

**An Evaluation of Contra Costa County's Mental Health
Senior Staff and The Mental Health Administration's
Policies and Procedures**

**Submitted By:
Public Employees Union Local One
Mental Health Unit**

Fall 2009

SUMMARY

Public Employees Union Local One - Mental Health Unit conducted a comprehensive survey of its members regarding the leadership of the Mental Health Division. 83% responded and regrettably an overwhelming majority of those who did expressed a lack of confidence in Donna Wigand, the Mental Health Director, Suzanne Tavano, the Mental Health Deputy Director, and Vern Wallace, the Chief of Child and Adolescent Services. The survey reported that most staff have never seen their "leaders" and revealed a demoralized work force. Furthermore, it brought to light that these senior managers are not only seen as absent but also as ineffective, unresponsive and unable to provide an inclusive vision failing the employees, consumers and taxpayers of Contra Costa County.

Set forth in this report is the detailed presentation of Purpose, Methodology, Literature Review, Discussions of individual and collective evaluations as well as other attachments. This survey provided an opportunity to all members to include additional comments, a cross-section of which included following each Discussion. These comments simply represent the views of individuals and are not the conclusions of this study.

PURPOSE

This evaluation of Mental Health Senior Staff and the Mental Health Administration's policies and procedures was conducted as a result of growing feelings among Local One Mental Health employees that the Mental Health Administration is out of touch with their concerns and beyond that, indifferent to and dismissive of them. An increasing staff dissatisfaction with the direction of the division, its lack of concern and communication, its demonstrated hostility and negativity and, its poor and inadequate planning to face the challenges of dwindling resources was communicated. Mental Health Administration's consideration of contracting out the Crisis Stabilization Unit (as part of a new Psychiatric Health Facility) at Contra Costa Regional Medical Center sent shock waves through the adult regional clinics. Employee sentiments subsequently reached a critical mass regarding the issue of direct service productivity when this administration unleashed punitive-only measures of intervention and discipline. This survey was undertaken to gain an aggregate evaluation of the Administration's management style and its effectiveness particularly with employee relations which research has shown to have a direct correlation to quantity and quality of services rendered to end users who are often among the poorest and most vulnerable.

METHODOLOGY

In a Local One Mental Health Unit meeting, a discussion was undertaken regarding effectively measuring the performance of senior staff and evaluating whether organizational goals are being met. It was noted and agreed that, in the absence of any form of evaluation of senior staff's performance in the past fourteen years, it was essential to conduct one at this time. The matter was voted on by the Mental Health Unit members and after a unanimous vote, a committee was selected, representing various parts of the division, to carry out this task in the spirit of our founder, Henry Clarke. The main purpose of the committee was to identify and utilize the most appropriate and applicable surveys/reviews of management performance. After careful consideration of these measures already used successfully by other entities such as *The Crisis Center*, questions were compiled concerning leadership of the Division and the Administration as a whole. Next, a list of all active Local One Mental Health workers was requested and received from The Mental Health Administration and the Union roster and was cross-checked for accuracy. Every individual page of the survey was stamped with proprietary Local One stamp for the purpose of authentication. The surveys were then distributed to all sites through shop stewards or volunteers with clear and strict instructions that all union activities were to be conducted on members' own time. The completed surveys were then individually placed in an envelope, sealed and returned to Local One to secure the respondents' anonymity. From the 159 surveys distributed, 132 were returned. The results were then tabulated by the committee, evaluated and presented to Local One membership. It is worthy to note here that results for Miles Kramer (Director of Psychiatric and Detention Services) were omitted

due to his departure. Also, program managers with less than six responses were not considered for the purpose of this evaluation.

LITERATURE REVIEW

The literature is enriched with studies about organizations, leadership styles and conditions of success and failure. One of the earlier studies of leadership was conducted by Lewin, Lippert and White (1939) in which they compared three styles of leadership: (1) **Autocratic leaders** make decisions alone and instruct their subordinates what to do on the basis of those decisions; (2) **democratic leaders** involve their subordinates in the decision-making process; and (3) **laissez-faire leaders** essentially leave it up to their subordinates to make their own decisions with little guidance or help from the leader. "Lewin and his colleagues found that subordinates with democratic leaders tend to be the most satisfied, motivated, and creative, are more likely to continue working when the leader is not present, and have better relationships with their leader."

Research conducted at Ohio State University in the 1940s and 1950s indicated that there were two basic and independent dimensions of leadership behavior: (1) **Consideration** referred to the amount of warmth, concern, rapport, and support a leader displayed towards his/her subordinates. Leaders high in consideration are regarded as person-oriented. (2) **Initiating structure** refers to the extent to which a leader defines, directs, and structures his/her own role and the roles of his/her subordinates. Leaders high in initiating structure are often considered as task-oriented. Subsequent research on these dimensions such as Yukl (1971) indicate that effective leadership requires high level of both dimensions, consideration and initiating structure.

Earlier studies on **personality traits** of leaders were inconclusive. More recent studies however indicate that there are some important differences. "Based on their review of the literature, Kirkpatrick and Locke (1991) conclude that successful leaders exhibit the following characteristics: drive, honesty and integrity, leadership motivation, self-confidence, high levels of cognitive ability, knowledge of the business, flexibility, and creativity."

The **Path-Goal Model** (House, 1971) suggests that an effective leader is one who can help create a path for subordinates that will allow them to fulfill their personal goals by achieving the group and organizational goals. According to House's theory, the primary function of a leader is to (1) clarify goals and the path that leads to their achievement and (2) provide rewards to subordinates by supporting and paying attention to their needs. "A leader can adopt either a directive, supportive, participative, or achievement-oriented leadership style to perform these functions, with the appropriate style depending on certain characteristics of the employee and the work environment."

From the mid-1970s, the focus of the literature on leadership has shifted from primarily modifying the task or manipulating contingent rewards and punishments to how to influence the followers. The influence is particularly measured on how the leaders increase their followers' commitment and alter their values and beliefs. Two influential leadership styles were identified. (1) **Charismatic leaders** "are characterized by self-confidence, a firm conviction in their beliefs, high expectations for and confidence in their followers, good impression management skills, and social sensitivity and empathy. They tend to rely primarily on expert and referent power to influence their followers. Followers of charismatic leaders exhibit a high degree of devotion and loyalty to their leader, emulate the leader's values and behaviors, and are willing to sacrifice their own interests for the larger collective goal (House, 1977)." (2) **Transformational leaders** "are characterized by an ability to recognize the need for change, to create a vision that guides that change, and to accomplish the change effectively. These leaders seek to empower employees, raise their consciousness through appeals to morality and justice and inspire employees by providing a vision and sense of mission (Bass, 1998; Tichy and Devanna, 1986). To accomplish the latter, transformational leaders use framing, which involves defining the organization's goals and activities in ways that make them more meaningful." According to Burns, (1978) transformational leaders are contrasted with **transactional leaders**, who focus more on stability than change, emphasize behaviors related to normal work-related activities, and rely on rewards and punishments and appeals to self-interest to motivate subordinates.

We know that conflict within organizations interferes with communication and performance along with other negative consequences. There are many theories and research about the topic of change within organization. Nadler's **Systems Model of Planned Change** is one of them. Nadler (1988) proposes that there are four factors involved in effective organizational change: (1) informal organizational elements such as communication patterns and leadership; (2) formal organizational elements such as formal structures and processes; (3) individual characteristics of employees and managers; and (4) characteristics of employee and managerial tasks. Nadler further proposed that change in any one area will initiate change in others.

Total Quality Management (TQM) is one of the commonly used interventions for organizational development. It is distinguished from other approaches mainly because of its unique focus on client satisfaction, employee involvement and empowerment, continuous improvement in the quality of goods and services, and ongoing measures of performance to identify problems. "TQM emphasizes teamwork and decision-making at all levels of the organization....The introduction of TQM into an organization usually requires a change in organizational structure from a traditional vertical managerial hierarchy to a flatter (horizontal) structure that has parallel work teams and fewer managers."

Organizational Justice has been another topic of interest to the researchers. It is noted that employees are often influenced by their perception of its fairness when evaluating an organizational process or policy including those related to organizational change. Those interested in the notion of fairness have distinguished three types of

justice: (1) **Procedural justice** which refers to the fairness in the way a procedure or policy is implemented; (2) **distributive justice** which refers to the fairness of the outcomes of an organizational procedure or policy; (3) **Interactional Justice** which refers how people are left to feel about the quality and content of person-to-person interactions. The research has revealed that the employees perceptions of the three types of justice have direct implications on job satisfaction, trust in management, intentions to leave the company, and willingness to engage in citizenship behaviors.

Discussion - Mental Health Administration

The Mental Health Administration evaluation consisted of 17 questions in the areas of transparency and accountability, communication, relational style with line staff, provision of resources and, morale. The results were overwhelmingly negative showing a strong indication that the line staff lacked confidence in this administration.

For the purpose of these discussions, the categories of “strongly agree” and “somewhat agree” were combined as were those of “strongly disagree” and “somewhat disagree”. The data revealed that **71%** of respondents **disagreed** that this administration has been transparent and accountable in terms of day-to-day operations and decisions. **61%** felt similarly in regards to transparency and accountability with MHSA/Prop 63 funds and program creation while **59%** shared these negative sentiments in regards to this administration’s responsible fiscal management.

When reviewing this Administration’s relational style to line staff, it was disappointing but not surprising to find out that **76%** felt that this administration **did not** create a culture supportive of staff which would foster individual motivation, high level of individual and team performance and, quality of service. Equally negative, **72%** believed that this administration **did not** foster a positive attitude in line staff. **70%** of respondents **did not** feel recognized or rewarded for individual or team successes and **69%** felt that the leadership **does not** generate a favorable climate for change and is not responsive and adaptable. Clearly, this administration is failing on all levels of its relations with the line staff.

While evaluating the issue of resources and training, this Administration once again continued its negative trend. Significantly, **60%** responded that they **have not** been provided with tools, technology and resources necessary for staff to perform their daily duties. **53%** of line staff **did not** believe that they have received training on best standards of practice. **52%** of respondents said that the administration **did not** encourage or support ongoing training and staff development which has direct correlation to quality and effectiveness of services provided.

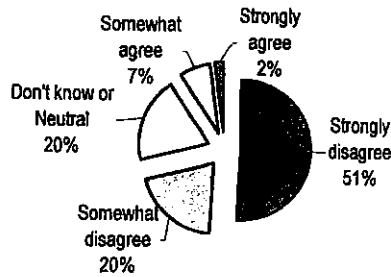
A resounding **68%** of these workers **do not** believe that this Administration sets clear policies and guidelines that are communicated to line staff. And, **67%** said that unified standards of performance **are not** applied to both Mental Administration and line staff. Additionally, **62%** believe that this Administration **does not** measure the effectiveness of current programs or those in development.

Given the strong negative evaluation of this Administration’s performance, low staff morale would be expected. Ratings of morale in the respondents’ work unit were 29% “very poor”, and 37% “poor” for a total of **66%** poor ratings. Only 15% said that morale was “good”. Individual ratings of morale came in at 46% “poor” and 21% “good”. A total of **56%** contributed the prevailing poor morale to this Administration. There is no indication that this Administration has an inkling about this low morale or cares enough to correct it. These situations inevitably result in a lower quality of services.

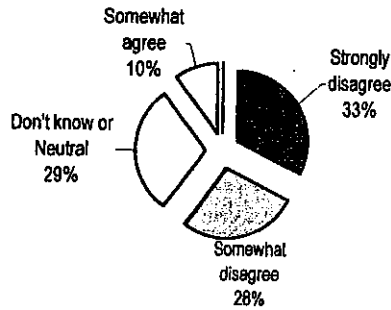
Performance Evaluation

MH Administration

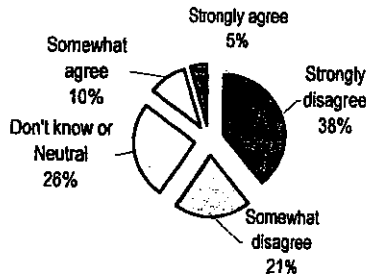
1. This administration has been consistently transparent and accountable in regards to our system's day-to-day operations and decisions.



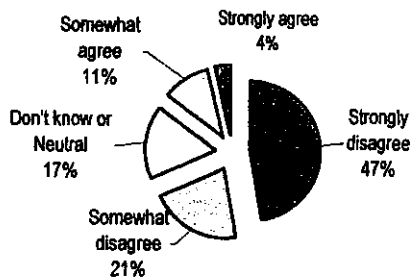
2. This administration has been transparent and accountable with MHSA (Mental Health Service Act/ Prop 63) funds and program creation.



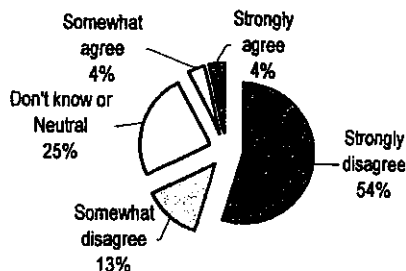
3. This administration has demonstrated responsible fiscal management.



4. This administration sets clear policies and guidelines and communicates them to line staff in a consistent and clear fashion.



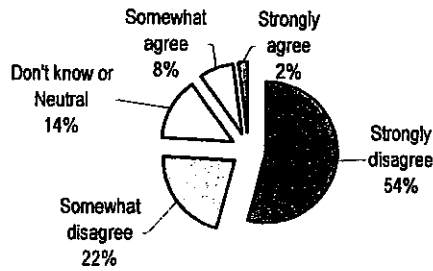
5. Unified standards of performance apply to both Mental Health Administration and line staff.



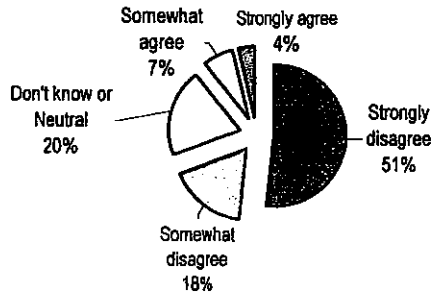
Performance Evaluation

MH Administration

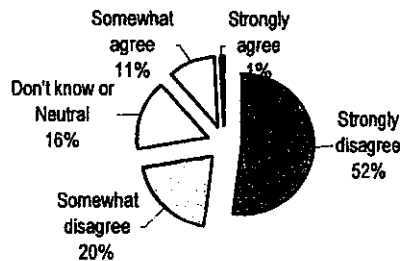
6. This administration creates a culture supportive of staff which fosters individual motivation, high levels of individual and team performance, and quality of service.



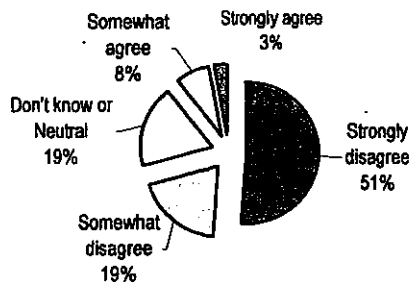
7. This administration generates a favorable climate for change and is responsive and adaptable.



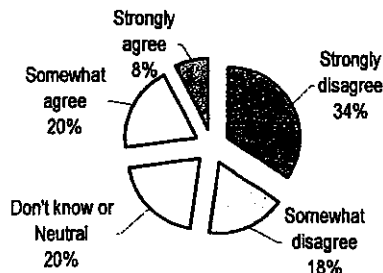
8. This administration fosters a positive attitude in line staff.



9. This administration rewards and recognizes individual and team successes.



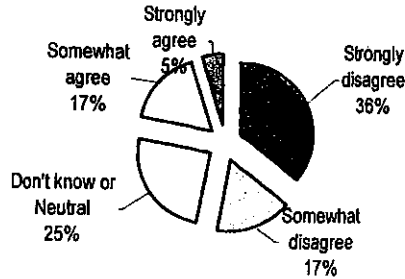
10. This administration encourages and is supportive of ongoing training and staff development.



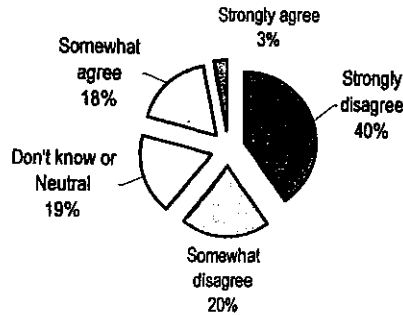
Performance Evaluation

MH Administration

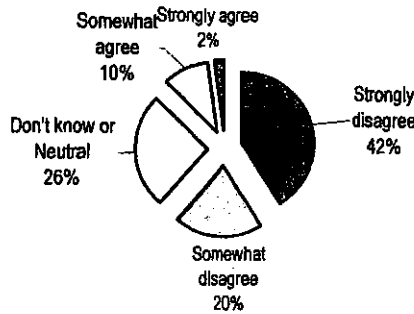
11. This administration has trained line staff on standards of best practice.



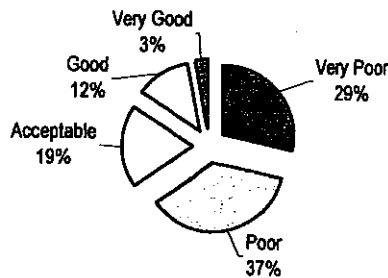
12. This administration provides the tools, technology, and resources necessary for line staff to perform their daily duties.



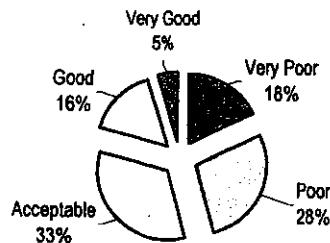
13. This administration has developed performance metrics of effectiveness of current programs and those in development.



14. Please rate the morale in your mental health unit.



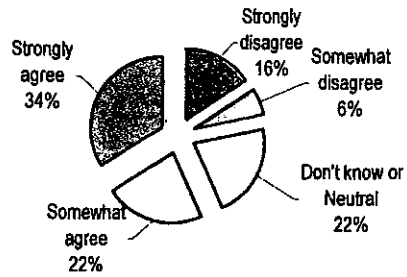
15. Please rate your own personal morale.



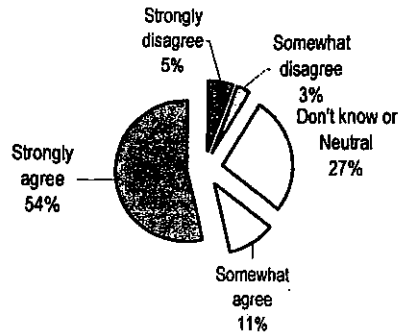
Performance Evaluation

MH Administration

16. This administration's action have strongly contributed to the prevailing morale.



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17. I would like to see an independent review of the Division's operations by an independent committee.



Discussion - Donna Wigand, Mental Health Director

Fifteen questions were asked on this survey to measure Ms. Wigand's performance. Like the Mental Health Administration, the Director of the Division, Donna Wigand, received very poor ratings. To begin, her contact with line staff is **negligible**. 59% said they never saw her and 36% said they seldom see her. This translates to an astonishing total of **95%** who do not have contact with the Director. Ms Wigand's ratings in the "neutral/don't know" category are primarily due to this lack of contact with direct service providers evidenced by their comments following this section.

A resounding **81%** of respondents **did not** believe that Ms. Wigand seeks and maintains contacts and relations with line staff. Wherever she gets her information about conditions on the ground it does not come from the workers who are engaged on the front lines every day. **78%** said that she **did not** develop and maintain effective and collaborative relationships with the line staff. **72%** **did not** believe that she is interested in or takes into consideration line staff's opinion in future organizational planning. **71%** found that Ms. Wigand's style of leadership **was not** collaborative or helpful and **67%** believed that she **is not** informed about all facets of the organization and challenges that face the line staff.

With respect to the productivity issue, **only 7%** felt that Ms. Wigand had handled the issue of line staff productivity fairly, equitably, and competently. The sentiments of the line staff are best summarized by a worker who wrote: "Donna Wigand and Suzanne Tavano have, through their inept and overzealous enforcement of productivity policy, unnecessarily created a highly adversarial atmosphere between line staff and the administration. They have hastily moved to discipline those who fall short with no understanding or respect for the difficulties facing line staff in meeting the productivity requirements. The fact that all disciplinary actions have had to be rescinded testify to the fact that actions were unwarranted in the first place. In their zeal to punish line staff they wasted taxpayer money and they have lost the respect of line staff." On behalf of the Mental Health Unit, the community, and the taxpayers in Contra Costa County, Roland Katz, supervising business agent of Local One, has tried to engage Ms. Wigand in a collaborative process and has been met only with rigidity and refusal (see letters in Appendix A).

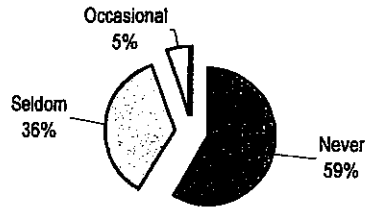
Other highly negative and deficient areas in Ms. Wigand's evaluation include vision, innovation and quality of work. **Only 9%** of the respondents believed that the Director has communicated a business vision in the form of a one- or five-year plan. Again, a mere **9%** agreed that her innovations have helped meet the objectives of the Mental Health Division. **Only 8%** of the respondents believed that she demonstrates a high level of competence and the same small percentage believed that she communicates well with the staff.

The results of this survey indicate an overwhelming lack of confidence in Ms. Wigand's leadership. She received a poor evaluation in her relations with line staff and in her management capabilities.

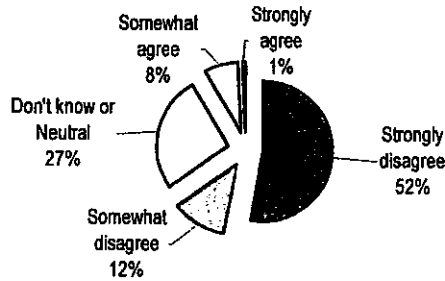
Performance Evaluation

Donna Wigand

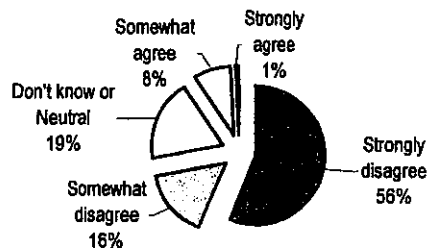
1. How often do you have contact with your Mental Health Director, Donna Wigand?



