewis County, 4 of 9 board members are affiliated with boards, commissions or agencies administered in the county and 2 of 9 are county officials, the Director of the Lewis County Public Health and Social Services and a representative of the Lewis County therapeutic courts.

On the contrary, Illinois statute is restrictive and indicates that county behavioral health boards may only include one county official (on boards with either 7 or 9 members). That official must be a member of the county’s governing board. In California, county behavioral health boards must have one county official who, similarly, must be a member of the local governing body. There is no language in California statute that would limit the number of county or county-affiliated officials that could be appointed to boards, as long as that doing so did not conflict with other statutory requirements. State statutes in Ohio, Missouri and California are silent on county official representation on their county behavioral health boards. Presumably, then, in these states, county official representation is permitted.

**In Washington State a significant percentage of behavioral health board members are county officials or represent other county-affiliated boards, commissions or agencies; Illinois and California both require that a member of a county’s governing body be on county behavioral health boards; and in Ohio and Missouri there is a presumption that county officials can hold seats on county behavioral health boards. As such, Bernalillo County may want to consider including county officials and/or representatives from county-affiliates on its behavioral health board.**

Authority to Appoint Board Members

Information provided in this section is based on a review of state statutes (IL, OH, MO and CA) and county ordinance (WA).

State/County	Who Makes Appointments
Snohomish (WA)	Appointed by county governing body (Board of Commissioners)
Kitsap (WA)	Appointed by county governing body (Board of Commissioners)
Whatcom (WA)	“Nine members are appointed by the County Executive subject to confirmation by a majority of the County Council. One member shall be a member of the County Council and shall be appointed by the County Council.” (Whatcom County Ordinance number 2012-042)
Lewis (WA)	Appointed by the county governing body (Board of Commissioners)
Jo Daviess De Witt Kane (IL)	Chairperson of the county governing body, with the advice of that body (Board of County Commissioners)
Summit (OH)	Six (6) members appointed by chairperson of county governing body (County Council) Eight (8) members appointed by County Council
Hamilton (OH)	Six (6) members appointed by chairperson of county governing body (County Council) Eight (8) members appointed by County Council

Lorain (OH)	Eight (8) members appointed by chairperson of county governing body (County Council) Ten (10) members appointed by County Council
Jackson St. Louis (MO)	Appointed by county governing body (Board of County Commissioners)
Sacramento San Francisco (CA)	Appointed by county governing body (Board of County Commissioners)

*Findings Related to Appointment Authority*

As presented in the table above, the authority to appoint behavioral health board members, in all but one county, resides with each county’s governing body, or county commission. The one exception is Whatcom County where the County Executive has the authority to appoint nine members to the board, subject to confirmation by a majority of the County Council (The 10th appointment to this board is a member of the County Council.).

All of the counties in Missouri and California, and in 3 counties in Washington (7 counties), grant the authority to appoint board members to their respective county commissions acting as a body.

In the counties in Illinois and Ohio (6 counties), the chairperson of the county governing body plays a greater role in making board appointments. In Illinois, the chairperson of the governing body makes the appointments with advice of the body. In Ohio, a distinction in authority is made. For boards with 14 members, 6 appointments are made by the chair of the governing body and 8 appointments are made by the body as a whole; for boards with 18 members, 8 appointments are made by the chair of the governing body and 10 appointments are made by the council as a whole.

It is important to note, however, that in Missouri, California, Illinois and Ohio, the authority provided to counties to make behavioral health board appointments is dictated by state statute. As such, these ways of appointing board members may not be what these counties would choose to do if they were provided a choice. The only state where this is not the case is Washington. In Washington, three of the four counties have chosen to grant appointing authority to their respective county governing bodies as a whole and, as indicated above, one county, Whatcom (WA) grants that authority to the county executive subject to confirmation by the county council.