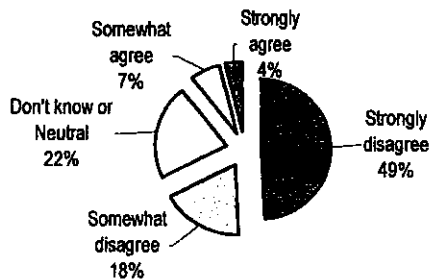
2. This manager has communicated a vision for the organization's future (for instance, in the form of a one-year and five-year plan).



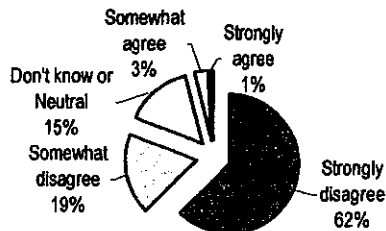
3. This manager is interested in and takes into consideration line staff's opinions when planning for the organization's future.



4. This manager is interested in and informed about all facets of the organization and challenges that face the line staff.



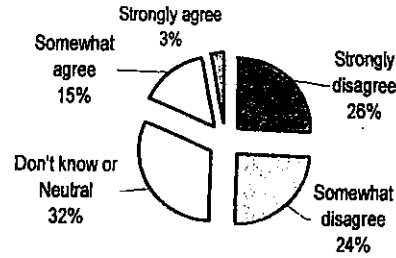
5. This manager seeks and maintains contacts and relations with line staff.



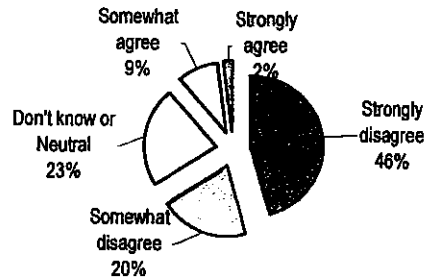
Performance Evaluation

Donna Wigand

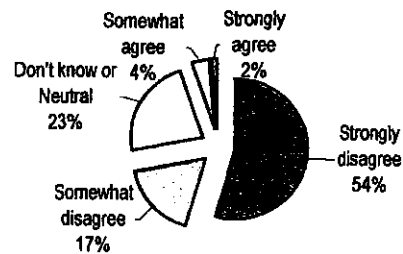
6. This manager appreciates the needs, realities, and desperation of the community mental health population.



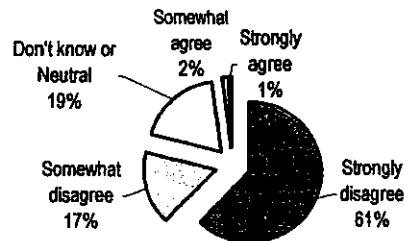
7. This manager appreciates the physical, mental, and emotional demands on direct service providers working within the community mental health system.



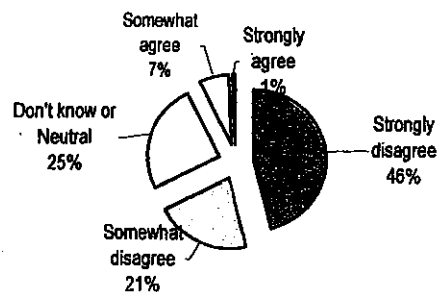
8. This manager's leadership style is collaborative and helpful.



9. This manager develops and maintains effective and collaborative relationships with line staff.



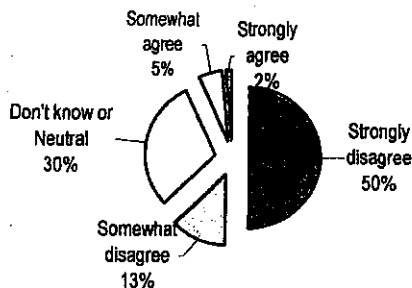
10. This manager communicates well with employees both verbally and in writing.



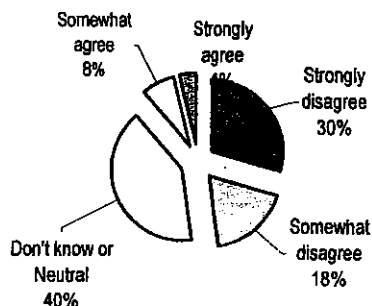
Performance Evaluation

Donna Wigand

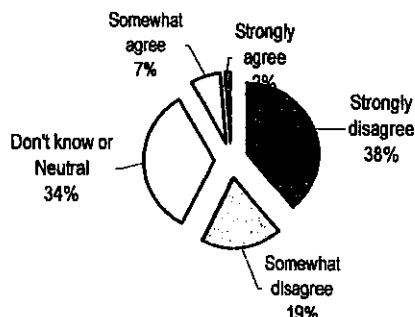
11. This manager has handled the issue of line staff productivity fairly, equitably, and competently.



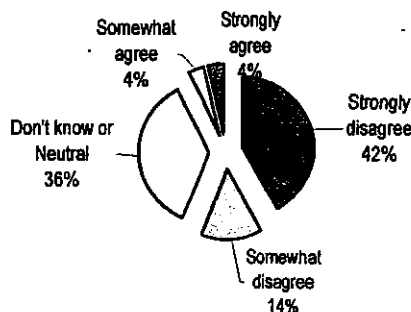
12. This manager possesses sufficient clinical understanding to competently manage line staff serving the community mental health population.



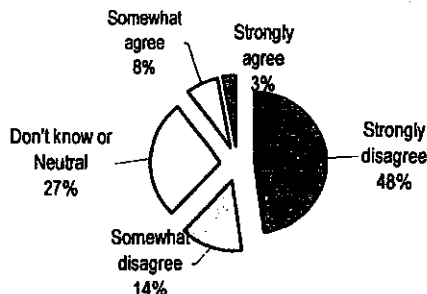
13. This manager's innovation have helped meet the objectives of the Mental Health Division.



14. This manager produces high quality work and demonstrates a high level of competence.



15. I have confidence in this manager.



Discussion - Suzanne Tavano, Deputy Mental Health Director

Ms. Tavano's ratings on this survey were consistently poor. She was rated with as little contact with line staff as was Ms. Wigand. **94%** of respondents said they either never saw her (59%) or seldom saw her (35%), and **only 6%** said they saw her occasionally. With these reported percentages for both the Mental Health Director and her Deputy, one is only left to wonder how they profess to know anything about the day-to-day operations, needs and obstacles.

Continuing with this trend, only **8%** believed that Ms. Tavano, the Deputy Director of this Division, has communicated a vision for the organization. **69%** of the respondents did **not** believe that she has pursued or maintained relations with line staff and thus it is not surprising to see that **only 10%** agreed that she is interested in and informed about all facets of the organization and challenges that face the line staff. This lack of contact and interest extends out to considerations of direct service provider's opinions when planning for the organization's future and it elicited a very low positive response of **9%** for Ms. Tavano.

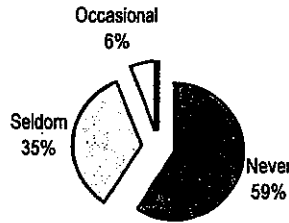
A very small **7%** of respondents believe that the Deputy Director's style of leadership is collaborative and helpful and yet a resounding **69% did not** believe that she maintains effective and collaborative relationships. Only **5%** of the participants believed that she has handled the issue of line staff productivity fairly, equitably and competently, and just **12%** found her work to be of high quality and competence. It is not by any measure surprising that from the large number of respondents, **only 10%** have communicated some level of confidence in Ms. Tavano.

Many questions seem to circulate around the manner in which Ms. Tavano has been treated during her tenure at Contra Costa County. Ms. Tavano, left this county to become the Mental Health Director at Napa County, but for unknown reasons returned after a few months to her previous position here which remained vacant and was never posted by Ms. Wigand, the Mental Health Director. Additionally, she was promoted to Deputy Director in one of the most heavily impacted fiscal years. These benefits and exceptions have not been offered to line staff and remain questionable and unjust, and they only further emphasize the different standards applied to line staff versus lead staff.

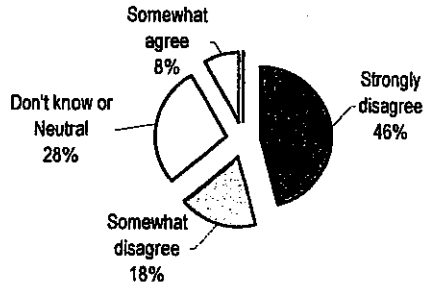
Performance Evaluation

Suzanne Tavano

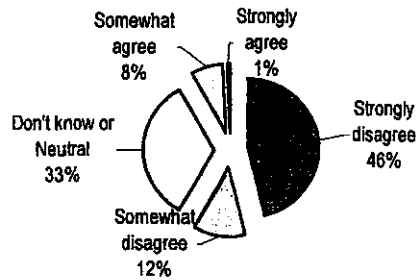
1. How often do you have contact with your Deputy Mental Health Director, Suzanne Tavano?



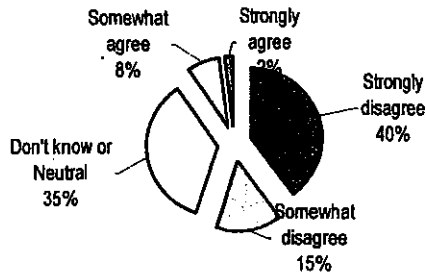
2. This manager has communicated a vision for the organization's future (for instance, in the form of a one-year and five-year plan).



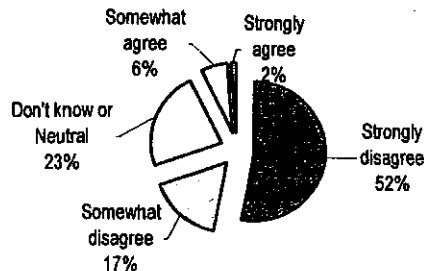
3. This manager is interested in and takes into consideration line staff's opinions when planning for the organization's future.



4. This manager is interested in and informed about all facets of the organization and challenges that face the line staff.



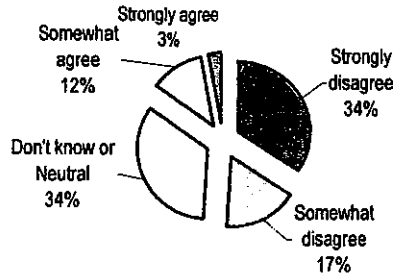
5. This manager seeks and maintains contacts and relations with line staff.



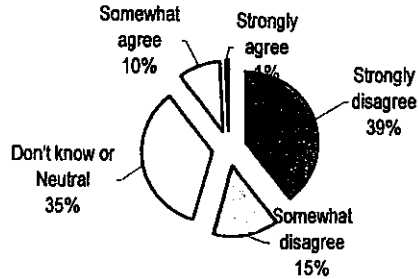
Performance Evaluation

Suzanne Tavano

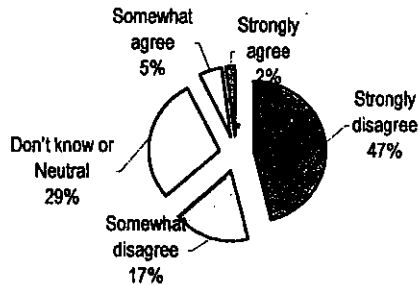
6. This manager appreciates the needs, realities, and desperation of the community mental health population.



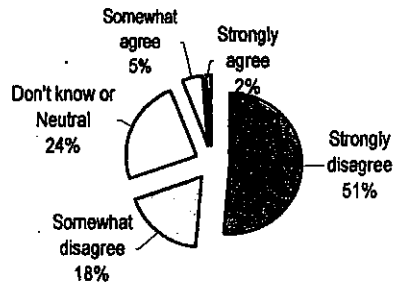
7. This manager appreciates the physical, mental, and emotional demands on direct service providers working within the community mental health system.



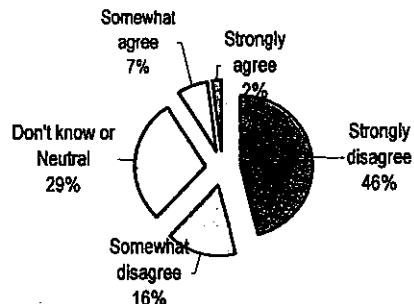
8. This manager's leadership style is collaborative and helpful.



9. This manager develops and maintains effective and collaborative relationships with line staff.



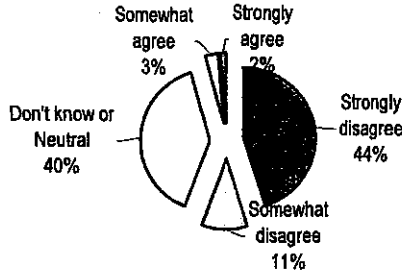
10. This manager communicates well with employees both verbally and in writing.



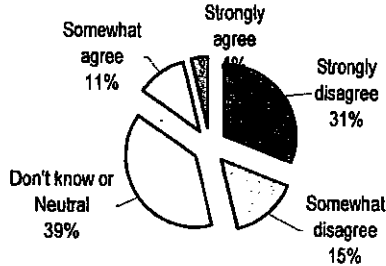
Performance Evaluation

Suzanne Tavano

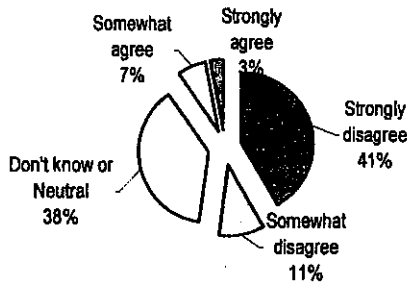
11. This manager has handled the issue of line staff productivity fairly, equitably, and competently.



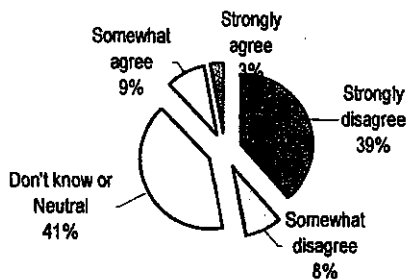
12. This manager possesses sufficient clinical understanding to competently manage line staff serving the community mental health population.



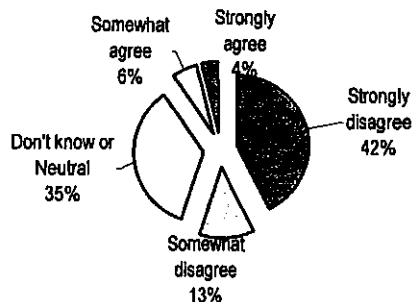
13. This manager's innovation have helped meet the objectives of the Mental Health Division.



14. This manager produces high quality work and demonstrates a high level of competence.



15. I have confidence in this manager.



Discussion - Vern Wallace, Chief of Child & Adolescent Mental Health

Mr. Wallace's performance ratings were for the most part negative. In tabulating the data it became clear that the regional clinics' responses were overwhelmingly different than those obtained from specialty programs. Subsequently, it was imperative to look at the results for Mr. Wallace both with and without data from specialty programs (SP).

While comparing the two sets of results, the negative trend remained the same but was buffered when specialty programs were included. The overwhelming negative responses to Mr. Wallace's performance from regional clinics may be attributed to lack of contact, engagement, hostile position in regards to productivity and/or clinical investment by the Chief in these programs.

Data from regional clinics indicated 6% never had contact with Mr. Wallace, 66% seldom, 26% occasional and only 3% often. This translates to the fact that **72%** of the staff essentially **never** see him. When specialty programs were included these numbers changed to 4%, 54%, 40%, and 2% respectively.

70% of respondents **did not** believe that Mr. Wallace has communicated a vision for the future in the form of a one-year or five-year plan. This number changed to **60%** with specialty clinics. **66%** **did not** believe that he is interested in or takes into consideration line staff's opinions in future organizational planning, (**52%** with SP). **63%** said he **is not** interested or informed about all facets of the organization and challenges that face the line staff, (**50%** with SP).

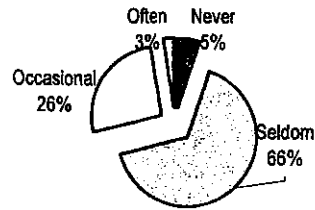
An overwhelming **76%** believed that Mr. Wallace **does not** develop and maintain effective and collaborative relationships with line staff, (**64%** with SP). **73%** **do not** believe that he seeks and maintains contacts and relations with direct providers, (**62%** with SP) and **70%** said he **does not** communicate well with employees, (**56%** with SP). **70%** of respondents reported that Mr. Wallace's leadership style is not collaborative and helpful, (**56%** with SP).

71% of line staff believe that Vern Wallace **has not** handled the issue of productivity fairly, equitably, and competently, (**60%** with SP). And **only 8%** believed that his innovations have helped meet the objectives of the division, (**24%** with SP). **57%** stated that Mr. Wallace did not produce high quality work and did not demonstrate a high level of competence, (**46%** with SP). A resounding **70%** of respondents gave this chief a vote of **no confidence**, (**58%** with SP).

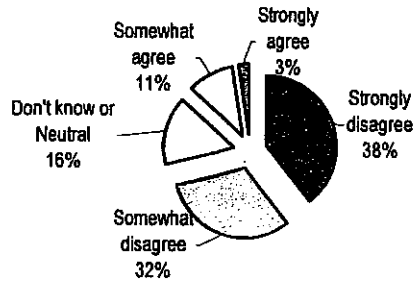
Performance Evaluation

Vern Wallace .

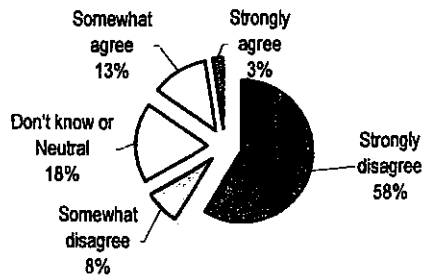
1. How often do you have contact with your Chief, Vern Wallace



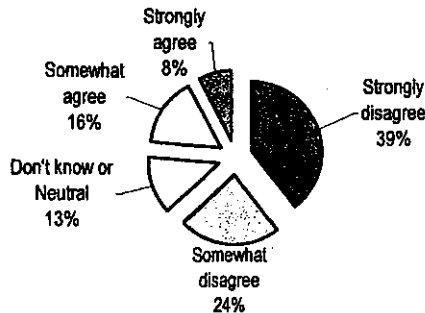
2. This manager has communicated a vision for the organization's future (for instance, in the form of a one-year and five-year plan).



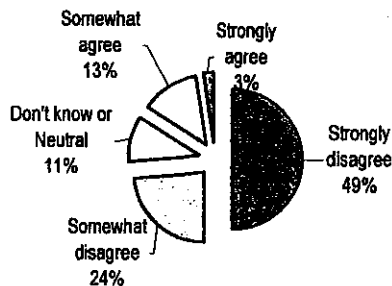
3. This manager is interested in and takes into consideration line staff's opinions when planning for the organization's future.



4. This manager is interested in and informed about all facets of the organization and challenges that face the line staff.



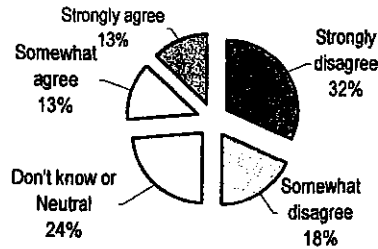
5. This manager seeks and maintains contacts and relations with line staff.



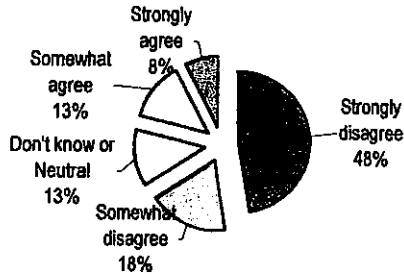
Performance Evaluation

Vern Wallace .

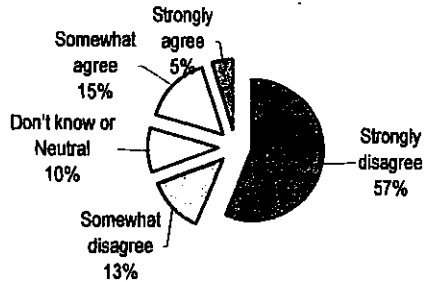
6. This manager appreciates the needs, realities, and desperation of the community mental health population.



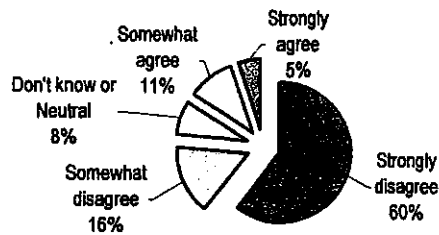
7. This manager appreciates the physical, mental, and emotional demands on direct service providers working within the community mental health system.



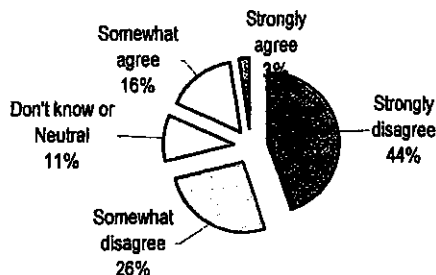
8. This manager's leadership style is collaborative and helpful.



9. This manager develops and maintains effective and collaborative relationships with line staff.



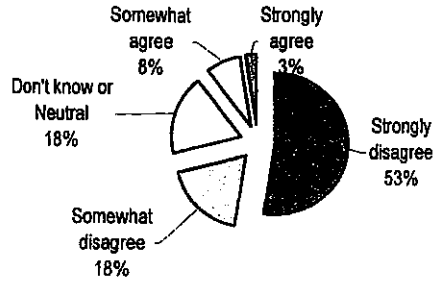
10. This manager communicates well with employees both verbally and in writing.



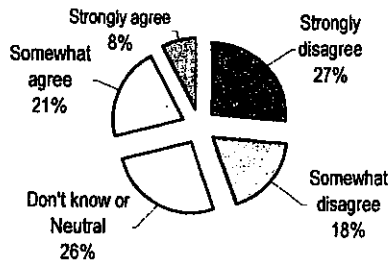
Performance Evaluation

Vern Wallace .

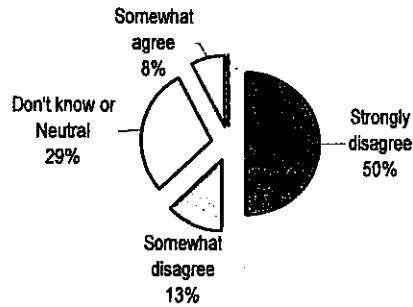
11. This manager has handled the issue of line staff productivity fairly, equitably, and competently.