It is telling that in all but one county examined in this study, the county governing body makes appointment to their respective behavioral health boards. **As such, Bernalillo County may want to consider granting this authority exclusively to the Bernalillo County Commission. If Bernalillo County chooses to give this authority exclusively to the County Commission, the County will also need to determine what, if any, additional authority the Chairperson of the Commission may have.**

**County Needs Assessments or Other Planning Processes to Inform the Distribution of Tax Revenues for Behavioral Health**

*Needs Assessment or Other Planning Processes Required by State Statute*

Three of the states examined in this study require local, county behavioral health boards to engage in a needs assessment or other planning process. The table below provides these salutatory requirements for Washington, Ohio, and California.

State	Statutory Requirement
Washington	Washington statute states that the county behavioral health boards in Washington shall “Conduct public hearings and other investigations to determine the needs and priorities of county citizens.” <sup>64</sup>
Ohio	Ohio statute provides that a county behavioral health board shall “[s]erve as the community addiction and mental health services planning agency for the county or counties under its jurisdictions, and in so doing it shall: evaluate the need for facilities and community addiction and mental health services” <sup>65</sup> Additionally, county behavioral health boards must, “In cooperation with other local and regional planning and funding bodies and with relevant ethnic organizations to assess the community addiction and mental health needs, evaluate strengths and challenges, and set priorities for services, including treatment and prevention.” <sup>66</sup> These assessments are then incorporated into annual plans that are submitted by county behavioral health boards to the Ohio Department of Mental Health and Addiction Services for approval.
Illinois	Nothing explicit in state statute. However, statute does indicate that local boards shall “review and evaluate community mental health services and facilities”; they are responsible for receiving and approving funding proposals, and establishing grant criteria. Thus, there are assessment mechanisms implied in order to carry out those functions. As a result, counties vary in how they do this. According to a Jo Daviess County representative, a needs assessment is conducted by the local board, which is done annually in carrying out the responsibilities of reading

	<p>grant applications and developing the mental health budget. They use their respective assessments in establishing their grant criteria.</p> <p>Similarly, the DeWitt County board conducts annual assessments, conducted specifically, for the development of annual community provisions plans and funding approvals.</p> <p>There was no information given regarding the Kane County board.</p>
Missouri	<p>Nothing in state statute</p> <p>In Jackson County, representative stated that local entity relies on following areas to inform community needs: County, Missouri Health Profile, the Kaiser Family Foundation’s State Health Facts, data from the Mid-America Regional Council, the U.S. Department of Health and Human Services, and the U.S. Census Bureau</p> <p>In St. Louis, Staff of the board responsible for performing needs assessments, writing and issuing RFPs, reading and funding proposals for service, and providing accounting functions related to administration of the tax revenues generated. The St. Louis board hired the Missouri Institute of Mental Health to conduct needs assessment concerning children’s services and hired Center for Mental Health Services Research at Washington University in St. Louis to conduct needs assessment to understand adult behavioral health services.</p>
California	<p>California state statute requires county behavioral health boards in California to “...review and evaluate the community’s mental health needs, services, facilities, and special problems; advise governing body and local mental health director as to any aspect of the program; review and approve the procedures used to ensure citizen and professional involvement at all stages of planning process; submit an annual report to the governing body on the needs and performance of the county’s mental health system; review and comment on county’s performance outcome data and communicate findings to California Mental Health Planning Council.”<sup>67</sup></p> <p>And (b): “It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.”<sup>68</sup></p> <p>According to a representative with the Sacramento</p>

	<p>County behavioral health board, they are “...responsible for identifying culturally relevant needs, monitoring cost-effective strategies and making recommendations to the County Board of Supervisors, review and evaluate the community’s mental health needs, services, facilities, and special problems, review county mental health contracts, review and approve procedures to ensure citizen and professional involvement in all stages of planning process, and submit an annual report to the governing body on the needs and performance of the county mental health system.”</p> <p>These activities are similarly conducted in San Francisco County, but a representative there indicated that this is done so in conjunction with the State Department of Health and Human Services. In considering local needs assessment and service evaluations, local entities are also required to weigh outcome and public health data and recommendations set forth by that department, which are developed annually in statewide public health plans. Thus, while the county is responsible for locally engaging in these needs and evaluations activities, they do so with significant state involvement and mandate(s).</p>
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Not surprisingly, Washington State provides the fewest requirements to counties concerning how counties must engage in needs assessments related to behavioral health. Ohio and California provide significantly more direction to their counties.