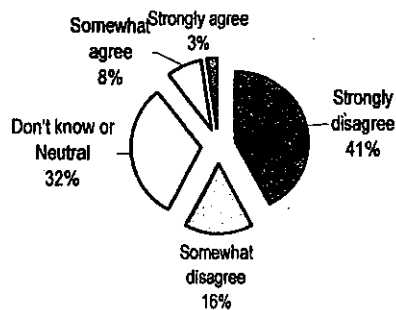
12. This manager possesses sufficient clinical understanding to competently manage line staff serving the community mental health population.



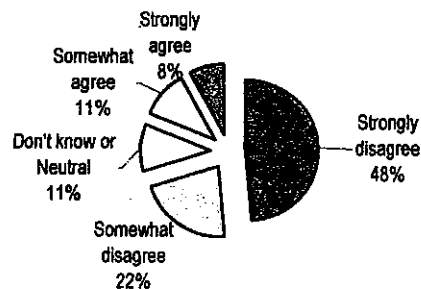
13. This manager's innovation have helped meet the objectives of the Mental Health Division.



14. This manager produces high quality work and demonstrates a high level of competence.



15. I have confidence in this manager.



Discussion - Victor Montoya, Chief of Adult Mental Health

Performance ratings for Mr. Montoya were mixed but weighted toward the positive which was a departure from his superiors, Ms. Wigand and Tavano as well as his counterpart Mr. Wallace. Not surprisingly line staff reported substantially greater contact with Mr. Montoya. 11% of respondents reported that they had contact often, 43% had contact occasionally and 33% seldom. Only 13% reported no contact. 36% of line staff believed that Mr. Montoya develops and maintains effective and collaborative relationships with employees and 35% rated his leadership style as "collaborative and helpful".

A large percentage of line staff seem to believe that Mr. Montoya understands what is going on in the trenches. 50% of respondents agreed with the statement that "this manager is interested in and informed about all facets of the organization and challenges that face the line staff", 35% disagreed. 45% believed that he is interested in and takes into consideration line staff's opinions when planning for the organization's future and 22% were neutral or did not know. On a closely related topic, two questions were considered revealing Mr. Montoya's level of engagement and interest. 44% agreed that "this manager appreciates the physical, mental, and emotional demands on direct service providers working within the community mental health system" while 50% of respondents believed that Mr. Montoya appreciates the needs, realities, and desperation of the community mental health population.

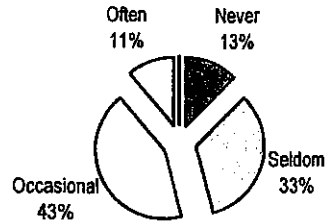
39% of respondents agreed that Mr. Montoya produced high quality work and demonstrated a high level of competence, 28% disagreed, and 33% were neutral. 38% of line staff reported that this manager's innovations have helped meet the objectives of the Mental Health Division, 31% were neutral or did not know and 31% disagreed. Strikingly different from other senior staff's evaluation was that 33% of respondents believed that Mr. Montoya has handled the issue of line staff productivity fairly, equitably, and competently, 31% were neutral and 36% disagreed.

43% communicated that they had confidence in this manager and 32% did not. 25% of respondents were neutral. This level of confidence is much greater than what we have seen for Ms. Wigand, Ms. Tavano or Mr. Wallace and it may be due to the fact that this manager is more accessible and makes more attempts to understand the day-to-day operations and assist line staff in meeting the demands placed on them.

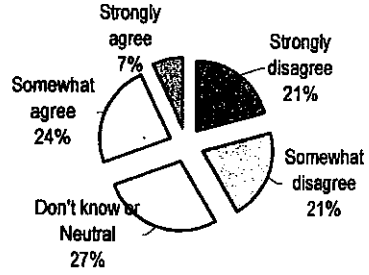
Performance Evaluation

Victor Montoya

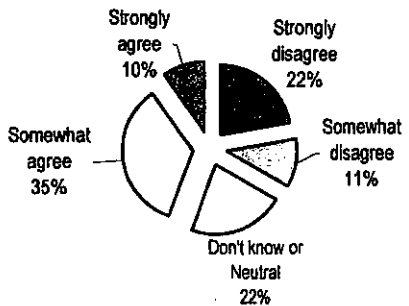
1. How often do you have contact with your Chief, Victor Montoya?



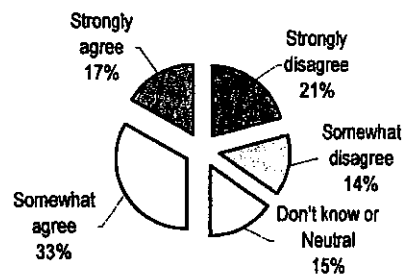
2. This manager has communicated a vision for the organization's future (for instance, in the form of a one-year and five-year plan).



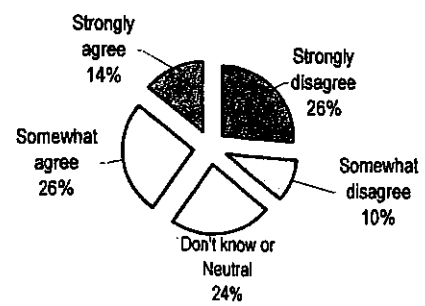
3. This manager is interested in and takes into consideration line staff's opinions when planning for the organization's future.



4. This manager is interested in and informed about all facets of the organization and challenges that face the line staff.



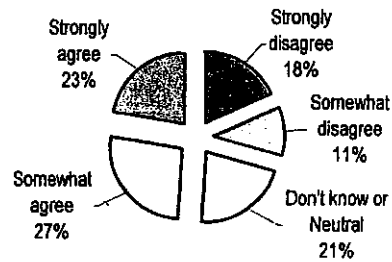
5. This manager seeks and maintains contacts and relations with line staff.



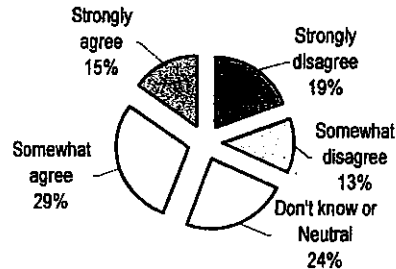
Performance Evaluation

Victor Montoya

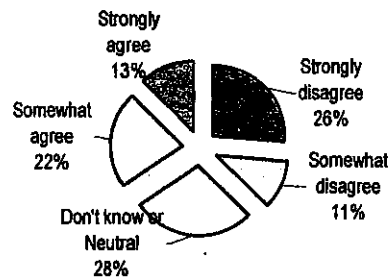
6. This manager appreciates the needs, realities, and desperation of the community mental health population.



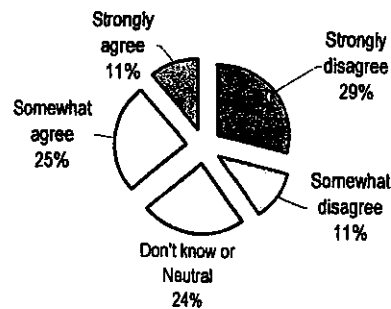
7. This manager appreciates the physical, mental, and emotional demands on direct service providers working within the community mental health system.



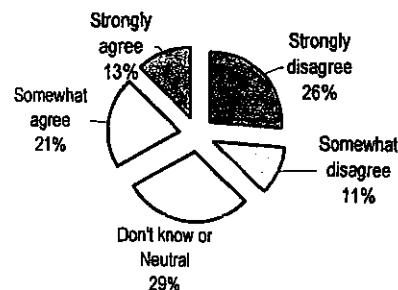
8. This manager's leadership style is collaborative and helpful.



9. This manager develops and maintains effective and collaborative relationships with line staff.



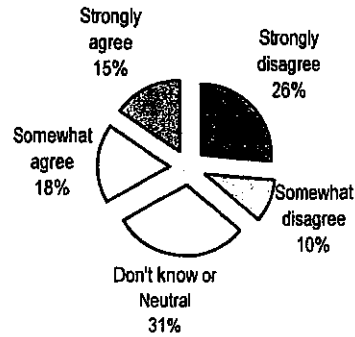
10. This manager communicates well with employees both verbally and in writing.



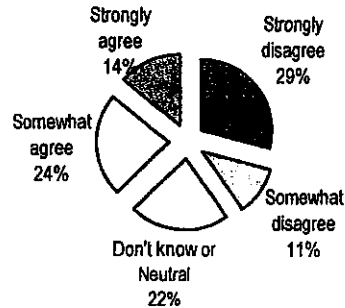
Performance Evaluation

Victor Montoya

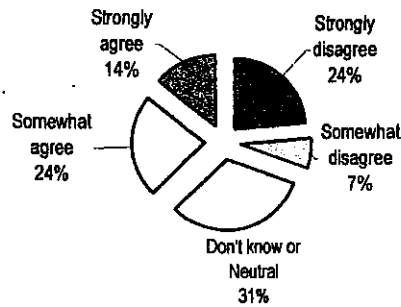
11. This manager has handled the issue of line staff productivity fairly, equitably, and competently.



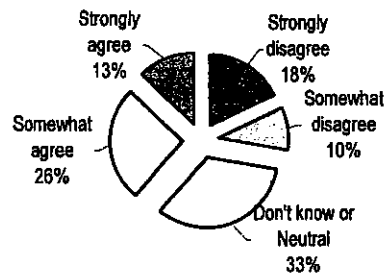
12. This manager possesses sufficient clinical understanding to competently manage line staff serving the community mental health population.



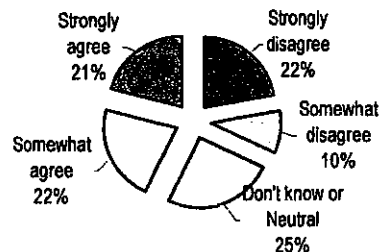
13. This manager's innovation have helped meet the objectives of the Mental Health Division.



14. This manager produces high quality work and demonstrates a high level of competence.



15. I have confidence in this manager.



CONCLUSION

This survey is an evaluation of this Administration. It was completed by 132 Local One members which constitutes 83% of the line staff work force in the Mental Health Division. Above all, this survey revealed a pervasive lack of confidence in the Mental Health Administration's two principle leaders, Ms. Wigand and Ms. Tavano, and in the Chief of Children's Services, Vern Wallace. The survey reported that most staff have never even seen their "leaders" and revealed a demoralized work force. Furthermore, it brought to light that these managers are not only seen as absent but also as ineffective, unresponsive and unable to provide an inclusive vision.

In contrast, this survey also provided positive feedback on some of the mid- managers. Those who recieved a vote of confidence greater than 65% were Grant Wyborny (70%), John Allen (87%), Cesar Court (100%), Rich Weisgal (91%) and Raymond Neuman (87%). These managers received consistently positive responses to other items included in the questionnaire.

To understand our strengths and shortcomings we must first discuss the standards that would be considered measures of "high quality" community mental health. In a 2006 report (see Appendix B), on health care systems for seriously mentally ill titled "**Grading the States**" NAMI determined that there are ten elements that characterize such systems which are as follow:

- 1) Comprehensive services and support
- 2) Integrated systems
- 3) Sufficient funding
- 4) Consumer- and family-driven systems
- 5) Safe and respectful treatment environments
- 6) Accessible information for consumers and family members
- 7) Access to acute care and long-term care treatment
- 8) Cultural Competence
- 9) Health promotion and mortality reduction
- 10) Adequate mental health workforce

The report goes on to say that a high quality mental health system should at minimum include: **a)** affordable and supportive housing, **b)** access to medications, **c)** assertive community treatment, **d)** integrated dual diagnosis treatment, **e)** illness management and recovery, **f)** family psychoeducation, **g)** supported employment, **h)** jail diversion, **i)** peer services and support, and **j)** crisis intervention services.

In the report, NAMI points out a critical issue when they write: "Complex, uncoordinated mental health service systems serve no one's interest - not providers, not families, and certainly not consumers. One important element of quality in a mental health system is the extent to which the various services required by individual consumers - and the funds used to pay for these services - are provided in the most user-friendly manner possible."

In an era of economic trouble and continuous budgetary issues, mental health services often are reviewed for cuts. NAMI's research revealed that the short-term savings through cuts to public mental health often have severe and costly long-term consequences in the form of hospitalizations, incarcerations, and other issues secondary to lack of treatment. NAMI further adds that in our efforts to transform our systems from institutionalized to community-based care, "adequate resources must be maintained for the provision of acute or long-term psychiatric treatment for those who need it" in the form of acute care beds, group homes and other 24-hour residential programs. It is also brought to attention the comorbidity of severe mental illness and serious medical disorders such as diabetes, hypertension and heart disease. "NAMI believes that a high quality mental health system must promote the overall health of those it serves through the integration of primary medical care with psychiatric treatment." Further, NAMI recognizes the shortage of qualified mental health personnel in providing these services and encourages systems to attract and nurture such individuals.

When we turn to our system of care to evaluate whether it is reaching that "high quality" mental health standard, we must look at our Mental Health Administration's leadership style and efforts. In the book "**Primal Leadership**" Daniel Goleman describes six different styles of leadership. The most effective leaders can move among these styles, adopting the one that meets the needs of the moment. They can all become part of the leader's repertoire. The first is **Visionary**. This style is adopted when an organization needs a new direction. Its goal is to move people towards a new set of shared dreams. This administration is not seen as setting forth any goals and has shown little innovation. Questions abound about the efficacy and overall systemic support provided by MHSA (Prop 63) programs while severe housing needs in the adult world remain unaddressed. The second is **Coaching**. This one-on-one style focuses on developing individuals, showing them how to improve their performance, and helping to connect their goals to the goals and vision of the organization. This administration actually discourages training and causes unnecessary and undue stress on its employees by not exempting hours spent at professional trainings from the monthly productivity calculation. The third style is **Affiliative**. This style emphasizes the importance of team work, and creates harmony in a group by connecting people to each other. Team work is not encouraged when staff never see their leaders. Leaders also lose touch with the realities of the mental health community when they do not maintain consistent communication with the employees who directly serve clients and families. The end result are leaders who are not informed about day-to-day operations. For example, at a June 2009 Board of Supervisors' Finance Committee meeting, Ms. Wigand informed County Supervisor Bonilla that there was an MHRS component at Crestwood- Pleasant Hill when it had been closed and converted to a Board & Care many months ago. The fourth is **Democratic**. This style draws on people's knowledge and skills, and creates a group commitment to the resulting goals. Attempts to get input from the staff that actually becomes part of the decision process are very limited at best by this administration, otherwise helpful insight could be provided that could result in enriched services and elimination of waste. The fifth is **Pacesetter**. In this style, the leader sets high standards for performance. He or she is "obsessive about doing things better and

faster, and asks the same of everyone." Goleman warns that this style should be used sparingly, because it can undercut morale and make people feel as if they are failing. He says that, more often than not, his data shows that pacesetting poisons the climate. Survey results indicate that line staff perceive the Mental Health Administration to be asking them to work better and faster but question whether this Administration is setting similar expectations and standards for itself. The sixth is **Commanding**. Goleman says that "this is a classic model of "military" style leadership - probably the most often used, but the least often effective." It undercuts morale, job satisfaction, and performance. Survey responses indicate that the majority of the line staff view management as having only one style, the commanding, or autocratic, as other leadership theorists call it.

The implementation of the productivity policy is an illustration of this Administration's autocratic approach to leadership. Given the budgetary realities of recent years, line staff appreciates the need to increase productivity and generate revenue. However, the results of the survey reflect a widespread dissatisfaction with the manner in which the policy is being implemented. Management is seen as acting in a unilateral, unreasonable, arbitrary, inflexible and punitive style without regard or consideration for unique work circumstances. There are many examples of this. Staff are given no consideration for productivity and are subject to punishment when they serve as team leaders and accept additional administrative responsibilities; or when their clients are in non-billable "lock-out" facilities and professional/ethical standards demand that these clients be served; or when they participate in second level chart reviews to support quality assurance and reduce the risk of financially damaging audits; or for serving as clinical supervisors and providing training to support intern programs as well as for attending training to further their own professional development.

Perhaps the most obvious examples of this Administration's arbitrary and rigid approach to productivity is its refusal to average staff productivity on a quarterly basis or to look at the obstacles faced by line staff in Children's to make appointments when schools are out. This has resulted in unwarranted disciplinary actions without merit, and waste of time and taxpayers' money. Attempts by Roland Katz of Local One to engage in a collaborative process with the Administration about productivity issues have all been met with steadfast refusal (see Appendix A). When increased productivity could be achieved either through inclusiveness, cooperation and respect, or through intimidation and punishment, with its ensuing alienation of line staff, it is difficult to understand this administration's choice of the latter. Fairness is another issue that has been left out of this productivity discussion and must be considered. Although staff may have the same classification and compensation, all staff are not subjected to the same productivity standards and/or disciplinary actions. Research shows that employee perceptions of injustice have direct implications for job satisfaction and trust in management.

In review of NAMI's 2006 report, and in consideration of the fact that 65% of respondents to this survey expressed an interest to see an independent review of the Division's operations, the following questions arise regarding our own system:

With respect to item **a) housing**, we ask: when housing remains such a great obstacle to serving adult clients and has bottlenecked available hospital beds, locked facilities, residential programs, shelters, etc. why hasn't this Administration been more proactive in utilizing the funds made available through MHSA for this very purpose when others such as San Francisco and Alameda Counties have three housing plans already approved and have a housing coordinator? Why has the original figure for Contra Costa County through MHSA Housing Funds, held at the state level (Department of Mental Health), been reduced? (see Appendix C) When we have been bombarded by budgetary restraints year after year, why has this administration placed too much of its financial business in the hands of a large organization such as Crestwood and continues to augment their services \$100-\$145 per day per patient? What extra is provided to these clients that would justify an estimated potential annual augmentation of \$5,249,472.00 to the Pleasant Hill and Vallejo facilities when the mere handful of small Board and Cares receive an augmentation of \$18-\$20 per day? Contra Costa County Auditor's records indicate that a total of \$32,374,705.32 was paid to Crestwood for the period of 11/10/2005 to 11/10/2009 (see Appendix D).

With respect to **b) access to medications**, we ask: when finances continue to be a concern of this county, why this Administration has not utilized patient assistance programs offered through pharmaceutical companies to provide medication coverage for the uninsured that can potentially relieve this county from a million dollar burden? Why are we the only county in the Bay Area refusing to take advantage?

With respect to **c) assertive community treatment**, when 70% of Contra Costa County Mental Health Services have been contracted out, why hasn't there been performance metrics put in place to measure the effectiveness of these programs? What standards are they subjected to and how are they accountable when they don't meet their goals? (see Appendix C) In regards to the dollars allocated to Capital Facilities from MHSA, Why is Contra Costa the only county offering its residents one choice and one choice only in the form of the proposed Psychiatric Pavilion at 20 Allen Street in Martinez, next to the current hospital and crisis unit only to be run again by an entity such as Crestwood?

With respect to **d) integrated dual diagnosis treatment**, with approximately 70% of mental health's clients dually diagnosed, why isn't there a greater array and more availability of services so this large population is not solely dependent on the limited capacity of Nevin House in Richmond, CA?

With respect to **f) family psychoeducation**, why is there no support for families at the structural level?

With respect to **j) crisis services**, why is there no mobile community outreach to prevent or reduce costly hospitalizations?

Beyond these issues there is a question of allocation of resources. Why is it necessary to have 1.3 administrators to every three line staff in Mental Health? Why is it

necessary to convert these administrative positions to MHSA positions at every opportunity? With six regional clinics, including both Adults and Children's, and a handful of other specialty programs, why is it necessary to have a director and a deputy director? Why is it necessary to have program managers that do not manage any staff? This is certainly a poor example of the "lean methodology" typified by the Toyota Model which we understand is endorsed by the Health Services Director, William Walker, MD. Why is it necessary to have such centralized administrative structure? Why doesn't this Administration engage line staff in system-related planning and development, the need for which is greater than ever before, in this time of increasing demand for services and dwindling resources?

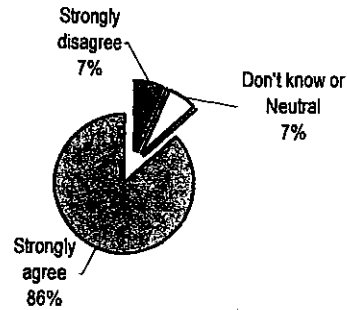
In closing, Goleman goes on to say that in the old economy the focus was on efficiency. "But in the new economy, where value comes increasingly from the knowledge of people, and where workers are no longer undifferentiated cogs in an industrial machine, management and leadership are not easily separated. People look to their managers, not just to assign them a task, but to define for them a purpose. And managers must organize workers, not just to maximize efficiency, but to nurture skills, develop talent and inspire results." It is with great sadness that we report that the times have passed this Administration by, and it is left only with the old smoke-stack leadership style. We firmly believe that this County's taxpayers and mental health consumers are deserving of much more.

PROGRAM MANAGERS

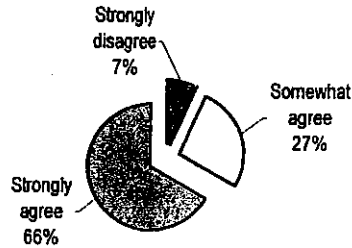
Performance Evaluation

John Allen

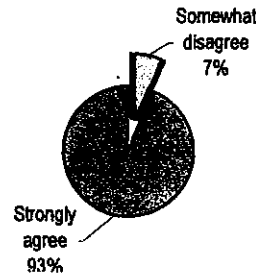
1. The manager appreciates the needs, realities, and desperation of the community mental health population.



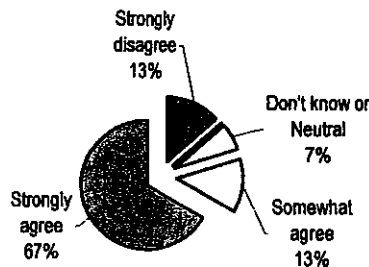
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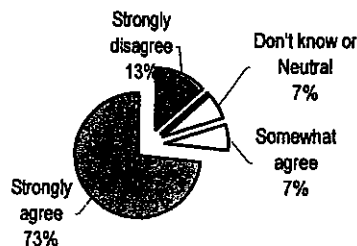
3. This manager possesses sufficient clinical understanding to completely manage line staff serving the community mental health population.



4. This manager is interested in and takes into consideration line staff's opinions when managing one's work site.



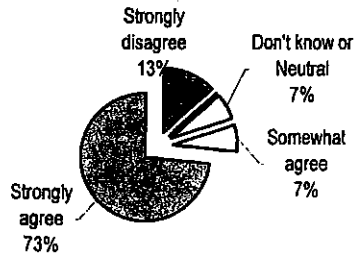
5. This manager seeks and maintains contacts and relations with line staff.



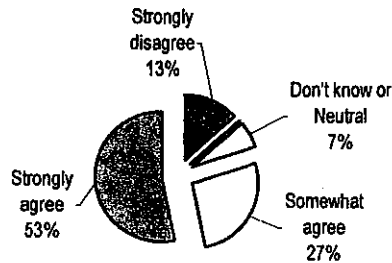
Performance Evaluation

John Allen

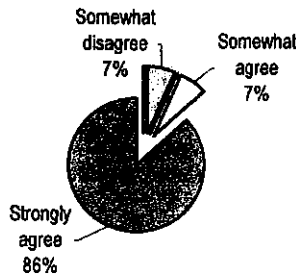
6. This manager's leadership style is collaborative and helpful.



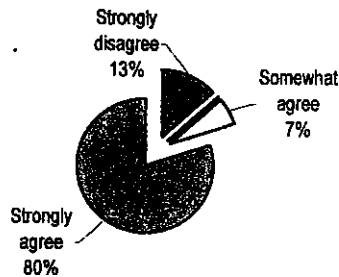
7. This manager has handled the issue of line staff productivity fairly, equitably, and competently.



8. This manager produces high quality work and demonstrates a high level of competence.



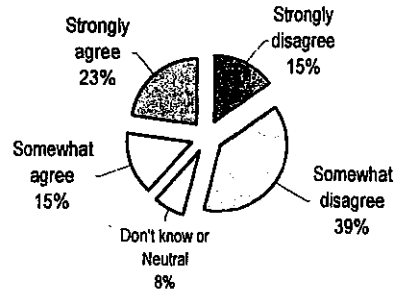
9. I have confidence in this manager.



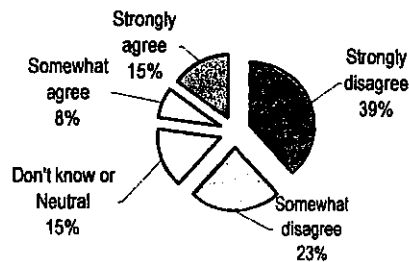
Performance Evaluation

Eileen Brooks

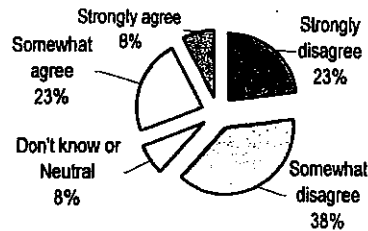
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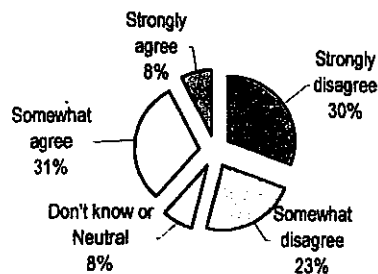
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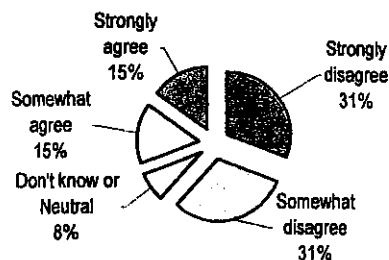
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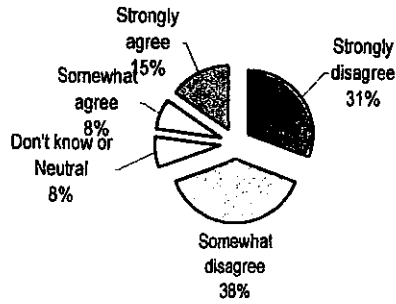
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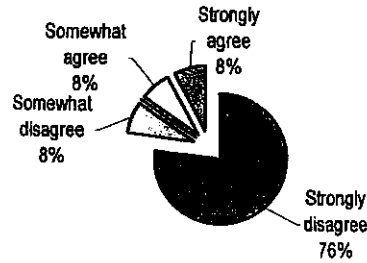
Performance Evaluation

Eileen Brooks

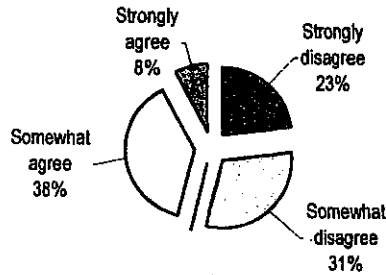
6. This manager's leadership style is collaborative and helpful.



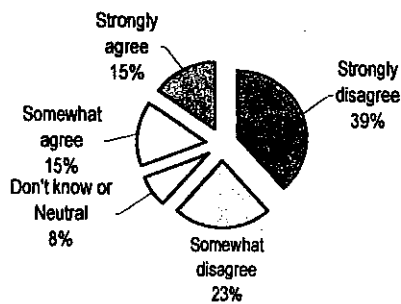
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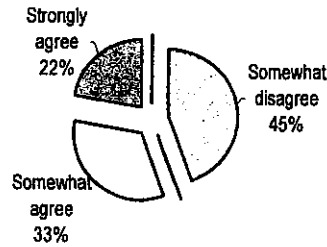
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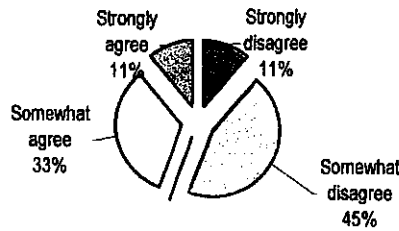
Performance Evaluation

Cheryl Bryan

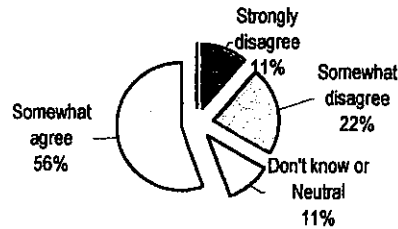
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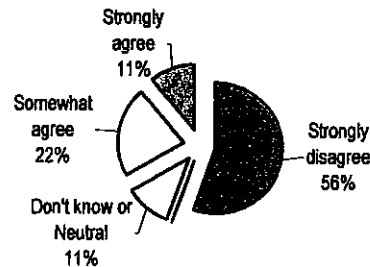
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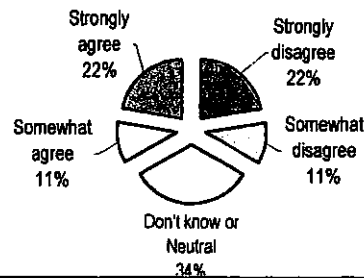
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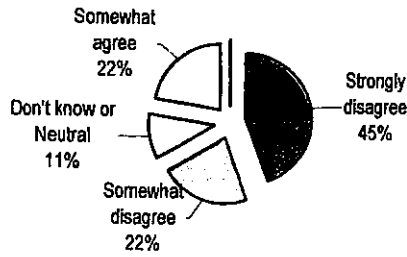
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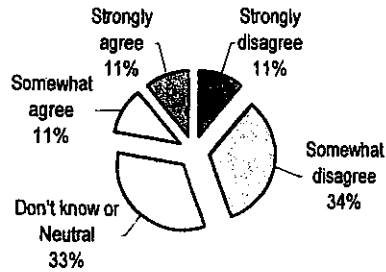
Performance Evaluation

Cheryl Bryan

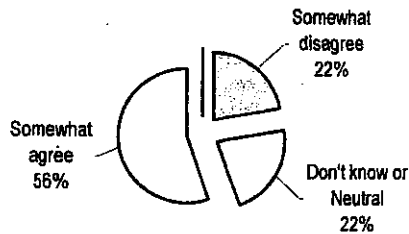
6 This manager's leadership style is collaborative and helpful.



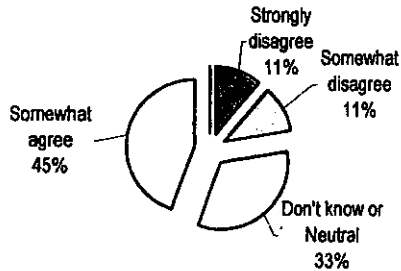
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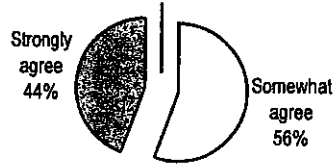
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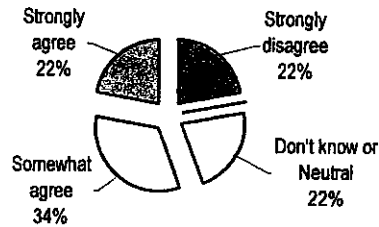
Performance Evaluation

Genoveva Calloway

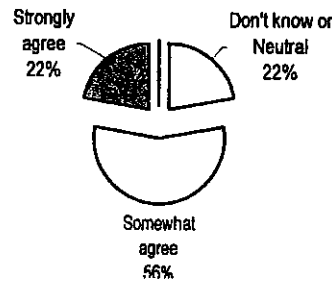
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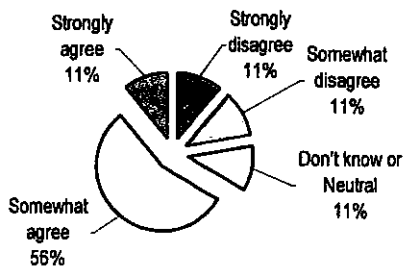
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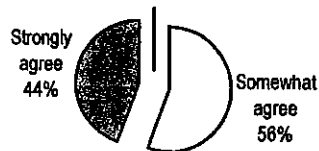
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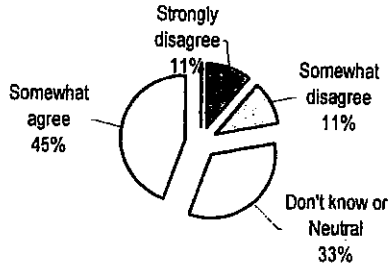
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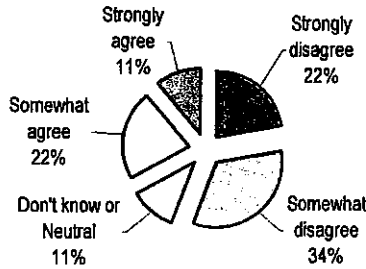
Performance Evaluation

Genoveva Calloway

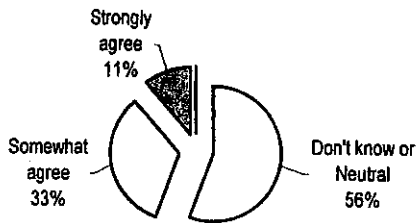
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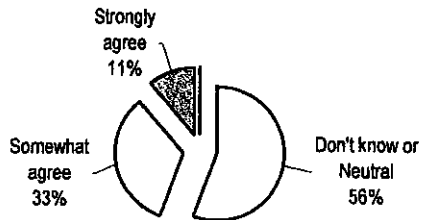
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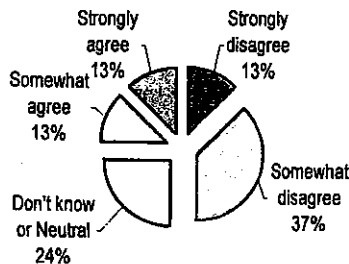
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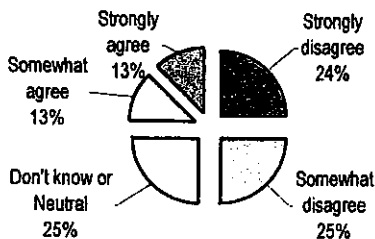
Performance Evaluation

Eric Cho

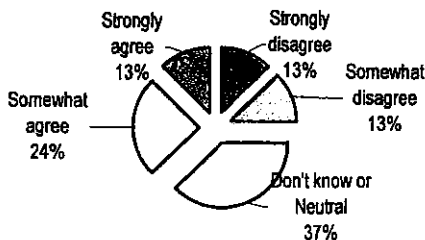
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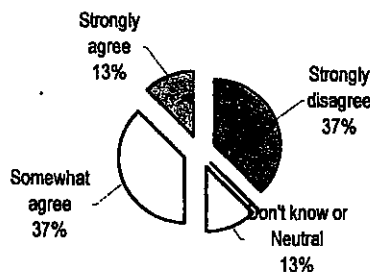
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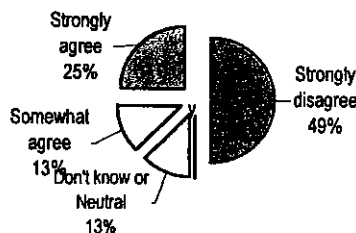
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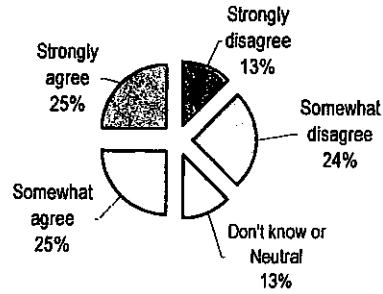
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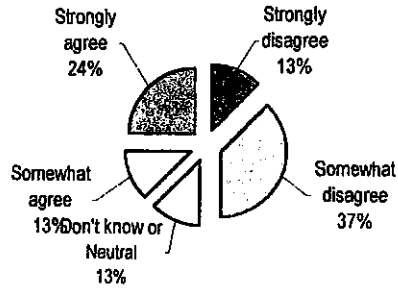
Performance Evaluation

Eric Cho

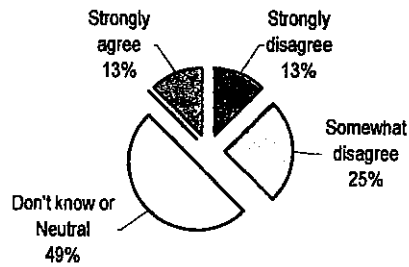
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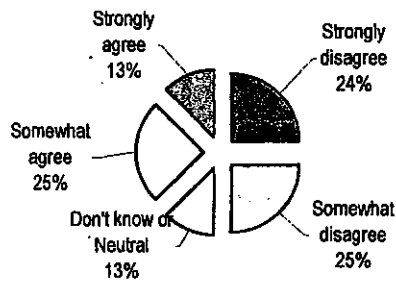
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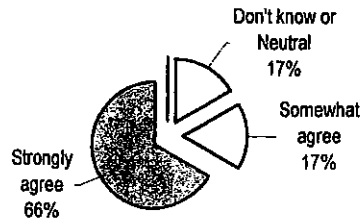
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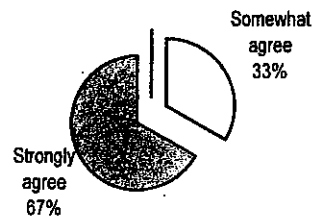
Performance Evaluation

Cesar Court

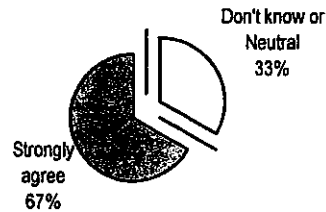
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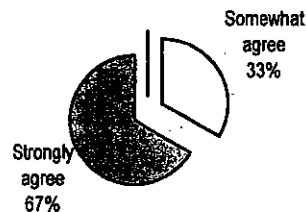
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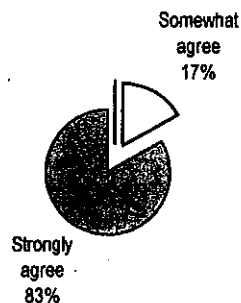
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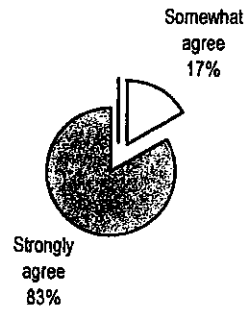
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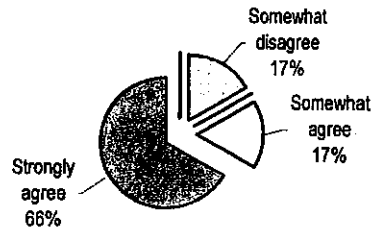
Performance Evaluation

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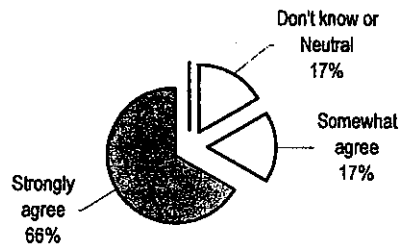
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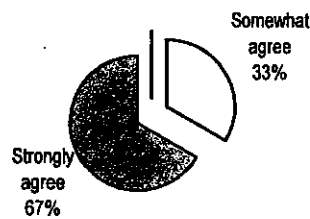
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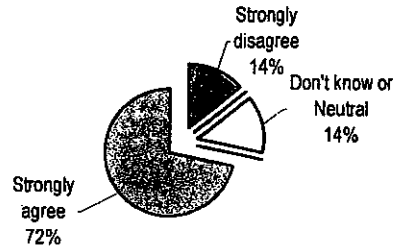
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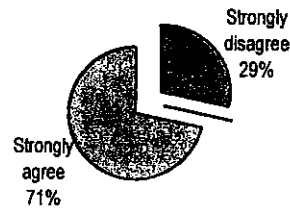
Performance Evaluation

John Hollander

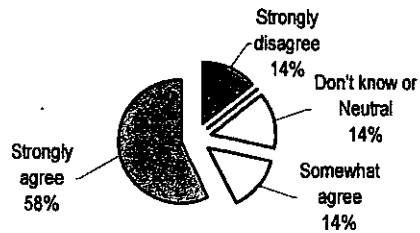
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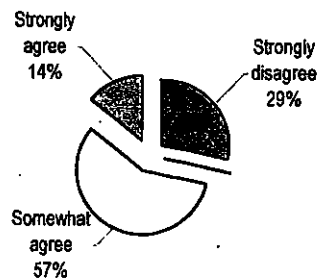
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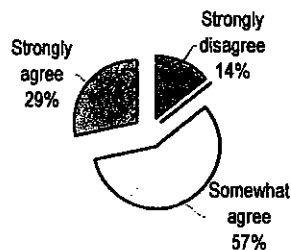
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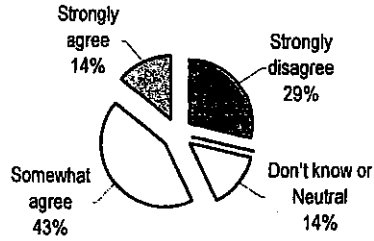
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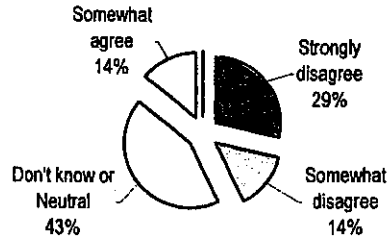
Performance Evaluation

John Hollander

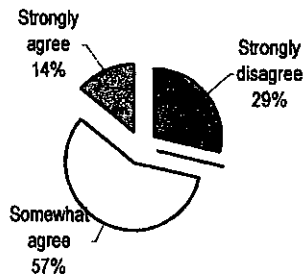
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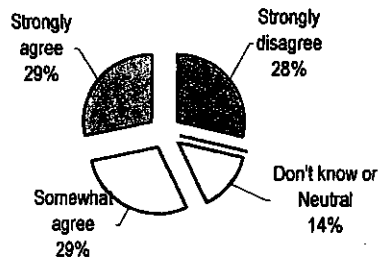
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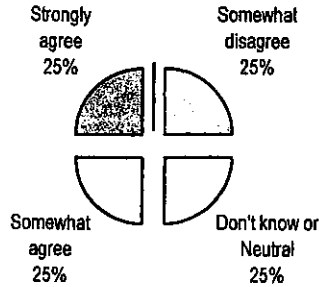
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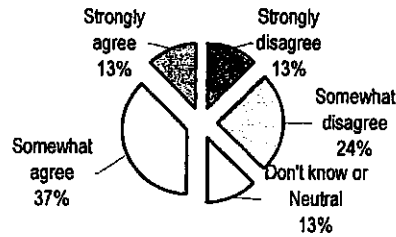
Performance Evaluation

Sandy Marsh

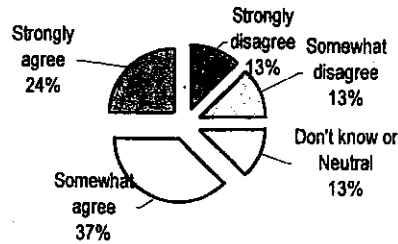
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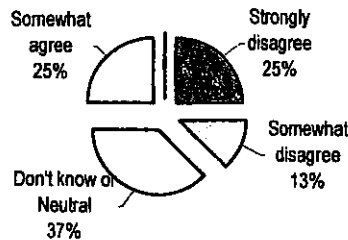
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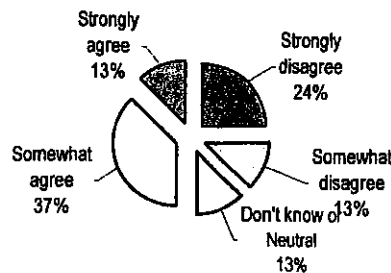
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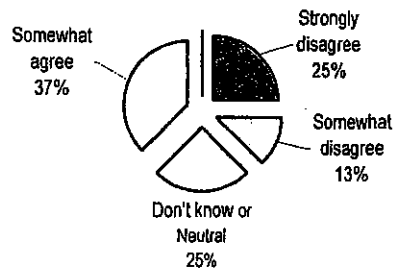
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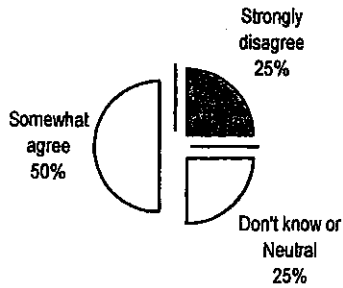
Performance Evaluation

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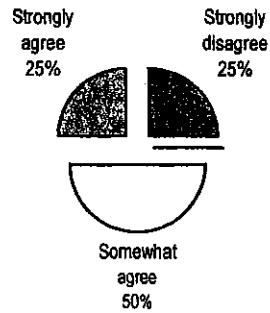
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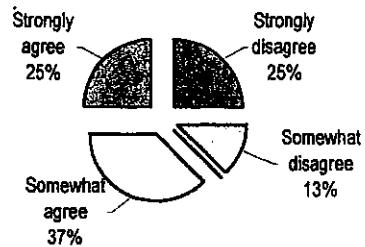
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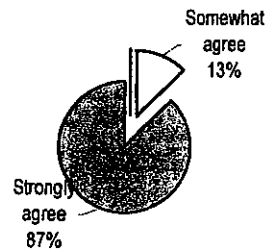
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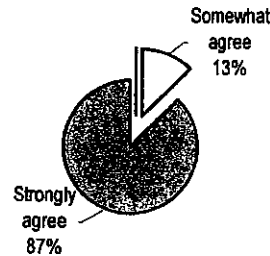
Performance Evaluation

Raymond Neuman

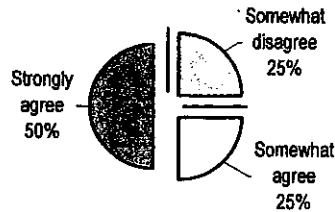
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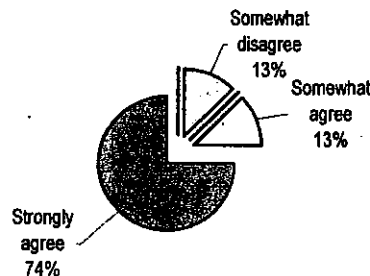
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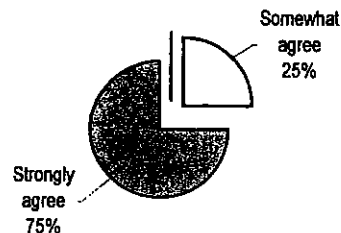
3. This manager possesses sufficient clinical understanding to completely manage line staff serving the community mental health population.