Statutes in both Ohio and California address periodicity, requiring that county behavioral health boards conduct needs assessment annually and that findings be submitted to the state annually. Additionally, both California and Ohio require that needs assessments be coordinated with other partners. Ohio requires that needs assessment be coordinated with “...other local and regional planning and funding bodies and with relevant ethnic organizations...” and California requires that their boards “...ensure citizen and professional involvement at all stages of planning process.”

County-Level Qualitative Findings Related to Needs Assessments or Other Planning Processes

In addition to reviewing state statutes, researchers contacted county officials to ask them about their specific, county-level needs assessment processes. Unfortunately, we did not receive responses to our requests for information from a number of counties in this study. This said, the information we did receive does provide a pretty clear indication of the types of processes that counties engage in in order to understand the needs within their communities.

All counties surveyed for this study conduct needs assessments or otherwise engage in a process to collect and review information and data to inform the distribution of tax revenues to improve behavioral health. Importantly, counties use different methods and processes to gather relevant information to inform the distribution of funds; they engage these processes at different frequencies; and they rely on different partners to assist with determining priority areas.

*Who Conducts or Participates in the Needs Assessment Process?*

All counties examined in this study, with the exception of one, rely on county personnel and/or their behavioral health boards to gather and review relevant information to identify priority areas. Only St. Louis County (MO) indicated that it outsources its needs assessment completely (to Washington University in St. Louis). Kane County (IL) conducts a joint needs assessment every 3 years. This process is performed in collaboration with local hospitals and the state's Department of Health. Representatives from Kane County indicated that by partnering in this way, they were able to reduce costs associated with a large-scale survey that would provide the county with more and better information. **Bernalillo County may want to consider developing the ability to conduct needs assessments in house and/or in collaboration with an outside entity(ies).**

*Needs Assessment and Other Planning Processes: Primary Data*

Counties use different methods and processes to gather information to inform their actions. Of the 12 counties examined in this study, 6 counties indicated that they receive primary data through community input in order to inform their priorities. This community input is gathered using one or more of the following methods – surveys, focus groups, public forums, stakeholder planning sessions, telephone interviews, and/or presentations to the board.<sup>2</sup>

In this section we present some of the ways counties and county behavioral health boards employ these different methods to gather primary data as part of their needs assessment and other planning processes.

Lorain County OH)

A representative from Lorain County described their process. Lorain County officials and board members launched a strategic planning process that began in the fall of 2013, the results of which would then inform behavioral health board priorities and funding for 2 and ½ years, January, 2014 through June, 2016. The process was coordinated jointly by the Chairperson of Lorain County's behavioral health board and the Executive Director of the county's Board of Mental Health that provides administrative support to the county's behavioral health board. An outside contractor facilitated the process.

Once the strategic plan was developed, and initiatives were undertaken, the county convened "quick hit teams." Quick hit teams are made up of various constituent groups in the community who convene for 2 or 3 meetings to address a specific item such as

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<sup>2</sup> It is very possible that additional counties also rely on community input to inform their planning. Unfortunately some counties did not provide information on this subject.

cultural diversity. The county representative indicated that, “[t]his method is helpful in garnering a variety of perspectives. It has also been successful because it does not require anyone to make a long term commitment of their time.”