4. This manager is interested in and takes into consideration line staff's opinions when managing one's work site.



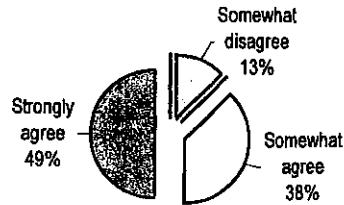
5. This manager seeks and maintains contacts and relations with line staff.



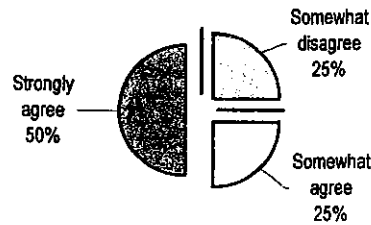
Performance Evaluation

Raymond Neuman

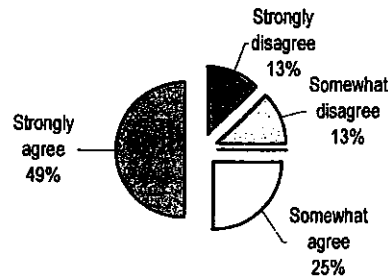
6. This manager's leadership style is collaborative and helpful.



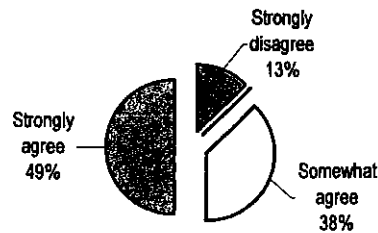
7. This manager has handled the issue of line staff productivity fairly, equitably, and competently.



8. This manager produces high quality work and demonstrates a high level of competence.



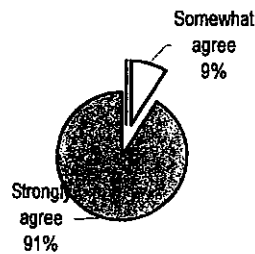
9. I have confidence in this manager.



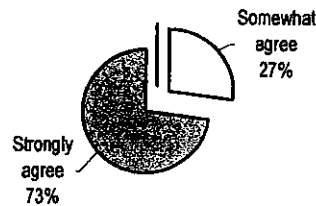
Performance Evaluation

Rich Weisgal

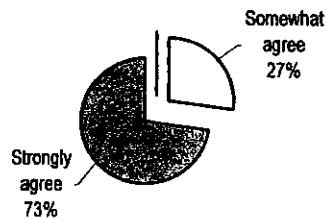
1. The manager appreciates the needs, realities, and desperation of the community mental health population.



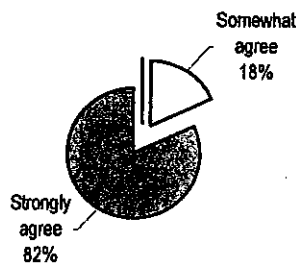
2. The manager appreciates the physical, mental, and emotional demands on direct service providers working within the community mental health system.



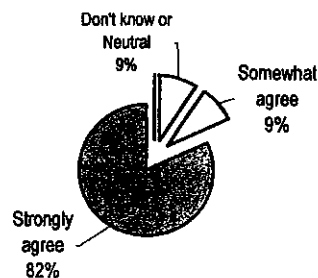
3. This manager possesses sufficient clinical understanding to completely manage line staff serving the community mental health population.



4. This manager is interested in and takes into consideration line staff's opinions when managing one's work site.



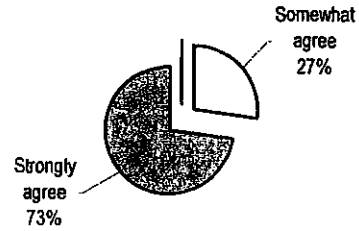
5. This manager seeks and maintains contacts and relations with line staff.



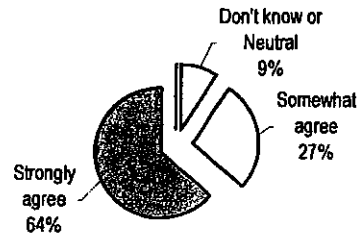
Performance Evaluation

Rich Weisgal

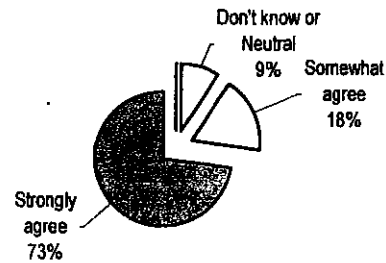
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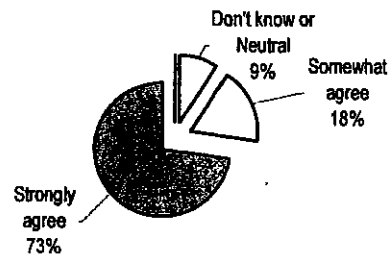
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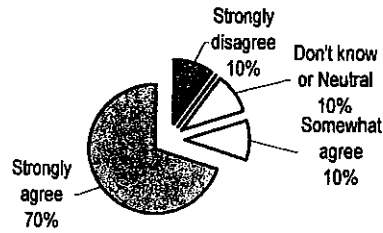
9. I have confidence in this manager.



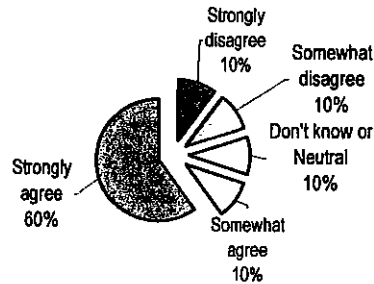
Performance Evaluation

Grant Wyborny

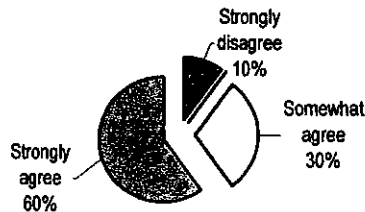
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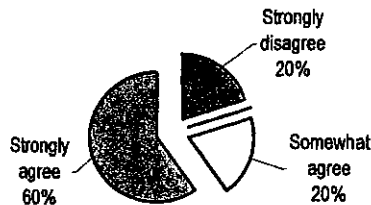
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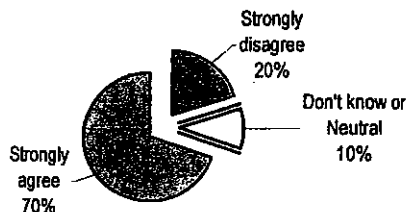
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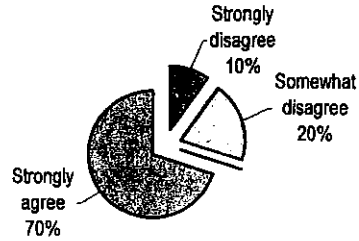
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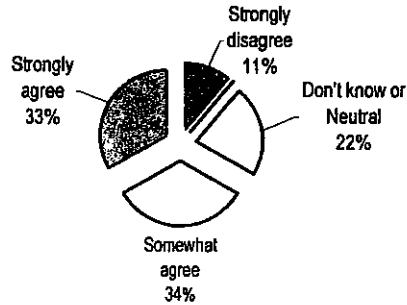
Performance Evaluation

Grant Wyborny

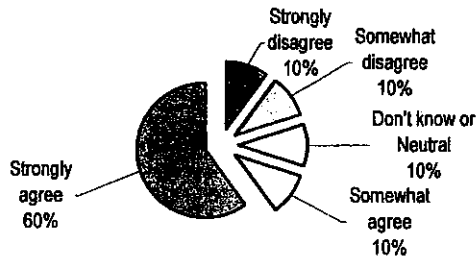
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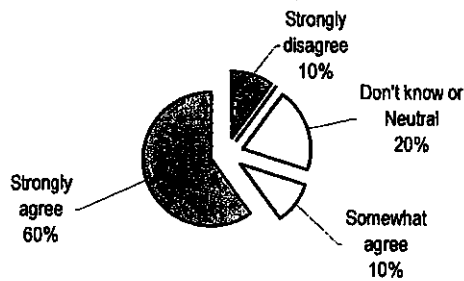
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9. I have confidence in this manager.



APPENDIX A



Public Employees Union, Local One

THE UNION FOR PUBLIC EMPLOYEES
ORGANIZED 1941

Mailing Address: PO Box 6783, Concord, CA 94524 ♦ Union Hall: 5034 Blum Road, Martinez
Phone: (925) 228-1600 ♦ Toll Free: 1-800-585-0054 ♦ Fax: (925) 228-1099
www.peu1.org ♦ info@peu1.org

June 15, 2009

Donna Wigand, LCSW
Director
Mental Health Services
Health Services Department
Contra Costa County
1340 Arnold Dr.
Martinez, CA 94553

Re: Productivity- Discipline

Dear Ms. Wigand:

Over the last several months, management has issued reprimands, Skelly Notices and Orders and Notices of Disciplinary Action. Each was premised on allegations that the employee subject to the action had not complied with the "productivity" policy, to wit: the employee allegedly had not met the "productivity" standard. I understand that each disciplinary action that we have grieved has been set aside and that in some instances disciplinary action was not taken after we responded to the Skelly Notice.

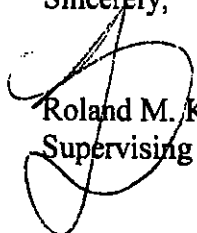
The net result of these efforts has been that employees have not been disciplined, management has wasted the taxpayers' money pursuing these actions which were ultimately set aside and our members' morale has been adversely affected. In our opinion, not only has nothing of value been gained by this effort my management, but real harm has been done to the Mental Health Division.

We should start anew to address our common and shared interests to, among other things, maximize reimbursement for services our members provide. From the beginning, we have stated our willingness to meet collaboratively with you and your management staff to discuss means by which we can achieve our common objective. The choice is still yours- management can continue down the path of confrontation by continuing to discipline employees regardless of merit, or management can join us on a path of cooperation.

Please let me know if you want to meet with us to discuss how we can move forward.

Thank you.

Sincerely,



Roland M. Katz
Supervising Business Agent

- c: John Gagnani, Unit President
- Debra Sell, Unit Vice President/Negotiator
- James Kenshalo, Chief Shop Steward
- All Unit members
- Larry Edginton, General Manager
- Bill Schlant, Sr. Business Agent
- William Walker, M.D., Director Health Services
- Ted Cwiek, Assistant County Administrator/Human Resources Director



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www.peu1.org ♦ info@peu1.org

July 30, 2009

Donna Wigand, LCSW
Director
Mental Health Services
Health Services Department
Contra Costa County
1340 Arnold Dr.
Martinez, CA 94553

Re: Productivity- Discipline

Dear Ms. Wigand:

We are surprised and disappointed that you have not responded to my June 15, 2009 letter regarding productivity and discipline.

We continue to be more than willing to meet with you to start anew to address our common and shared interests to, among other things, maximize reimbursement for services our members provide. As I said in my June 15th letter, "The choice is still yours- management can continue down the path of confrontation by continuing to discipline employees regardless of merit, or management can join us on a path of cooperation."

Please let me know if you want to meet with us to discuss how we can move forward.

Thank you.

Sincerely,


Roland M. Katz
Supervising Business Agent

c: John Gragnani, Unit President
Debra Sell, Unit Vice President/Negotiator
James Kenshalo, Chief Shop Steward
All Unit members
Larry Edginton, General Manager
Bill Schlant, Sr. Business Agent
William Walker, M.D., Director Health Services
Ted Cwiek, Assistant County Administrator/Human Resources Director

WILLIAM B. WALKER, M.D.
Health Services Director
DONNA M. WIGAND, L.C.S.W.
Mental Health Director



CONTRA COSTA
HEALTH SERVICES

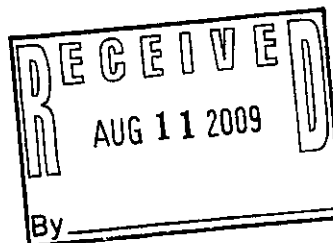
CONTRA COSTA
MENTAL HEALTH

ADMINISTRATION

1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5150
Fax 925/957-5156

August 7, 2009

Roland M. Katz
Supervising Business Agent
Public Employees Union, Local One
P.O. Box 6783
Concord CA 94524



RE: Productivity-Discipline

Dear Mr. Katz:

Thank you for your correspondence of 6/15/09 and 7/30/09. While I appreciate that you have continued concerns, I must admit that we perceive this process of working on individuals' productivity in very different ways.

Because of due diligence on both management and a great majority of your members, in the last 1½ yrs in particular, productivity, and therefore billable services rendered, has significantly increased. Two years ago, there were approximately two dozen individuals who apparently could not maintain spending at least 55% of their time performing these activities. Because of the work that has been done in the last 1½ yrs on both sides, that number is now down to a handful. There has been real progress made.

I believe that the great majority of your members have really focused on this issue, and have worked in partnership with management to be able to generate more revenue in order to preserve this Mental Health System so that much needed services can continue to be delivered to this County's residents. We will continue to work with the few individuals remaining in this system, who after several years appear to continue to have difficulty responding to the minimum standard of practice. These few individuals in no way overshadow the great amount of effort that the vast majority of your members and my managers have put into this endeavor.

So, in essence, we believe that for the great majority of staff that the "path" you refer to in your correspondence has been one of cooperation, and not confrontation.

-1-

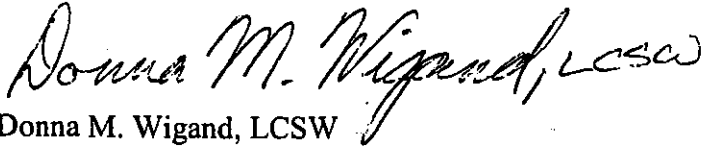


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Roland M.Katz, Supervising Business Agent
Re: Productivity-Discipline
Page 2

If you would like to discuss this further with me, please don't hesitate to contact me at 925-957-5111.

Sincerely,



Donna M. Wigand, LCSW
Mental Health Director

DMW:jd

Cc: Ted Cwiek, Assistant County Administrator/Human Resources Director
William Walker, M.D., Health Services Director
Suzanne Tavano, Deputy Director of Mental Health
Vic Montoya, Adult/Older Adult Program Chief
Vern Wallace, Children/Adolescent Program Chief
Larry Edginton, General Manager Local One
Bill Schlant, Senior Business Agent-Local One
John Gragnani, Unit President
Debra Sell, Unit Vice President/Negotiator
James Kenshalo, Chief Shop Steward



Public Employees Union, Local One

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www.peu1.org ♦ info@peu1.org

September 8, 2009

Donna Wigand, LCSW
Director
Mental Health Services
Health Services Department
Contra Costa County
1340 Arnold Dr.
Martinez, CA 94553

Re: Productivity- Discipline

Dear Ms. Wigand:

I am writing to respond to your August 7, 2009 letter. We continue to be disappointed in your apparent unwillingness to meet with us to discuss the Division's approach to "Productivity" which at this point seems to be nothing more than a rote application of discipline based upon numbers alone.

We understand the importance of our members performing billable work. We also believe you and your managers are making a grave mistake if you believe that this ongoing challenge has been reduced to a handful of members who aren't spending enough time performing billable services and that the way to address that "problem" is to "write them up" and then discipline them.

Your managers, presumably at your direction, are continuing to take a rigid and confrontational approach to this issue. 55% "Productivity," no "write up," no discipline." 54% productivity, a counseling memo, followed by a reprimand, followed by a loss of pay, without any determination of the facts and circumstances that may have given rise to those numbers.

We've had a member tell us of receiving a counseling memo (being "written up") because the member's number for one month was less than 55% (more than 50%). This member told us of regularly having numbers in the 70%.

And what about the member whose numbers are 60%, 62%, 57%, 63%, 54%, 59, 61%? Will that member get a counseling memo for the month the member had a 54%? If the member has three more months over 60%, and then a month with 53% will that member be reprimand for the 53% or will management manage and make some evaluation of the facts and circumstances that have led to those numbers. Compare that member to the member has 55%, 56%, 55%, 55%, 57%, 56%, 55%. Presumably, member # 2 will never receive a counseling memo or be disciplined, even though member # 2 might average fewer "productive" hours per month than his/her colleague, member # 1, who has received a counseling memo and been reprimanded (disciplined).

We continue to be more than willing to meet with you to start anew to address our common and shared interests to, among other things, maximize reimbursement for services our members provide. As I said in my June 15th and July 30th letters, "The choice is still yours- management can continue down the path of confrontation by continuing to discipline employees regardless of merit, or management can join us on a path of cooperation."

Please let me know if you want to meet with us to discuss how we can move forward.

Thank you.

Sincerely,



Roland M. Katz
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All Unit members
Larry Edginton, General Manager
Bill Schlant, Sr. Business Agent
William Walker, M.D., Director Health Services
Ted Cwiek, Assistant County Administrator/Human Resources Director

APPENDIX B



Grading the States 2006

A Report on America's Health Care System for Serious Mental Illness

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[Overview](#)

[State by State](#)

[Methodology](#)

[Recommendations](#)

[Full Report](#)

[Newsroom](#)

Grading the States 2006: Standards for a Quality Mental Health System: A Vision of Recovery

The starting point for conducting a comprehensive evaluation of state mental health services is to define what a good public mental health system looks like. This section of the report outlines the standards NAMI used to conduct this evaluation.

In setting forth these standards, we acknowledge that no State Mental Health Authority (SMHA) has unilateral control over all elements of mental health services in its state. In a number of states, responsibility for administering community mental health services is vested at county levels, with the state responsible for such functions as running hospitals, setting standards for community services, setting rates, and monitoring provider performance.

Moreover, multiple state agencies, not just the SMHA, affect in some way the provision of mental health services. These agencies include corrections, housing, vocational rehabilitation, Medicaid, and others.

Despite these factors, our assumption in conducting this evaluation is that the SMHA plays the most critical role in organizing and implementing the statewide system of services and coordinating the various funding streams that help support these services. As the state agency directly responsible for mental health services, the SMHA therefore ultimately must be held accountable for how these services are organized and delivered.

Based on NAMI's review, we have determined that high quality state mental health systems are characterized by the following 10 elements.

1. Comprehensive services and support
2. Integrated systems
3. Sufficient funding
4. Consumer- and family-driven systems
5. Safe and respectful treatment environments
6. Accessible information for consumers and family members
7. Access to acute care and long-term care treatment
8. Cultural competence
9. Health promotion and mortality reduction
10. Adequate mental health workforce

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1. Comprehensive Services and Supports

Today, it is widely understood that a diagnosis of a serious mental illness need not relegate a person to a lifetime of suffering or dependency. With appropriate services and supports, people with serious mental illnesses can and do recover and lead lives that are productive and meaningful. Moreover, the term "recovery" does not mean simply relieving or controlling medical symptoms. It focuses more broadly on the process of restoring "self-esteem and identify and on attaining meaningful roles in society." Recovery also does not necessarily refer to "curing" mental illness, but rather describes a process of restoring consumers' independence, self-sufficiency, dignity, and personal fulfillment.

Serious mental illnesses affect people in a wide variety of ways. Therefore, the specific services needed and the intensity of those services will vary from person to person. However, a high quality mental health system should, at a minimum, include the following services.

A. Affordable and supportive housing.

Housing is the cornerstone of recovery for people with serious mental illnesses. Without stable housing, it is very difficult for consumers to benefit from other services. Supportive housing is an approach that combines affordable housing with supportive services to help people with serious mental illnesses achieve stable and productive lives. Supportive housing has proven effective in alleviating homelessness and aiding recovery.

Unfortunately, supportive housing options are in short supply in most parts of the country due to federal cuts in vital programs such as Section 8 and Section 811, and the prohibitive costs of housing. Nationally, the average monthly cost of a one-bedroom rental apartment exceeds the total amount of monthly income under Supplemental Security Income (SSI). Thus, even though SMHAs may not be directly responsible for funding housing programs, NAMI believes that it is very important for these agencies to be integrally involved in strategies to develop supportive housing opportunities for consumers at both state and local levels.

B. Access to medications.

Significant progress has been made in the past several decades in discovering medications that alleviate and help to control the most profound symptoms of serious mental illnesses such as schizophrenia, bipolar disorder, and major depression. Medication decisions are best made on an individualized basis, taking into consideration factors such as consumers' past treatment history, side effect profiles, and other clinical concerns. A high quality mental health system should include full access to approved psychiatric medications and should enable clinicians, in partnership with consumers, to make informed medication decisions tailored to the individual. The system also should include mechanisms for providing physicians with feedback about

prescribing patterns and ongoing education about best practices.

C. Assertive Community Treatment (ACT).

ACT is the most studied and widely adopted model for addressing the needs of people with serious mental illnesses who require multiple services at a high intensity and level of support. ACT programs are characterized by inclusion of all key service components (mental health, substance abuse, etc.) under one administrative entity; low staff-to-client ratios; services that are available on a 24-hour, seven-day-a-week basis; a client-centered program philosophy that encourages the provision of services at whatever location that client prefers; and a mobile crisis management capability. While relatively expensive, ACT programs have a track record of success in reducing far costlier hospitalizations and other adverse consequences of lack of treatment.

D. Integrated Dual Diagnosis Treatment (IDDT).

IDDT is an evidence-based program designed for people with co-occurring mental illnesses and substance abuse disorders. It is characterized by both mental health and substance abuse treatment provided at the same time and in one setting. Research results demonstrate that integrated approaches to mental health and substance abuse treatment are more effective and produce better outcomes than non-integrated approaches.

E. Illness Management and Recovery.

Illness management programs are intended to educate consumers about their mental illness so they may make informed decisions and generally manage the course of their illness effectively. These programs generally are conducted by professionals and are distinguished from illness-self-management programs which are conducted by peers. While these programs provide strategies for minimizing symptoms and preventing relapse, many go further and try to help recipients achieve personal goals and recovery. Research conducted on these programs provides promising indications that they are successful in increasing consumer knowledge and fostering recovery.

F. Family psychoeducation.

Family psychoeducation programs are designed to educate and inform family members about the mental illness of a loved one and to participate in a meaningful and informed way, in partnership with consumers and providers, in helping to prevent relapse and to foster recovery. Studies show a reduction in relapse and re-hospitalization rates among consumers whose families have participated in family psychoeducation programs.

G. Supported Employment.

Supported employment is an evidence-based approach to helping consumers find and maintain competitive employment. Unlike the traditional approach to vocational rehabilitation, which involved job training and subsequent job placement, supported employment follows a "place and train" model. People with mental illnesses are helped to find a suitable job and are provided with job coaching and related services designed to help them keep it. Research on supported employment demonstrates its effectiveness in improving employment outcomes for consumers.

H. Jail Diversion.

Jails and prisons have become de facto psychiatric treatment facilities. It is conservatively estimated that 16 percent of all inmates - more than 300,000 people - in U.S. jails and prisons suffer from serious mental illnesses. Jail diversion programs are collaborations between criminal justice and mental health systems designed to link individuals (primarily non-violent offenders diagnosed with serious mental illnesses or co-occurring mental illness and substance abuse disorders) with appropriate services instead of incarceration. Jail diversion strategies include pre-booking diversion initiated prior to arrest, and post-booking diversion, which is initiated following arrest and is often under the ongoing supervision of courts.

I. Peer Services and Supports.

The provision of services by peers is a growing trend in the mental health field. These services include case management, drop-in centers and clubhouses, outreach programs and consumer-run businesses. The benefits of these services are two-fold: first, they provide meaningful work for consumers employed as peer specialists and peer counselors, and second, there is emerging evidence that peer services produce positive outcomes. In recognition of this, peer specialists are now included as part of recommended staffing for ACT teams.

J. Crisis Intervention Services.

A quality mental health system must have mechanisms in place to respond in a timely and compassionate manner to people with serious mental illnesses in crisis. Too often, these responsibilities are left to law enforcement. Mobile crisis intervention services should be available on a 24-hour, seven-day-a-week basis. Acute care hospital beds and/or crisis residential services must be available for individuals identified as needing that level of service.

The list set forth above represents NAMI's judgment about what constitutes the essential elements of high quality mental health services. It is by no means an exhaustive list. Other services that should be available include psychiatric rehabilitation, clubhouses or drop-in centers, and supported education.

2. Integrated Systems

To achieve recovery, people with serious mental illnesses require multiple services, ranging from psychiatric treatment to housing to rehabilitative services. Typically, these services are furnished by different providers accessing different sources of funding, and therefore operating under different rules. The result is a mental health system that, in the words of President Bush's New Freedom Commission on Mental Health, "looks more like a maze than a coordinated system of care."

Complex, uncoordinated mental health service systems serve no one's interest - not providers, not families, and certainly not consumers. One important element of quality in a mental health system is the extent to which the various services required by individual consumers - and the funds used to pay for these services - are provided in the most user-friendly manner possible. This requires close collaboration among the systems responsible for providing the various services.

One method being tried involves integrating diverse funding streams into one general fund. However, even without blended funding, it is possible to coordinate services to design effective service systems at local levels. Coordination must occur, for example, between SMHAs and regional or local mental health systems and providers to facilitate seamless transitions from inpatient to outpatient services. And, coordination also must occur among the myriad state agencies offering services for people with serious mental illnesses.

As the entity most knowledgeable about the services consumers need and how best to deliver them, SMHAs should be at the center of these integration efforts. Moreover, SMHAs should be aware of all services for consumers, even those for which they are not directly responsible. For example, SMHAs should be involved in the design of jail diversion or supportive housing initiatives, even though they may not be directly responsible for funding these services. Similarly, SMHAs should be aware of where these programs and services exist at local levels.

3. Sufficient Funding

In recent years, many states faced with budget deficits have cut mental health services funding and/or increasingly relied on Medicaid to pay for community mental health services. Today, Medicaid is the largest single payer of public mental health services. Since Congress has recently enacted cuts to the federal portion of Medicaid, burdens on states are likely to increase even more.

Continuing disparities in mental health coverage in health insurance is also a factor. Although 36 states have enacted parity laws, the lack of a federal parity law is an impediment to achieving true equity in coverage of mental illnesses in private health insurance. And, costs not picked up by private insurance frequently are shifted to state mental health systems.

There is increasing awareness that short-term savings accrued through cuts in public mental health funding lead to increased long-term public costs associated with hospitalizations, incarcerations,

and other costly consequences of lack of treatment. NAMI's research for this project reveals that a few states have increased mental health funding in recent years, even in the face of overall budget deficits.

Funding is not the only solution. Funds allocated for services that don't work or systems that don't effectively coordinate mental health services are wasteful and inefficient. However, the provision of high quality mental health services cannot be achieved without adequate funding. The sad reality today is that few states are funding public mental health services at levels sufficient to enable all or even most who need those services to receive them.

4. Consumer and Family Driven

Historically, consumers have had little involvement in the services they receive or the settings in which they receive them. Some consumers continue to have negative experiences with the treatment system, which deters many from continuing to participate in services. Families, too, often have been discounted as having any role to play despite the fact that, in many cases, families function in a primary caregiving role.

In recent years, there has been some progress in creating systems that are responsive to the concerns of consumers and family members. For example, successful efforts in many states to reduce the use of restraints and limit consumers' seclusion in hospitals can be directly traced to the efforts of consumer advocates.

A system that is truly consumer- and family-driven is characterized by meaningful involvement of consumers and families in the design, implementation and evaluation of services. Consumers and family members should be regarded as true partners in this enterprise, not as mere advisors whose feedback can be ultimately discounted. Mental health systems should operate in a transparent manner, welcoming and supporting monitoring and feedback from consumers and family members. One promising development in a few states is the emergence of consumer and family teams responsible for monitoring the quality of psychiatric treatment facilities and other mental health services.

5. Safe and Respectful Treatment Environments

As discussed above, many consumers have had painful experiences with the treatment system. These experiences - such as being put into restraints or seclusion, suffering abuse and assault, or encountering a general disregard of one's concerns while in a treatment facility - reduce trust and willingness to participate in future treatment. Inpatient psychiatric treatment facilities and community treatment or residential programs are unsafe and even dangerous in some parts of the country.

As any consumer of healthcare services would expect, people with serious mental illnesses should be treated with dignity and respect while in inpatient or community treatment programs. Adequate staffing must be maintained and program staff should receive training on crisis de-escalation techniques in order to avoid the use of restraints or seclusion. Consumer complaints of abuse and

neglect should be investigated promptly, the findings shared with the consumer, and steps taken to remedy any problems that are identified. All deaths or serious injuries that occur in psychiatric treatment programs must be reported and investigated.

6. Accessible Information for Consumers and Family Members

Being diagnosed with mental illness is a traumatic and unsettling experience for consumers and their families. At such times, accurate information about the specific diagnosis, treatment options and community resources is vitally important. Unfortunately, this information is frequently unavailable.

NAMI believes that SMHAs play a critical role in disseminating information to the public about mental illnesses and where people diagnosed with these illnesses can go for help. As reliance on the Internet increases, this information should be available on the SMHA website. Moreover, SMHAs should develop written materials and resources and provide training to their employees about how to respond effectively to inquiries from the public.

7. Access to Acute and Long-Term Care Treatment

As efforts to transform state mental health systems from institutional to community-based care continue, adequate resources must be maintained for the provision of acute or long-term psychiatric treatment for those who need it. These resources should include acute care beds, group homes or other 24-hour residential programs for people who require continuous care on a long-term basis. The use of nursing homes or unlicensed and unregulated board and care homes to address the needs of previously institutionalized individuals is not appropriate.

8. Cultural Competence

Communities throughout the country are becoming more diverse, with a rich mix of racial and ethnic groups. Mental health services should be designed and delivered in a culturally competent manner. A number of states have made significant strides in developing culturally competent services, some of which are highlighted in this report. Awareness of the need for cultural and language competence should be incorporated in all aspects of mental health planning and service delivery, including staff recruitment, staff training, development of resource materials, and service delivery.

9. Health Promotion and Mortality Reduction

Studies have shown that people with schizophrenia and other serious mental illnesses have a higher risk of medical disorders such as diabetes, hypertension, and heart disease than people without mental illnesses. There are a number of possible contributing factors, including high rates of smoking among people with mental illnesses, reduced physical activity and fitness levels, and the side effects of psychiatric medications. NAMI believes that a high quality mental health system must promote the overall health of those it serves through the integration of primary medical care with psychiatric treatment. Health-promoting activities such as

exercise, smoking-cessation programs, and dietary education must be offered and data about medical risk factors and health mortality rates collected.

10. Adequate and Qualified Mental Health Workforce

There is a significant shortage of qualified mental health personnel across the country. This shortage pervades all aspects of the field, from psychiatrists to caseworkers and other direct service personnel. NAMI believes that SMHAs should work in partnership with other relevant agencies and institutions (e.g., universities) on initiatives to ensure an adequate supply of qualified mental health personnel. These initiatives should consider strategies such as educational subsidies, loan forgiveness programs, continuing education, competitive salary and benefit structures, and inclusion of consumers and family members within the mental health workforce.

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APPENDIX C

Contra Costa County MHSA Family Steering Committee
Memorandum of Family Concerns
February 9, 2009

For the last three years the Family Steering Committee (FSC) has conducted many meetings to review the startup and enrollment of Full Service Partners (FSP) in new MHSA programs in Contra Costa County. During this time period the Committee has been concerned about the numbers of FSPs being served and the delays in the rollouts of all of the programs, especially the Older Adult Program. The FSP numbers appear to have stabilized since the 4th Quarter of FY 07-08. This report will address the time period up to and including this quarter, exclusive of the Older Adult Program.

There have been enormous sums of MHSA dollars flowing into Contra Costa Mental Health. The programs created are serving approximately 200 FSPs. To date the FSC has been unable to find reliable available statistics to demonstrate the dollar amount that has been spent on these 200 FSPs for an estimation of the expense per enrolled FSP.

The FSC has concluded that based on fiscal data we have been given, the results are questionable. We believe that the delivery of services needs to be redesigned to provide more cost effective results. Some of the questions that have been raised are as follows:

- 1) Do we need to change the programs and or restructure them?
- 2) Do we need to change providers to ensure more cost effective results?
- 3) Do we need to re-evaluate the focal populations?

The FSC would suggest adopting broader focal populations, as described in the CMHDA 2008 California Counties *Transforming Local Mental Health Systems*, to serve only those with Severe Mental Illness (SMI). We are concerned that program funding is being used for FSPs who do not qualify as having SMI, as targeted by the MHSA. Again we would address the need to re-think focal populations and offer the following suggestions:

-----Children's: Those at risk of hospitalization, with a dual diagnosis, in child welfare or juvenile justice system, or at risk of school failure

-----TAY (16-25): Youth who are unable to manage independence, isolated, cannot work, are frequently hospitalized, or leaving foster care

-----Adults: Those having difficulty with employment, education, and socialization, those who are homeless, frequently hospitalized or in psychiatric emergency care, isolated, or institutionalized.

-----Older Adults: Those who are hospitalized institutionalized, socially isolated due to lack of wellness programs, those without housing, or with complex medical problems.

According to the White Paper dated July 2006, Contra Costa committed to a Housing First approach. The FSC is gravely concerned that the housing program has currently run out of vouchers. Since we have not reached our target goals, for FSPs in the TAY or the Adult Programs, we would like to know why more vouchers were not allocated. In addition, why hasn't a housing coordinator been hired? We would also like information on how much MHSA money is being used for augmentation to place FSPs into Board and Care homes. There are many consumers who cannot thrive in

independent living. Have MHSA placements been made in licensed Board and Cares? If so, in order to avoid competing for beds, the FSC strongly believes that new contracts must be developed to ensure that non MHSA clients are not excluded from suitable Board and Care placements.

The amount of money that has been spent on Planning, Administrative Supports, and Consultants is disturbing. Specifically, the FSC believes that the amount of money paid to consultants has been excessive and unnecessary. We are aware of the limitations that the state guidelines put forth, some of which were not accurate, but it appears that the time, money, and manpower exerted on the development of new programs could have been better spent to enhance existing services to previously underserved populations. This FSC would redirect planning funds to client services

How much has actually been spent on programs and services to date? This is information that we asked for a year ago and have never received in a format that is understandable. Additionally, how much is being held in prudent reserve? The financial information must be simplified in order for public evaluation to be conclusive and meaningful.

The FSC requests the evaluation criteria for each program. What performance measurement strategies are being employed to monitor the service provider contracts for these programs? Where do these performance reviews end up? What is the mechanism of oversight for our county? It is difficult for us to know if the results we are seeing are due to poor use of funds, inadequate planning, or a fundamental lack of imagination.

The FSC is disappointed with the inadequate collaborative efforts with Family members. We were hopeful when our Mental Health Director, Donna Wigand, promised that a key goal for this county would be to have family driven implementation and involvement, with family members hired to work in MHSA positions. The failure to employ family members to positions within the new adult programs is alarming. The MHSA recognizes the family voice as valuable and unique, yet that resource has been wasted in Contra Costa County.

Initially we were told that MHSA funding was primarily intended to develop new and innovative programming for clients that had previously been unserved or unidentified. It is now known that MHSA funding can be used to enhance existing programs. It is essential that the existing system of care is funded rather than continue a 2-tier system. It is the decision of this FSC that MHSA funds can and should be used, in this very critical financial time, to enhance existing programs.

We are committed to the collaborative promise of MHSA and look forward to hearing from Mental Health Administration at your earliest opportunity.

Respectfully submitted,
CCC MHSA Family Steering Committee

cc: CCC Mental Health Commission, NAMI Contra Costa, Sherry Bradley, MPH

APPENDIX D

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Vendor History

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Vendor #	Vendor Name	Warrant #	Date	Description	Amount
06764	CRESTWOOD BEHAVIORAL HLTH	299005	11/5/2009	9/09 CRESTWOOD 24933	\$214,166.44
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06764	CRESTWOOD BEHAVIORAL HLTH	296633	10/30/2009	9/09 CRESTWOOD 74286	\$16,530.00
06764	CRESTWOOD BEHAVIORAL HLTH	296633	10/30/2009	9/09 CRESTWOOD 24933	\$132,100.00
06764	CRESTWOOD BEHAVIORAL HLTH	296633	10/30/2009	9/09 CRESTWOOD 74286	\$43,500.00
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06764	CRESTWOOD BEHAVIORAL HLTH	273976	10/7/2009	7/09 BRIDGE 24933	\$187,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	284214	9/23/2009	8/09 CRESTWOOD 74286	\$69,020.00
06764	CRESTWOOD BEHAVIORAL HLTH	283290	9/18/2009	8/09 CRESTWOOD 24933	\$67,000.00
06764	CRESTWOOD BEHAVIORAL HLTH	283290	9/18/2009	8/09 CRESTWOOD 24933	\$189,800.00
06764	CRESTWOOD BEHAVIORAL HLTH	283290	9/18/2009	8/09 CRESTWOOD 24933	\$224,205.80
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06764	CRESTWOOD BEHAVIORAL HLTH	262855	7/29/2009	6/09 BRIDGE 24933	\$173,100.00
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06764	CRESTWOOD BEHAVIORAL HLTH	252133	7/27/2009	E/C 5/09 CBH OURHOUSE VAL	\$6,200.00
06764	CRESTWOOD BEHAVIORAL HLTH	252133	7/27/2009	E/C 5/09 CBH OURHOUSE VAL	(\$6,200.00)
06764	CRESTWOOD BEHAVIORAL HLTH	252133	7/27/2009	E/C 5/09 OURHOUSE YEAREND	(\$51,200.00)
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06764	CRESTWOOD BEHAVIORAL HLTH	264771	7/27/2009	E/C 6/09 OURHOUSE YEAREND	\$51,600.00
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06764	CRESTWOOD BEHAVIORAL HLTH	240525	7/15/2009	E/C 409 CBH OUR HOUSE VAL	\$6,000.00
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06764	CRESTWOOD BEHAVIORAL HLTH	201582	7/10/2009	E/C 109 CBH OUR HOUSE VAL	\$6,200.00
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06764	CRESTWOOD BEHAVIORAL HLTH	240525	7/10/2009	E/C 409 CBH OUR HOUSE VAL	(\$6,000.00)
06764	CRESTWOOD BEHAVIORAL HLTH	240525	7/10/2009	E/C 409 CBH OUR HOUSE VAL	\$3,000.00
06764	CRESTWOOD BEHAVIORAL HLTH	240525	7/10/2009	E/C 409 CBH OUR HOUSE VAL	(\$3,000.00)
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06764	CRESTWOOD BEHAVIORAL HLTH	252133	7/10/2009	E/C 509 CBH OUR HOUSE VAL	(\$6,200.00)
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06764	CRESTWOOD BEHAVIORAL HLTH	224439	4/20/2009	3/09 PATHWAY 74286	\$62,350.00
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06764	CRESTWOOD BEHAVIORAL HLTH	220688	4/16/2009	3/09 WELLNESS 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	220688	4/16/2009	3/09 BRIDGE 24933	\$184,500.00
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06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	2/09 C B H 74286	(\$54,665.00)
06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	2/09 WELLNESS 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	2/09 WELLNESS 74286	(\$32,250.00)
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06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	2/09 C B H 74286	\$54,665.00
06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	2/09 CRESTWOOD 24933	\$167,300.00
06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	2/09 C B H 74286	\$54,665.00
06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	1/09 WELLNESS 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	209825	3/16/2009	2/09 CRESTWOOD #24933	(\$167,300.00)
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06764	CRESTWOOD BEHAVIORAL HLTH	201582	2/25/2009	1/09 CRESTWOOD #24933	\$192,500.00

06764	CRESTWOOD BEHAVIORAL HLTH	201582		2/25/2009	1/09 BRIDGE 24933	\$192,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	688643		1/21/2009	12/08 CRESTWOOD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	687115		1/16/2009	12/08 CRESTWOOD #24933	\$192,900.00
06764	CRESTWOOD BEHAVIORAL HLTH	687115		1/16/2009	12/08 CRESTWOOD 24933	\$310,869.00
06764	CRESTWOOD BEHAVIORAL HLTH	687115		1/16/2009	12/08 CRESTWOOD 24933	\$192,900.00
06764	CRESTWOOD BEHAVIORAL HLTH	687115		1/16/2009	12/08 CRESTWOOD 74286	\$72,210.00
06764	CRESTWOOD BEHAVIORAL HLTH	687115		1/16/2009	12/08 CRESTWOOD #24933	(\$192,900.00)
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	11/08 CRESTWD 24933	\$344,473.00
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	10/08 CRESTWD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	9/08 CRESTWD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	11/08 CRESTWD 24933	\$175,100.00
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	11/08 CRESTWOOD #24933	(\$175,100.00)
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	11/08 CRESTWD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	11/08 CRESTWOOD #24933	\$175,100.00
06764	CRESTWOOD BEHAVIORAL HLTH	677143		12/18/2008	11/08 CRESTWD 74286	\$68,875.00
06764	CRESTWOOD BEHAVIORAL HLTH	667682		11/25/2008	10/08 CRESTWOOD #24933	\$178,800.00
06764	CRESTWOOD BEHAVIORAL HLTH	667682		11/25/2008	10/08 CRESTWOOD #24933	(\$178,800.00)
06764	CRESTWOOD BEHAVIORAL HLTH	667682		11/25/2008	10/08 CRESTWOOD 24933	\$178,800.00
06764	CRESTWOOD BEHAVIORAL HLTH	667682		11/25/2008	10/08 CRESTWOOD 24933	\$356,957.73
06764	CRESTWOOD BEHAVIORAL HLTH	667682		11/25/2008	10/08 CRESTWOOD 74286	\$64,380.00
06764	CRESTWOOD BEHAVIORAL HLTH	663446		11/12/2008	7/08 WELLNESS 74286	\$32,250.00
TOTAL						\$7,075,929.95

The Accounts Payable **Vendor History** can be queried online.
Please enter one or more fields to search on:

Vendor #: *	<input type="text" value="06764"/>	Name: *	<input type="text"/>	<input type="button" value="Search"/>	<input type="button" value="Clear"/>
P.O. #: *	<input type="text"/>	Description:	<input type="text"/>	<input type="checkbox"/> view in EXCEL 97	
Warrant #: *	<input type="text"/>	Account #:	<input type="text"/>	<input type="text" value="2000"/> records maximum	
From Date:	<input type="text" value="11/10/2008"/>	Thru Date:	<input type="text" value="11/10/2009"/>		
Dept #: *	<input type="text"/>	Org #: *	<input type="text"/>		
Fund #:	<input type="text"/>	Activity:	<input type="text"/>		
Task:	<input type="text"/>	Option:	<input type="text"/>		

(* You must enter AT LEAST ONE of these fields to search on...