This representative further indicated that county officials and county behavioral health board members use a variety of methods to solicit input from the community, relying primarily on the use of surveys and focus groups. For example, consumer satisfaction is assessed annually at each of the mental health centers funded with county generated behavioral health tax revenues. Consumers are surveyed by phone. The county relies on focus groups as needed. They are generally used when there are “emerging or pressing issues.” Additionally, the county’s behavioral health board works with local hospitals, adding specific questions related to behavioral health service needs in the county to a survey that local hospitals are required to conduct under the Affordable Care Act.

#### Kitsap County (WA)

In Kitsap County, the County Commission appoints members to a “Behavioral Health Strategic Planning Team.” This team is different from the county’s behavioral health board and is made up of individuals with “expertise in chemical dependency and mental health treatment, therapeutic courts, law enforcement, housing, medical and emergency services, public health, and education.”<sup>69</sup> This team then is “responsible to research existing local data for behavioral health service needs, existing capacities, gaps in service, and community readiness to address the needs and gaps. The team will create a plan with goals, objectives, and strategies aimed at meeting the behavioral health needs of the Kitsap community.”<sup>70</sup> This work and plan, in turn, inform the behavioral health board’s decisions. (Interestingly, this team also provides “technical expertise and education on the continuum of care for treating chemical dependency and mental health in Kitsap County” to the county’s behavioral health board.”)<sup>71</sup>

#### Hamilton County (OH)

Hamilton County has sought and received grants to support behavioral health planning. Hamilton County (OH) received a State Incentive Grant in 2010. This grant allowed for the creation of a Strategic Prevention Framework (SPF) that gathered ongoing input related to behavioral health from 18 to 25 year olds. Input was gathered through monthly meetings and annual surveys of a large group of young adult representatives volunteering time and resources to Hamilton County’s behavioral health board. Hamilton County’s behavioral health board also received a 9 million dollar, 6-year SAMSHA System of Care grant. The grant is currently in its 5<sup>th</sup> year and supports the gathering of input from provider agencies, community partners, and families and youth related to the needs, gaps and disparities in services for transitional age youth. In addition, Hamilton County’s behavioral health board contracts with the University of Cincinnati’s Institute for Policy Research, to collect relevant grant-related data and to report to SAMSHA.

#### *Some Other Processes from Other Counties*

A representative from Summit County (OH) indicated that that county’s behavioral health board will hold various types of forums to gather community, consumer and

family input, specifically when the behavioral health board is planning for specific programs or significant changes in priorities.

A representative from Lewis County (WA) indicated that their behavioral health board, with support from county staff, convened a large community forum to identify behavioral health priorities in the county immediately after the county passed its 1/10 of 1% tax increase and prior to distributing any of these revenues.

Some counties, like Lewis (WA), Whatcom (WA) and Jackson County (MO) indicated that they rely heavily on program evaluations of their funded programs to inform subsequent funding decisions. These representatives said that their reviews of program efficacy informed their decisions to continue or discontinue funding to specific programs, and to inform them on the types of efforts that were positively impacting behavioral health outcomes in their counties.

**Bernalillo County may want to consider gathering primary data using one or more of the following methods – surveys, focus groups, public forums, stakeholder planning sessions, telephone interviews, and/or presentations to the board.**

**Further, the County may want consider using “quick hit” teams and/or a Behavioral Health Strategic Planning Team, as do Lorain County (OH) and Kitsap County (WA), to assist Bernalillo County’s behavioral health board as described above.**

**Further, Bernalillo County may want to consider convening large community forum(s) to identify behavioral health priorities in the County prior to distributing any of these revenues, as does Lewis County (WA).**

**Further, Bernalillo County may want to consider employing a rigorous program evaluation process that can determine which funded programs are effective and should be considered for additional funding, and to inform the county more generally about the types of programs that are positively impacting behavioral health in the County and should be replicated or expanded.**

**Further, Bernalillo County may want to seek grant funding to support data collection and analysis and needs assessment or other planning processes.**

*Needs Assessment and Other Planning Processes: Secondary Data*

All counties examined in this study rely on secondary data to inform their priorities. For example, Jackson County (MO) and Whatcom County (WA) indicated that they rely on secondary data sources that include state health profiles, the Kaiser Family Foundation’s State Health Facts, existing community needs assessments, county level health plans, local behavioral health plans, U.S. Health and Human Services Department data and reports, and U.S. census data.