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Vendor #	Vendor Name	Warrant #	Date	Description	Amount
06764	CRESTWOOD BEHAVIORAL HLTH	656459	10/24/2008	09/08 CRESTWOOD #24933	(\$173,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	656459	10/24/2008	09/08 CRESTWOOD #24933	\$173,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	656459	10/24/2008	9/08 PATHWAY 74286	\$55,100.00
06764	CRESTWOOD BEHAVIORAL HLTH	656459	10/24/2008	9/08 CRESTWOOD 24933	\$377,132.20
06764	CRESTWOOD BEHAVIORAL HLTH	656459	10/24/2008	9/08 BRIDGE 24933	\$173,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	644939	9/25/2008	8/08 CRESTWOOD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	642798	9/18/2008	08/08 CRESTWOOD #24933	\$178,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	642798	9/18/2008	08/08 CRESTWOOD #24933	(\$178,400.00)
06764	CRESTWOOD BEHAVIORAL HLTH	642798	9/18/2008	8/08 CRESTWOOD 74286	\$55,100.00
06764	CRESTWOOD BEHAVIORAL HLTH	642798	9/18/2008	8/08 CRESTWOOD 24933	\$373,453.92
06764	CRESTWOOD BEHAVIORAL HLTH	642798	9/18/2008	8/08 CRESTWOOD 24933	\$178,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	633761	8/21/2008	7/08 CRESTWOOD 24933	\$64,960.00
06764	CRESTWOOD BEHAVIORAL HLTH	633761	8/21/2008	7/08 CRESTWOOD 24933	\$362,076.00
06764	CRESTWOOD BEHAVIORAL HLTH	633761	8/21/2008	07/08 CRESTWOOD #24933	\$177,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	633761	8/21/2008	07/08 CRESTWOOD #24933	(\$64,960.00)
06764	CRESTWOOD BEHAVIORAL HLTH	633761	8/21/2008	07/08 CRESTWOOD #74286	\$64,960.00
06764	CRESTWOOD BEHAVIORAL HLTH	633761	8/21/2008	07/08 CRESTWOOD #24933	(\$177,400.00)
06764	CRESTWOOD BEHAVIORAL HLTH	633761	8/21/2008	7/08 CRESTWOOD 24933	\$177,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	632438	8/19/2008	6/08 CRESTWOOD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	8/5/2008	E/C 707 CRESTWOOD TO 5725	(\$69,000.00)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	8/5/2008	E/C 1007 CRESTWOOD TO 572	(\$81,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	8/5/2008	E/C 1007 CRESTWOOD FR 594	\$81,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	8/5/2008	E/C 907 CRESTWOOD TO 5725	(\$21,692.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	8/5/2008	E/C 907 CRESTWOOD TO 5725	(\$74,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	8/5/2008	E/C 907 CRESTWOOD FR 5942	\$74,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	8/5/2008	E/C 907 CRESTWOOD FR 5942	\$21,692.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	8/5/2008	E/C 807 CRESTWOOD TO 5725	(\$68,600.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	8/5/2008	E/C 807 CRESTWOOD TO 5725	(\$21,750.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	8/5/2008	E/C 807 CRESTWOOD FR 5942	\$68,600.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	8/5/2008	E/C 707 CRESTWOOD TO 5725	(\$66,265.00)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	8/5/2008	E/C 707 CRESTWOOD FR 5942	\$69,000.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	8/5/2008	E/C 707 CRESTWOOD FR 5942	\$66,265.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	8/5/2008	E/C 1107 CRESTWOOD FR 594	\$87,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	8/5/2008	E/C 1007 CRESTWOOD TO 572	(\$24,650.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	8/5/2008	E/C 807 CRESTWOOD FR 5942	\$21,750.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	8/5/2008	E/C 408 CRESTWOOD TO 5725	(\$102,900.00)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	8/5/2008	E/C 1007 CRESTWOOD FR 594	\$24,650.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	8/5/2008	E/C 1107 CRESTWOOD FR 594	\$58,290.00

06764	CRESTWOOD BEHAVIORAL HLTH	621237	8/5/2008	E/C 608 CRESTWOOD TO 5725	(\$172,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	621237	8/5/2008	E/C 608 CRESTWOOD FR 5942	\$172,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	610573	8/5/2008	E/C 508 CRESTWOOD FR 5942	\$140,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	8/5/2008	E/C 408 CRESTWOOD FR 5942	\$102,900.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	8/5/2008	E/C 308 CRESTWOOD TO 5725	(\$105,000.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	8/5/2008	E/C 308 CRESTWOOD FR 5942	\$105,000.00
06764	CRESTWOOD BEHAVIORAL HLTH	576580	8/5/2008	E/C 208 CRESTWOOD TO 5725	(\$101,300.00)
06764	CRESTWOOD BEHAVIORAL HLTH	567117	8/5/2008	E/C 108 CRESTWOOD TO 5725	(\$111,400.00)
06764	CRESTWOOD BEHAVIORAL HLTH	567117	8/5/2008	E/C 108 CRESTWOOD FR 5942	\$111,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	8/5/2008	E/C 1207 CRESTWOOD TO 572	(\$24,824.00)
06764	CRESTWOOD BEHAVIORAL HLTH	560795	8/5/2008	E/C 1207 CRESTWOOD FR 594	\$24,824.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	8/5/2008	E/C 1107 CRESTWOOD TO 572	(\$87,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	576580	8/5/2008	E/C 208 CRESTWOOD FR 5942	\$101,300.00
06764	CRESTWOOD BEHAVIORAL HLTH	610573	8/5/2008	E/C 508 CRESTWOOD TO 5725	(\$140,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	545367	8/5/2008	E/C 1107 CRESTWOOD TO 572	(\$58,290.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/25/2008	E/C 8/07 CRESTW FR 5984	(\$425,275.54)
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/25/2008	E/C 6/08 CRESTW FR 5984	(\$172,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/25/2008	E/C 608 CRESTW TO 5942	\$172,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/25/2008	E/C 7/07 CRESTW FR 5984	(\$445,988.24)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/25/2008	E/C 7/07 CRESTW FR 5984	(\$36,462.00)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/25/2008	E/C 7/07 CRESTW TO 5942	\$445,988.24
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/25/2008	E/C 7/07 CRESTW TO 5942	\$285,817.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/25/2008	E/C 8/07 CRESTW TO 5942	\$32,922.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/25/2008	E/C 8/07 CRESTW FR 5984	(\$212,624.00)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/25/2008	E/C 5/08 CRESTW TO 5942	\$361,513.90
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 3/08 CRESTW FR 5984	(\$381,074.97)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/25/2008	E/C 8/07 CRESTW FR 5984	(\$32,922.00)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/25/2008	E/C 5/08 CRESTW TO 5942	\$41,300.00
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/25/2008	E/C 5/08 CRESTW FR 5984	(\$361,513.90)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/25/2008	E/C 5/08 CRESTW FR 5984	(\$41,300.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 308 CRESTWD TO 5724	\$66,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 308 CRESTWD FROM 5984	(\$66,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 3/08 CRESTW TO 5942	\$381,074.97
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 3/08 CRESTW TO 5942	\$187,620.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 3/08 CRESTW FR 5984	(\$187,620.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 3/08 CRESTW FR 5984	(\$36,580.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/25/2008	E/C 8/07 CRESTW TO 5942	\$212,624.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/25/2008	E/C 7/07 CRESTW TO 5942	\$36,462.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/25/2008	E/C 3/08 CRESTW TO 5942	\$36,580.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/25/2008	E/C 11/07 CRESTW FR 5984	(\$31,860.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/25/2008	E/C 8/07 CRESTW TO 5942	\$425,275.54
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/25/2008	E/C 7/07 CRESTW FR 5984	(\$285,817.00)
06764	CRESTWOOD BEHAVIORAL HLTH	546195	7/25/2008	E/C 11/07 CRESTW TO 5942	\$435,021.40
06764	CRESTWOOD BEHAVIORAL HLTH	546195	7/25/2008	E/C 11/07 CRESTW FR 5984	(\$435,021.40)
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/25/2008	E/C 1107 CRESTW FR 5984	(\$58,290.00)

06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/25/2008	E/C 11/07 CRESTW TO 5942	\$183,992.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/25/2008	E/C 11/07 CRESTW TO 5942	\$58,290.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/25/2008	E/C 11/07 CRESTW FR 5984	(\$183,992.00)
06764	CRESTWOOD BEHAVIORAL HLTH	540249	7/25/2008	E/C 10/07 CRESTW TO 5942	\$433,799.53
06764	CRESTWOOD BEHAVIORAL HLTH	540249	7/25/2008	E/C 10/07 CRESTW FR 5984	(\$433,799.53)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/25/2008	E/C 10/07 CRESTW TO 5942	\$180,640.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/25/2008	E/C 10/07 CRESTW TO 5942	\$32,922.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/25/2008	E/C 10/07 CRESTW FR 5984	(\$180,640.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 907 CRESTW FR 5984	(\$74,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	515865	7/25/2008	E/C 12/06 CRESTW TO 5942	\$2,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 9/07 CRESTW TO 5942	\$31,860.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/25/2008	E/C 11/07 CRESTW TO 5942	\$31,860.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/25/2008	E/C 10/07 CRESTW FR 5984	(\$32,922.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 9/07 CRESTW TO 5942	\$74,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	515865	7/25/2008	E/C 12/06 CRESTW FR 5984	(\$2,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 9/07 CRESTW TO 5942	\$115,260.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 907 CRESTW FR 5984	(\$115,260.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 907 CRESTW FR 5984	(\$415,546.62)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 907 CRESTW FR 5984	(\$31,860.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/25/2008	E/C 9/07 CRESTW TO 5942	\$415,546.62
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW FR 5984	\$74,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW TO 5942	(\$187,620.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW TO 5942	(\$381,074.97)
06764	CRESTWOOD BEHAVIORAL HLTH	515865	7/24/2008	E/C 12/06 CRESTW TO 5942	(\$2,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW TO 5942	(\$36,580.00)
06764	CRESTWOOD BEHAVIORAL HLTH	515865	7/24/2008	E/C 12/06 CRESTW FR 5984	\$2,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW TO 5724	(\$66,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW FR 5984	\$66,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW FR 5984	\$115,260.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/24/2008	E/C 8/07 CRESTW TO 5942	(\$32,922.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW TO 5942	(\$115,260.00)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/24/2008	E/C 5/08 CRESTW FR 5984	\$361,513.90
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW FR 5984	\$415,546.62
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW FR 5984	\$31,860.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/24/2008	E/C 7/07 CRESTW TO 5942	(\$285,817.00)
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/24/2008	E/C 6/08 CRESTW TO 5942	(\$172,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/24/2008	E/C 5/08 CRESTW TO 5942	(\$41,300.00)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/24/2008	E/C 5/08 CRESTW TO 5942	(\$361,513.90)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/24/2008	E/C 10/07 CRESTW TO 5942	(\$32,922.00)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/24/2008	E/C 7/07 CRESTW FR 5984	\$445,988.24
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW TO 5942	(\$74,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/24/2008	E/C 7/07 CRESTW FR 5984	\$285,817.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/24/2008	E/C 7/07 CRESTW TO 5942	(\$445,988.24)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/24/2008	E/C 8/07 CRESTW TO 5942	(\$212,624.00)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/24/2008	E/C 7/07 CRESTW TO 5942	(\$36,462.00)

06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/24/2008	E/C 5/08 CRESTW FR 5984	\$41,300.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/24/2008	E/C 8/07 CRESTW FR 5984	\$212,624.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/24/2008	E/C 8/07 CRESTW FR 5984	\$32,922.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/24/2008	E/C 8/07 CRESTW FR 5984	\$425,275.54
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/24/2008	E/C 8/07 CRESTW TO 5942	(\$425,275.54)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/24/2008	E/C 7/07 CRESTW FR 5984	\$36,462.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/24/2008	E/C 11/07 CRESTW FR 5984	\$58,290.00
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/24/2008	E/C 6/08 CRESTW FR 5984	\$172,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	546195	7/24/2008	E/C 11/07 CRESTW TO 5942	(\$435,021.40)
06764	CRESTWOOD BEHAVIORAL HLTH	546195	7/24/2008	E/C 11/07 CRESTW FR 5984	\$435,021.40
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/24/2008	E/C 11/07 CRESTW TO 5942	(\$31,860.00)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/24/2008	E/C 10/07 CRESTW FR 5984	\$180,640.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/24/2008	E/C 11/07 CRESTW TO 5942	(\$183,992.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW TO 5942	(\$31,860.00)
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/24/2008	E/C 11/07 CRESTW FR 5984	\$31,860.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/24/2008	E/C 11/07 CRESTW FR 5984	\$183,992.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/24/2008	E/C 10/07 CRESTW FR 5984	\$32,922.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW FR 5984	\$381,074.97
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/24/2008	E/C 11/07 CRESTW TO 5942	(\$58,290.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/24/2008	E/C 9/07 CRESTW TO 5942	(\$415,546.62)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW FR 5984	\$187,620.00
06764	CRESTWOOD BEHAVIORAL HLTH	540249	7/24/2008	E/C 10/07 CRESTW TO 5942	(\$433,799.53)
06764	CRESTWOOD BEHAVIORAL HLTH	540249	7/24/2008	E/C 10/07 CRESTW FR 5984	\$433,799.53
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/24/2008	E/C 10/07 CRESTW TO 5942	(\$180,640.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/24/2008	E/C 3/08 CRESTW FR 5984	\$36,580.00
06764	CRESTWOOD BEHAVIORAL HLTH	576580	7/23/2008	E/C 208 CRESTW TO 5984	(\$80,376.00)
06764	CRESTWOOD BEHAVIORAL HLTH	576580	7/23/2008	E/C 208 CRESTW FR 5942	\$80,376.00
06764	CRESTWOOD BEHAVIORAL HLTH	567117	7/23/2008	E/C 108 CRESTWD FR 5724	\$62,350.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	7/23/2008	E/C 408 CRESTWD TO 5725	(\$58,145.00)
06764	CRESTWOOD BEHAVIORAL HLTH	567117	7/23/2008	E/C 108 CRESTW TO 5984	(\$99,552.00)
06764	CRESTWOOD BEHAVIORAL HLTH	567117	7/23/2008	E/C 108 CRESTW FR 5942	\$99,552.00
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/23/2008	E/C 608 CRESTW FR 5984	\$172,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/23/2008	E/C 1007CRESTW FR 5984	\$81,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	567117	7/23/2008	E/C 108 CRESTWD TO 5725	(\$62,350.00)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/23/2008	E/C 508 CRESTW FR 5942	\$28,356.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	7/23/2008	E/C 408 CRESTWD FR 5724	\$58,145.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	7/23/2008	E/C 408 CRESTW TO 5984	(\$74,256.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/23/2008	E/C 308 CRESTWD TO 5725	(\$66,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/23/2008	E/C 308 CRESTWD FR 5984	\$66,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	576580	7/23/2008	E/C 208 CRESTWD FR 5724	\$61,045.00
06764	CRESTWOOD BEHAVIORAL HLTH	576580	7/23/2008	E/C 208 CRESTWD TO 5725	(\$61,045.00)
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/23/2008	E/C 308 CRESTW FR 5984	\$105,000.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	7/23/2008	E/C 408 CRESTW FR 5942	\$74,256.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	7/23/2008	E/C 308 CRESTW TO 5942	(\$105,000.00)
06764	CRESTWOOD BEHAVIORAL HLTH	610573	7/23/2008	E/C 508 CRESTW TO 5984	(\$28,356.00)





06764	CRESTWOOD BEHAVIORAL HLTH	560795	7/23/2008	E/C 1207 CRESTW FR 5942	\$99,552.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/23/2008	E/C 1007 CRESTWD FR 5957	\$36,975.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/23/2008	E/C 1007 CRESTWD TO 5725	(\$36,975.00)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/23/2008	E/C 1007 CRESTWD TO 5942	(\$24,650.00)
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/23/2008	E/C 1107 CRESTW FR 5984	\$87,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/23/2008	E/C 1107 CRESTW TO 5942	(\$87,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/23/2008	E/C 907 CRESTWD TO 5942	(\$21,692.00)
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/23/2008	E/C 1107 CRESTWD TO 5942	(\$58,290.00)
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/23/2008	E/C 1007 CRESTW TO 5942	(\$81,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	560795	7/23/2008	E/C 1207 CRESTW TO 5984	(\$99,552.00)
06764	CRESTWOOD BEHAVIORAL HLTH	560795	7/23/2008	E/C 1207 CRESTWD FR 5957	\$37,236.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	7/23/2008	E/C 1207 CRESTWD FR 5984	\$24,824.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	7/23/2008	E/C 1207 CRESTWD TO 5725	(\$37,236.00)
06764	CRESTWOOD BEHAVIORAL HLTH	560795	7/23/2008	E/C 1207 CRESTWD TO 5942	(\$24,824.00)
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/23/2008	E/C 608 CRESTW TO 5942	(\$172,700.00)
06764	CRESTWOOD BEHAVIORAL HLTH	545367	7/23/2008	E/C 1107 CRESTWD FR 5984	\$58,290.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/23/2008	E/C 807 CRESTWD FR 5984	\$21,750.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/23/2008	E/C 707 CRESTW FR 5984	\$69,000.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/23/2008	E/C 707 CRESTW TO 5942	(\$69,000.00)
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/23/2008	E/C 707 CRESTWD FR 5984	\$66,265.00
06764	CRESTWOOD BEHAVIORAL HLTH	504320	7/23/2008	E/C 707 CRESTWD TO 5942	(\$66,265.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/23/2008	E/C 807 CRESTW FR 5984	\$68,600.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	7/23/2008	E/C 1007 CRESTWD FR 5984	\$24,650.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/23/2008	E/C 807 CRESTWD FR 5957	\$32,625.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/23/2008	E/C 907 CRESTWD TO 5725	(\$32,538.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/23/2008	E/C 807 CRESTWD TO 5725	(\$32,625.00)
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/23/2008	E/C 807 CRESTWD TO 5942	(\$21,750.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/23/2008	E/C 907 CRESTW FR 5984	\$74,500.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/23/2008	E/C 907 CRESTW TO 5942	(\$74,500.00)
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/23/2008	E/C 907 CRESTWD FR 5957	\$32,538.00
06764	CRESTWOOD BEHAVIORAL HLTH	523474	7/23/2008	E/C 907 CRESTWD FR 5984	\$21,692.00
06764	CRESTWOOD BEHAVIORAL HLTH	512871	7/23/2008	E/C 807 CRESTW TO 5942	(\$68,600.00)
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	8/07 CRESTWOOD 74286	\$9,312.50
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	11/07 CRESTWOOD 74286	\$10,412.50
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	12/07 CRESTWOOD 74286	\$12,562.50
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	10/07 CRESTWOOD 74286	\$11,362.50
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	6/07 CRESTWOOD 74286	\$8,447.40
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	7/07 CRESTWOOD 74286	\$7,937.50
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	5/07 CRESTWOOD 74286	\$4,255.20
06764	CRESTWOOD BEHAVIORAL HLTH	621827	7/18/2008	9/07 CRESTWOOD 74286	\$8,887.50
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/16/2008	6/08 HELIOS 24933 PY	\$35,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/16/2008	6/08 CRESTWOOD 24933	\$65,105.00
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/16/2008	6/08 CRESTWOOD 24933	\$172,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	621237	7/16/2008	6/08 CRESTWOOD 24933	\$352,599.02
06764	CRESTWOOD BEHAVIORAL HLTH	611442	6/20/2008	2/08 CRESTWOOD 74286	\$32,250.00

06764	CRESTWOOD BEHAVIORAL HLTH	611442	6/20/2008	1/08	CRESTWOOD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	611442	6/20/2008	3/08	CRESTWOOD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	611442	6/20/2008	4/08	CRESTWOOD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	611442	6/20/2008	5/08	CRESTWOOD 74286	\$32,250.00
06764	CRESTWOOD BEHAVIORAL HLTH	610573	6/18/2008	5/08	CRESTWOOD 24933	\$361,513.90
06764	CRESTWOOD BEHAVIORAL HLTH	610573	6/18/2008	5/08	CRESTWOOD 24933	\$41,300.00
06764	CRESTWOOD BEHAVIORAL HLTH	610573	6/18/2008	5/08	CRESTWOOD 24933	\$168,856.00
06764	CRESTWOOD BEHAVIORAL HLTH	610573	6/18/2008	5/08	CRESTWOOD 24933	\$56,695.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	5/23/2008	4/08	CRESTWOOD 74286	\$58,145.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	5/23/2008	4/08	CRESTWOOD 24933	\$348,315.68
06764	CRESTWOOD BEHAVIORAL HLTH	600924	5/23/2008	4/08	CRESTWOOD 24933	\$37,760.00
06764	CRESTWOOD BEHAVIORAL HLTH	600924	5/23/2008	4/08	CRESTWOOD 24933	\$177,156.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	4/18/2008	3/08	CRESTWOOD 24933	\$187,620.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	4/18/2008	3/08	CRESTWOOD 24933	\$381,074.97
06764	CRESTWOOD BEHAVIORAL HLTH	588359	4/18/2008	3/08	CRESTWOOD 74286	\$66,700.00
06764	CRESTWOOD BEHAVIORAL HLTH	588359	4/18/2008	3/08	CRESTWOOD 24933	\$36,580.00
06764	CRESTWOOD BEHAVIORAL HLTH	580346	3/27/2008	2/08	CRESTWOOD 24933	\$36,934.00
06764	CRESTWOOD BEHAVIORAL HLTH	576580	3/19/2008	2/08	CRESTWOOD 24933	\$374,587.10
06764	CRESTWOOD BEHAVIORAL HLTH	576580	3/19/2008	2/08	CRESTWOOD 24933	\$181,676.00
06764	CRESTWOOD BEHAVIORAL HLTH	576580	3/19/2008	2/08	CRESTWOOD 74286	\$61,045.00
06764	CRESTWOOD BEHAVIORAL HLTH	567117	2/20/2008	1/08	CRESTWOOD 24933	\$99,552.00
06764	CRESTWOOD BEHAVIORAL HLTH	567117	2/20/2008	1/08	CRESTWOOD 74286	\$62,350.00
06764	CRESTWOOD BEHAVIORAL HLTH	567117	2/20/2008	1/08	CRESTWOOD 24933	\$40,238.00
06764	CRESTWOOD BEHAVIORAL HLTH	567117	2/20/2008	1/08	CRESTWOOD 24933	\$385,944.46
06764	CRESTWOOD BEHAVIORAL HLTH	567117	2/20/2008	1/08	CRESTWOOD 24933	\$111,400.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	2/5/2008	12/07	CRESTWOOD 24933	\$40,238.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	2/5/2008	12/07	CRESTWD 74286	\$24,824.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	2/5/2008	12/07	CRESTWD 933	\$189,888.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	2/5/2008	12/07	CRESTWD 74286	\$37,236.00
06764	CRESTWOOD BEHAVIORAL HLTH	560795	2/5/2008	12/07	CRESTWD 933	\$420,857.16
06764	CRESTWOOD BEHAVIORAL HLTH	546195	12/27/2007	11/07	CRESTWOOD 24933	\$435,021.40
06764	CRESTWOOD BEHAVIORAL HLTH	545367	12/24/2007	11/07	CRESTWOOD 24933	\$31,860.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	12/24/2007	11/07	CRESTWOOD 24933	\$183,992.00
06764	CRESTWOOD BEHAVIORAL HLTH	545367	12/24/2007	11/07	CRESTWOOD	\$58,290.00
06764	CRESTWOOD BEHAVIORAL HLTH	540249	12/7/2007	10/07	CRESTWOOD 24933	\$433,799.53
06764	CRESTWOOD BEHAVIORAL HLTH	534910	11/21/2007	10/07	CRESTWOOD 24933	\$32,922.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	11/21/2007	10/07	CRESTWOOD 24933	\$180,640.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	11/21/2007	10/07	CRESTWOOD 74286	\$36,975.00
06764	CRESTWOOD BEHAVIORAL HLTH	534910	11/21/2007	10/07	CRESTWOOD 74286	\$24,650.00
TOTAL						\$8,148,489.94