In Hamilton County (OH), the Student Drug Use Survey<sup>72</sup> is distributed to more than 26,000 students every two years. The behavioral health board uses data from this survey related to student tobacco, alcohol and illegal drug use and data related to other risk and protective factors to inform its priorities. Additionally, these data are used to provide a baseline and to measure improvement at the population level in their community over time. The Hamilton County behavioral health board also reviews data related to length of stay and hospital days at the state hospital. These data are collected and reviewed monthly to assess needs and improvements.

**Bernalillo County may want to consider which secondary data sources the County’s behavioral health board should have access to and review to inform board priorities.**

**Further, Bernalillo County may want to use Youth Risk and Resiliency (and other regular administered surveys) to identify priorities and to measure progress.**

#### Periodicity

There is significant variance in the periodicity of assessing behavioral health needs and planning. As indicated in the preceding section, California and Ohio require counties to conduct an annual needs assessment. Lorain County (OH) engaged in a strategic planning process, the results of which would then inform behavioral health board priorities and funding for a 2 and ½ year period. A representative from Kitsap County (WA) indicated that the behavioral health board in that county conducts a needs assessment “at least every 3 years.” And, as discussed in this section, some counties are continually engaged in assessing needs and planning.

**Bernalillo County may want to consider the periodicity of needs assessments and planning processes that its behavioral health board undertakes.**

#### County Administration and Infrastructure to Support the Activities of Behavioral Health Boards

This section provides a brief discussion of the ways that counties staff and support the activities of their behavioral health boards. This information was obtained from responses to survey questions and/or via telephone call and/or email. In most cases, with the exception of some smaller counties in this study, it was difficult for county officials to quantify just how much support county personnel provide to their behavioral health boards because that support is distributed among a number of different people who provide different types of support, but do not work exclusively on behalf of their boards.— Only a percentage of each individual’s time supports board activities.

One notable exception to this norm is Lorain County (OH, population 304,216) where support for the county’s behavioral health board is provided out of one office. In Lorain County, 11 FTE support the board. One FTE is the Director who is responsible for coordinating all activities. There are 4 FTE on a “clinical team” that addresses “client grievances, program planning, program evaluation, forensic monitoring and clinical audits.” 4 more FTE provide finance and IT support that includes responsibility for

“budgeting, audits, claims processing, facility management and payment processing to provider agencies and other vendors.” Two more FTE provide clerical support. Additionally, this office contracts with, or hires consultants for specific projects where particular expertise is needed. It should be noted that while Lorain County, on behalf of its behavioral health board, does issue contracts for behavioral health services, the county itself also administers and provides services.

A representative from Hamilton County (OH, population 806,631) indicated that 25 FTE directly support the activities of this county’s behavioral health board, and that the county as a whole provides additional support. Unfortunately, we did not receive additional information indicating the roles and responsibilities of these individuals or the FTE effort of the county staff that also support the board. (It is safe to assume, however, that these personnel are also involved in other activities related to behavioral health and public health in the county beyond supporting behavioral health board activities.)

A representative from Whatcom County (WA, population 208,315, administering \$3.7 million in earmarked behavioral health funds annually) indicated that 4 dedicated staff directly support the activities of their behavioral health board by conducting needs assessments and strategic planning, building community partnerships, overseeing program development and implementation, contracting, monitoring and evaluating programs, and reporting. 1 FTE is a Human Services Manager (director), 1 FTE is a Housing and Homeless Housing Program Specialist, and 2 FTE are Behavioral Health Program Specialists. A Human Services Clerk/Secretary, a Contracts Coordinator, a Staff Accountant and an IT/data systems specialist also support this team.

This representative provided the following formula for determining the appropriate ratio of staff to revenues to be spent on behavioral health: “1 FTE for every \$1 million at a base minimum, possibly even closer to 1 FTE for every \$750,000 depending upon the scope of the programs. This estimate does not include County indirect costs.” This formula, if applied to the annual anticipated behavioral health tax revenue for Bernalillo County (\$21 million) would suggest that the County dedicate between 21 and 28 FTE to support behavioral health board activities.<sup>3</sup>

In contrast to these counties with relatively significant infrastructures, an official from De Witt County (IL, population 16,284) indicated that the board’s only support is the .15 FTE effort of one individual. A representative from Kitsap County (WA, population 253,968) indicated that the only direct, dedicated support for the Kitsap County behavioral health board included 1 FTE Master Planner, approximately .25 FTE for fiscal oversight and .25 FTE for admin support. This representative also indicated that their County Auditor also provides support to the board, though that person’s FTE effort was not offered. Presumably, in the case of these 2 counties, other county officials provide at least limited legal, accounting, and other support as needed.

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<sup>3</sup> This number of FTE seems high to the authors of this report.

Although the information in this section above is informative, it does not allow for a rigorous analysis. Too few counties responded with specific information related to the FTE effort, and types of effort that is required to support the activities of their behavioral health boards. However, the information provided by these counties, and Lewis County (WA, population 75,081), does offer another way to think about the types of activities and people needed to support a behavioral health board with collection of tax revenue, planning for the use of these revenues, convening and supporting the board itself, overseeing the issuance of RFPs, writing and awarding contracts, program evaluation and accountability, and other activities.

The types of activities, then, that were specifically identified in the section above include:

- Oversight and coordination of all activities (a Program Director or Master Planner)
- Financial and accounting support generally (account)
- Financial support specifically (County Auditor and County Treasurer)
- Conducting and/or coordinating needs assessments and other planning process, including strategic planning
- Collection and analysis of behavioral health-related data for needs assessments and tracking of improvements in behavioral health outcomes
- Provision of clinical mental health and/or substance abuse expertise
- Provision of expertise related to housing and homelessness
- Provision of expertise related to prevention
- Liaising with the community and building community partnerships
- Development and issuance of RFPs
- Review of proposals
- Issuance of contracts
- Legal and financial reviews of RFPs and contracts
- Monitoring and evaluating funded program efficacy and outcomes
- IT and data support
- Human Resources support
- Clerical support

At this point it may be difficult for Bernalillo County to estimate the amount of effort that will be required from County personnel (and possibly others) to support each of these activities. It is not possible to predict, at this point, the volume of RFPs, proposals, contracts, associated program accountability functions, and planning and other activities that Bernalillo County's behavioral health board will direct. The number and kinds of activities will likely be informed by the priorities identified by the board through a needs assessment process or processes. Additionally, the County and its behavioral health board may decide to contract out some of these activities. Given these unknowns, it may be prudent for the County to staff for these activities in an iterative fashion.

**As such, the County may wish to engage in a process to determine which of these board-related activities can be supported by current County staff and, simultaneously, hire an initial core team to support the board and initial board-**

**directed activities. Then, once the volume of board-related activities becomes clearer, the County can hire additional staff as needed.**

It should be noted that there is precedent from the counties examined in this study to use behavioral health tax revenues to pay for the FTEs who support the activities of behavioral health boards. **As such, the County may wish to use behavioral health tax**

**revenues to fund some or all of the FTE effort that supports the activities of the County's behavioral health board.**

### **Final Considerations**

#### *Regarding Distribution of Funds and Services Funded*

All counties examined in this study use an RFP process to identify entities to provide services. All but one county issue formal RFPs. One county posts behavioral health priorities on its webpage and invites the submission of proposals that respond to these priorities. These are then considered for funding by this county's behavioral health board.

It should be noted that, unlike New Mexico, the states and counties examined in this study, and the states and counties in the rest of the country, have strong public health infrastructure at the county level. In New Mexico, this infrastructure resides almost entirely at the state level. This important difference requires consideration as it directly impacts the ways in which funding is distributed and how priorities are determined. The counties examined in this study have, to varying, but also greater degrees than Bernalillo County, county-administered public health infrastructures and county-administered direct services. As such, in addition to distributing behavioral health tax revenues through an RFP process, funding also supports county-administered programs to a greater degree than might be expected in Bernalillo County. **As such, the County may need to determine how much funding, if any, would be earmarked to support County-administered programs.**

#### *Some of the Programs and Services Funded by Some of the Counties Examined in this Study*

Given the distinction described above, and the understanding that the counties examined in this study use behavioral health tax revenues to fund their behavioral health public health infrastructures and county-administered direct services to a greater degree than would be expected in Bernalillo County, what follows is an overview of some of the types of services and programs funded in some of the counties examined in this study. This information is presented not to influence the decisions that Bernalillo County and its behavioral health board will make, but to provide an overview of some of the possibilities.

Specifically identified programs and services funded by the counties examined for this study using the revenues from their behavioral health taxes include:

*Direct Services*

- Crisis services
- Triage facilities
- Jail mental health services
- Services to reduce the incidence and severity of chemical dependency and/or mental health disorders in adults and youth
- Services to reduce the number of individuals with chemical dependency and/or mental health disorders using costly interventions such as hospitals, emergency rooms, or jails
- Services to divert adults and youth with chemical dependency and/or mental health disorders from initial or further involvement with the criminal justice system
- Prevention/early intervention services
- New or expanded chemical dependency and mental health treatment services for youth and adults
- Trauma services (sexual and domestic violence)
- Trauma-informed care
- Efforts to prevent and decrease opiate overdoses and deaths for youth and adults
- Suicide prevention for youth and adults
- Emergency stabilization services for youth and adults
- Intensive community-based services for youth and adults
- Vocational and recovery support
- Peer support and consumer operated services
- Inpatient services and outpatient services
- Day care and other partial hospitalization
- Emergency services
- Diagnostic services
- Rehabilitation
- Screening
- Follow-up care
- Alcoholism and alcohol abuse prevention and treatment services

*Care Coordination Services*

- Liaison services
- Care coordination

*Therapeutic Court Services*

- Therapeutic courts (judges, prosecutors, defense attorneys, court clerks and treatment)

*Outreach, Awareness and Education Services and Efforts*

- Outreach generally and to underserved populations

- Advocacy efforts related to mental health and chemical dependency
- Public awareness and education campaigns
- Identifying and sharing best practices

*System Coordination Efforts*

- Efforts to better link providers and increase collaboration
- Efforts to increase mental health integration across systems

*Services related to Housing and Homelessness*

- Services and efforts to reduce homelessness
- Housing and supportive housing
- Transitional living

Other Services

- Money management
- Vocational training and support

**Closing**

It has been a great honor to work with Bernalillo County on this study. It is hoped that the information provided here will assist the County as it builds a comprehensive and accountable system to oversee the distribution of tax revenue earmarked for behavioral health services and programs. It is further hoped that the services and programs funded by the County significantly improve the lives of individuals with behavioral health challenges in Bernalillo County.

## End Notes

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- 52 All county population estimates are from the US Census, 2014 at:  
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<sup>71</sup> Ibid

<sup>72</sup> While we are not sure if this survey is the same as the Youth Risk and Resiliency Survey (YRRS), YRRS data for Bernalillo County could be used in the same fashion

## **NOTES & DISCLAIMER**

This report was prepared for the Bernalillo County Commission

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