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Dept #: *	<input type="text"/>	Org #: *	<input type="text"/>	
Fund #:	<input type="text"/>	Activity:	<input type="text"/>	
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Vendor #	Vendor Name	Warrant #	Date	Description	Amount	
06764	CRESTWOOD BEHAVIORAL HLTH	523474	10/23/2007	9/07 CRESTWD-BRDGE 933C	\$74,500.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	523474	10/23/2007	9/07 CRESTWD-PATH 286C	\$32,538.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	523474	10/23/2007	9/07 CRESTWOOD 933C	\$31,860.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	523474	10/23/2007	9/07 CRESTWD-PH 933C	\$115,260.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	523474	10/23/2007	9/07 CRESTWD-PATH 286C	\$21,692.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	523474	10/23/2007	9/07 CRESTWD-FRMT 933C	\$415,546.62	F
06764	CRESTWOOD BEHAVIORAL HLTH	515865	10/3/2007	12/06 CRESTWOOD 933	\$2,500.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	512871	9/25/2007	8/07 CRESTWOOD 286-COST	\$21,750.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	512871	9/25/2007	8/07 CRESTWOOD 933 IMD	\$212,624.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	512871	9/25/2007	8/07 CRESTWOOD 933 IMD	\$425,275.54	F
06764	CRESTWOOD BEHAVIORAL HLTH	512871	9/25/2007	8/07 CRESTWOOD 286-COST	\$32,625.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	512871	9/25/2007	8/07 CRESTWOOD 933-IMD	\$32,922.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	504320	8/24/2007	7/07 CRESTWOOD 933 IMD	\$36,462.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	504320	8/24/2007	7/07 CRESTWOOD 933 IMD	\$285,817.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	504320	8/24/2007	7/07 CRESTWOOD 933 IMD	\$445,988.24	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	8/06 CRESTWOOD 24933	\$8,375.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	6/07-PH CRESTWOOD 24933	\$238,327.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	9/06 CRESTWOOD 24933	\$10,375.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	10/06 CRESTWOOD 24933	\$9,875.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	12/06 CRESTWOOD 24933	\$6,250.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	6/07 CRESTWOOD 24933	\$427,556.32	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	6/07 CRESTWOOD 24933	\$35,400.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	493169	7/23/2007	11/06 CRESTWOOD 24933	\$8,375.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	487788	7/9/2007	5/07 WELLNESS CLINIC	\$7,788.80	F
06764	CRESTWOOD BEHAVIORAL HLTH	487788	7/9/2007	4/07 WELLNESS CLINIC	\$10,382.90	F
06764	CRESTWOOD BEHAVIORAL HLTH	487788	7/9/2007	1/07-WELLNESS CLINIC	\$9,550.95	F
06764	CRESTWOOD BEHAVIORAL HLTH	487788	7/9/2007	2/07 WELLNESS CLINIC	\$6,523.75	F
06764	CRESTWOOD BEHAVIORAL HLTH	487788	7/9/2007	3/07 WELLNESS CLINIC	\$9,759.55	F
06764	CRESTWOOD BEHAVIORAL HLTH	479803	6/15/2007	5/07-PH 24933	\$233,107.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	479803	6/15/2007	5/07 CRESTWOOD 24933	\$426,804.87	F
06764	CRESTWOOD BEHAVIORAL HLTH	479803	6/15/2007	5/07 CRESTWOOD 24933	\$36,580.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	479803	6/15/2007	4/07 CRESTWOOD 24933	(\$80,000.00)	F
06764	CRESTWOOD BEHAVIORAL HLTH	471739	5/25/2007	4/07 CRESTWOOD 24933	\$478,765.96	F
06764	CRESTWOOD BEHAVIORAL HLTH	470909	5/22/2007	4/07 CRESTWOOD 24933	\$218,027.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	470909	5/22/2007	4/07 CRESTWOOD 24933	\$31,860.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	460290	4/23/2007	3/07 CRESTWOOD 24933	\$32,922.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	460290	4/23/2007	3/07 CRESTWOOD 24933	\$251,334.00	F
06764	CRESTWOOD BEHAVIORAL HLTH	460290	4/23/2007	3/07 CRESTWOOD 24933	\$385,796.96	F

06764	CRESTWOOD BEHAVIORAL HLTH	451992		3/27/2007	2/07	CRESTWOOD 933	\$349,980.35	F:
06764	CRESTWOOD BEHAVIORAL HLTH	451992		3/27/2007	2/07	CRESTWOOD 933	\$29,736.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	451992		3/27/2007	2/07	CRESTWOOD 933	\$229,999.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	441424		2/23/2007	1/07	CRESTWOOD 933	\$262,971.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	441424		2/23/2007	1/07	CRESTWOOD 933	\$384,612.84	F:
06764	CRESTWOOD BEHAVIORAL HLTH	441424		2/23/2007	1/07	CRESTWOOD 933	\$32,922.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	429879		1/23/2007	12/06	CRESTWOOD 933	\$267,397.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	429879		1/23/2007	12/06	CRESTWOOD 933	\$412,346.16	F:
06764	CRESTWOOD BEHAVIORAL HLTH	429879		1/23/2007	12/06	CRESTWOOD 933	\$32,450.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	424966		1/8/2007	11/06	CRESTWOOD 933	\$31,860.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	424966		1/8/2007	11/06	CRESTWOOD 933	\$433,658.18	F:
06764	CRESTWOOD BEHAVIORAL HLTH	424966		1/8/2007	11/06	CRESTWOOD 933	\$267,365.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	412978		11/30/2006	10/06	CRESTWOOD 933	\$34,220.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	412978		11/30/2006	10/06	CRESTWOOD 933	\$280,934.00	F:
06764	CRESTWOOD BEHAVIORAL HLTH	412978		11/30/2006	10/06	CRESTWOOD 933	\$439,302.13	F:
TOTAL							\$8,480,851.12	

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Vendor #	Vendor Name	Warrant #	Date	Description	Amount	
06764	CRESTWOOD BEHAVIORAL HLTH	403907	10/31/2006	9/06	\$35,400.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	403907	10/31/2006	9/06	\$261,851.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	403907	10/31/2006	9/06	\$435,725.87	F.
06764	CRESTWOOD BEHAVIORAL HLTH	391883	9/25/2006	8/06 CRESTWOOD 933	\$242,953.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	391883	9/25/2006	8/06 CRESTWOOD 933	\$464,906.24	F.
06764	CRESTWOOD BEHAVIORAL HLTH	391883	9/25/2006	8/06 CRESTWOOD 933	\$36,580.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	384253	8/29/2006	7/06 CRESTWOOD 933	\$36,580.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	384253	8/29/2006	7/06 CRESTWOOD 933	\$450,494.43	F.
06764	CRESTWOOD BEHAVIORAL HLTH	384253	8/29/2006	7/06 CRESTWOOD 933	\$229,028.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	369319	7/13/2006	6/06 CRESTWOOD 933	\$35,400.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	369319	7/13/2006	6/06 CRESTWOOD 933	\$220,300.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	369319	7/13/2006	6/06 CRESTWOOD 933	\$449,565.41	F.
06764	CRESTWOOD BEHAVIORAL HLTH	363414	6/27/2006	5/06 CRESTWOOD-933	\$218,200.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	363414	6/27/2006	5/06 CRESTWOOD-933	\$487,530.04	F.
06764	CRESTWOOD BEHAVIORAL HLTH	363414	6/27/2006	5/06 CRESTWOOD-933	\$36,580.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	363414	6/27/2006	CRESTWOOD 933	\$23,918.25	F.
06764	CRESTWOOD BEHAVIORAL HLTH	356610	6/9/2006	3/06 CRESTWOOD	\$52,800.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	351432	5/25/2006	4/06 CRWD B H INC 933	\$489,421.21	F.
06764	CRESTWOOD BEHAVIORAL HLTH	351432	5/25/2006	4/06 CRWD B H INC 933	\$35,400.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	351432	5/25/2006	4/06 CRWD B H INC 933	\$204,120.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	340962	4/25/2006	3/06 CRESTWOOD 933	\$514,206.63	F.
06764	CRESTWOOD BEHAVIORAL HLTH	340962	4/25/2006	3/06 CRESTWOOD 933	\$36,580.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	340962	4/25/2006	3/06 CRESTWOOD 933	\$178,200.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	327795	3/16/2006	2/06 CRESTWOOD 24-933	\$33,984.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	327795	3/16/2006	2/06 CRESTWOOD BH-24-933	\$418,886.34	F.
06764	CRESTWOOD BEHAVIORAL HLTH	327795	3/16/2006	2/06 CRESTWOOD BH 24-933	\$202,680.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	318775	2/17/2006	1/06 CRESTWOOD 24933	\$226,060.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	318775	2/17/2006	1/06 CRESTWOOD 24933	\$479,210.06	F.
06764	CRESTWOOD BEHAVIORAL HLTH	318775	2/17/2006	1/06 CRESTWOOD 24933	\$37,760.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	318184	2/14/2006	12/05 CRESTWOOD 24933	\$465,166.90	F.
06764	CRESTWOOD BEHAVIORAL HLTH	309694	1/25/2006	12/05 CRESTWOOD	\$40,238.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	309694	1/25/2006	12/05 CRESTWOOD 24933	\$204,300.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	303898	1/5/2006	11/05 CRESTWOOD 24933	\$188,600.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	303898	1/5/2006	11/05 CRESTWOOD 24933	\$431,180.67	F.
06764	CRESTWOOD BEHAVIORAL HLTH	303898	1/5/2006	11/05 CRESTWOOD 24933	\$43,070.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	289025	11/17/2005	10/05 CRESTWOOD 24933	\$44,250.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	289025	11/17/2005	10/05 CRESTWOOD 24933	\$218,720.00	F.
06764	CRESTWOOD BEHAVIORAL HLTH	289025	11/17/2005	10/05 CRESTWOOD 24933	\$459,588.26	F.

TOTAL

\$8,669,434.31

The Accounts Payable Vendor History can be queried online.
Please enter one or more fields to search on:

Vendor #: *	<input type="text" value="06764"/>	Name: *	<input type="text"/>	<input type="button" value="Search"/>	<input type="button" value="Clear"/>
P.O. #: *	<input type="text"/>	Description:	<input type="text"/>	<input type="checkbox"/> view in EXCEL 97	
Warrant #: *	<input type="text"/>	Account #:	<input type="text"/>	<input type="text" value="2000"/> records maximum	
From Date:	<input type="text" value="11/10/2005"/>	Thru Date:	<input type="text" value="11/10/2006"/>		
Dept #: *	<input type="text"/>	Org #: *	<input type="text"/>		
Fund #:	<input type="text"/>	Activity:	<input type="text"/>		
Task:	<input type="text"/>	Option:	<input type="text"/>		

(* You must enter AT LEAST ONE of these fields to search on...

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original



PROFESSIONAL & TECHNICAL ENGINEERS, LOCAL 21, AFL-CIO
An Organization of Professional, Technical, and Administrative Employees

January 26, 2010

William B. Walker, M.D., Director
Health Services
Contra Costa County
50 Douglas Drive
Martinez, California 94553

Re: **Response to Local 1 Survey of Contra Costa County Mental Health Senior Staff and Administration**

Dear Dr. Walker:

Our union, IFPTE Local 21, now represents over 800 professional, supervisory and management employees in the County who were formerly unrepresented. In Health Services we represent many management employees who though they chose representation by a labor union out of a desire to have a voice in their salaries, benefits and working conditions they view the mission of the organization to provide quality services to the public as at least as important to their professional lives. We believe it is an important role of their union to advance those interests as well as the more traditional union interests of economic advocacy and protection on the job.

Recently, I have been meeting with our represented management employees in the Mental Health Division over a disturbing survey report put out by Public Employees Local 1 that we believe is not objective and that is harmful to the mission of the Mental Health Division. I now understand that this so-called survey has been released beyond the Mental Health Division and even to the media. Given the economic challenges we are continuing to face, I can't think of anything more self-defeating of the interests of all workers in the Mental Health Division. I don't relish the idea of a disagreement with another labor union, but that union did not consult with us before they went down this path.

One thing that particularly struck me in my meetings with our member managers in the Mental Health Division was their willingness to address any issues raised by Local 1 in an effort and atmosphere conducive to problem solving. I am looking forward to our union being a part of that effort. In the meantime, we feel it is essential to respond to the survey.

Main Office: 1182 Market Street, Room 425 San Francisco, CA 94102 T: 415 864-2100 F: 415 864-2166
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www.ifpte21.org

The Deputy Director, Adult/Older Adult Program Chief, Child/Adolescent Program Chief and Program Managers of the Mental Health Division, all represented by our union, worked together on the following response to the Local 1 document titled, "*An Evaluation of Contra Costa County's Mental Health Senior Staff and The Mental Health Administration's Policies and Procedures*" submitted in December, 2009 by Public Employees Union Local 1 Mental Health Unit. While Senior Staff is open to continued dialogue with Local 1 members regarding on-going quality improvement efforts in the Division, we are compelled to express our disagreement and objection to the "evaluation". We do so on a number of counts.

1. **It is apparent in the survey that the majority of concern expressed is in response to enforcement of the Division's productivity standards.** A productivity policy and procedure was developed and negotiated with Local 1 over 10 years ago. Local 1 objects that the policy should not be enforced at this time since it was not in the past. This needs a response. After the policy was established, it was found that the existing information system was not capable of generating accurate productivity reports. Mental Health Administration did not want to enforce the policy until there was a high level of confidence that reports for each staff person were correct. There were many attempts over the years to resolve questionable data points in the reports produced by the Information Systems Department, but given technological challenges to consolidate pertinent information from multiple databases, resolution was not achieved. It was not until the Division had the staff and adequate access to necessary information to independently produce reliable reports that the productivity policy was enforced. Once the reports were tested and deemed reliable, all staff were advised six months in advance of the intent to implement the policy so each clinician would have the opportunity to receive during that preparation time a personalized, monthly summary of their clinical service hours so they could begin to adjust their work load in order to spend at least 55% of their work hours in direct, reimbursable services to mental health consumers. The reasons for this policy are primarily:

a. **The Division's commitment to ensure access to care for mental health consumers dependent on Contra Costa's community mental health system.** The Mental Health Division has been subject to annual budget reductions for the last eight years, with a total reduction of approximately \$25 million, but the need for mental health services has continued to increase. In order to address the needs of the most vulnerable members of our community, it was essential to ensure that each clinician work efficiently in providing direct care.

b. **The Division's responsibility to stay within budget.** The Mental Health Division is dependent on several funding sources, but chief among them is MediCal reimbursement. The State Department of Mental health establishes a Standard Maximum Allowance (SMA). The County can not claim cost for services above the SMA. Any costs over the SMA require funding from the County General Fund. As the County encountered reductions in its general fund, there were less available dollars to supplement MediCal payments. The fewer MediCal reimbursable services the Division provides, the higher the cost of providing those services and the higher we exceed the SMA. It is essential to have staff provide enough reimbursed services so the SMA is not exceeded.

c. **Senior staff's duty to maintain the public trust by ensuring tax dollars are spent judiciously and result in direct care of consumers.**

d. **The Division's commitment to maintain not only services to consumers but also the continued employment of staff.** If the policy had not been enforced, thereby increasing revenues and reducing dependence on County funds, more staff reductions would have been necessary.

2. **Though the evaluation states that 83% of Local 1 members participated in the survey this cannot be accurate, since not all program managers were included and entire programs or services were omitted.** Factually, the number of members was understated in the report so the stated percentage of responding members is inflated. For the sake of establishing context, it should be noted that Division nurses and physicians are not represented by Local 1 but are service providers asked to spend at least 55% of their worked hours in direct care. They were not included in the evaluation process.

3. **Rather than utilize a standardized, credible management assessment tool in conducting the "evaluation" of managers, Local 1 seems to have constructed its own measures.** These do not demonstrate validity, reliability or objectivity. Further, there is no author of the report or indication of who constructed the questions and analyzed the data. The following is a detailed response to the report and associated evaluation methodology:

General Critique

The evaluation document is an odd mix of documents including:

- 1) A survey given to Local 1 staff members on Mental Health Administration (MHA), Senior Administration staff members, and Program Managers;
- 2) A high level literature review about organizations and leadership styles;
- 3) A series of letters between Local 1 and Donna Wigand regarding the productivity standards;
- 4) A "Grading the States" document by NAMI in 2006;
- 5) A two-page "Memorandum of Family Concerns" from the MHSA Family Steering Committee in February, 2009; and
- 6) 13 pages of line items from the County Auditor's Intranet site for payments to Crestwood since November 2005.

A copy of the survey was not even included, so a review of questions and answers can only be inferred from the survey results section. It would be advantageous to have a copy of the survey that staff members completed. The organization, structure, and instructions on the survey itself are often integral to the analysis. It would also be useful to have the raw data as well for an independent analysis.

Rather than using the survey as a constructive tool for quality improvement purposes, it is clear that the agenda behind the evaluation document was to single out and negatively review Mental Health Administration and specific staff in Administration, as well as some program managers.

In fact, the author of the document surprisingly states this bias in the "Purpose" section: *"This evaluation... was conducted as a result of growing feelings among Local 1 Mental Health employees that the Mental Health Administration is out of touch with their concerns and beyond that, indifferent and dismissive of them."* The "Purpose" section actually reads like an attack on Mental Health Administration: *"An increasing staff dissatisfaction with the direction of the division, its lack of concern and communication, its demonstrated hostility and negativity and, its poor and inadequate planning to face the challenges of dwindling resources was communicated."*

An impartial and properly organized report on a survey project would state an objective goal of gathering feedback from staff on a series of questions. It would not, as this report does, start with the author's biased conclusions as a part of the first introductory paragraph. Coupled with the strange mix of supplementary documents, it is clear that the intent of the document in its entirety was to further the underlying agenda of attacking Mental Health Administration on a collective and personal level.

Critique of Survey

Lack of Detail. The professional standard in a survey report is to include a copy of the survey itself so those reviewing the report can refer to the original document. This was lacking in this report, as were the instructions that staff received in terms of completing the survey. Although it states that the sample was inclusive of all Local 1 members (total n = 159), this number is at odds with current Local 1 enrollment numbers. Additionally, some work units never received the survey. Furthermore, in the Results section of the survey report, it only states percentages for each response category and it never reports how many staff responded to any given category. Given the stated percentages, it appears that some work units were as small as six, which makes summary analyses highly dubious given the small sample size. Along the same lines, eliminating data for program managers with less than six responses is in itself a questionable practice. Why would they be eliminated from the general analysis? Or were they simply eliminated from the review of each program manager and left in the general analysis? It is impossible to determine this given the way the report was written.

Response Categories. The survey used a standard Likert scale format with 5 response options: “Strongly Agree”, “Somewhat Agree”, “Don’t Know or Neutral”, “Somewhat Disagree”, or “Strongly Disagree”. For each question, the frequency of each response was tabulated and the percent of staff that responded in each category was displayed in a pie chart. Unfortunately, the middle category (“Don’t Know or Neutral”) was lumped together, despite the fact that they have entirely different meanings. A response of “Don’t Know” would imply that the respondent does not have enough information to answer the question. A response of “Neutral” implies that the respondent has either a mixed response (i.e., both agrees and disagrees to some extent) or has decided that there is a relatively equal weighting on either side that forms their overall impression of “Neutral.” In any case, using this category on the survey leads to confusing and ambiguous results. This ambiguous category constituted a significant portion of responses, in many cases over 25% of all responses.

Leading and Ambiguous Questions. The bias in the survey design is also apparent in the phrasing of the questions themselves. Some are nearly impossible to interpret, such as the first question: *“This administration has been consistently transparent and accountable in regards to our system’s day-to-day operations and decisions.”* The meaning of this statement is unclear. Some questions do not make any sense to ask, such as question 5: *“Unified standards of performance apply to both Mental Health Administration and line staff.”* It is not clear what “unified” means, but more importantly the standards of performance *should* be different between line staff and Administration staff, given line staff and MHA staff have different job roles. Some questions are simply leading, making assumptions as part of the question itself. For example, Number 16 states: *“This administration’s action have strongly contributed to the prevailing morale.”* The statement itself assumes that the prevailing morale is low, which is a leading commentary and does not belong in a survey that is supposed to elicit honest feedback from staff.

Order Effect. One of the most common issues that arise in survey data collection is order effect – after respondents answer a question one way, they will seek to stay consistent with their first response throughout the remainder of the survey. The first question sets the tone for the rest of the survey. There are techniques to alleviate this effect, but none were employed in this survey. In fact, it appears that just the opposite occurred on this survey. The very first question alluded to earlier uses flashpoint language, apparently to take advantage of the order effect, using words like “consistently transparent” and “accountable.” Language such as this coupled with an unclear question would naturally lead to a negative review on this question, which in turn would have implications for the questions on the rest of the survey.

Critique of Analysis

Staff Contact. Staff overwhelmingly stated they had very little contact with the two principal targets of the survey, Donna Wigand and Suzanne Tavano. Well over 90 percent of staff stated they never or seldom had contact with either of these individuals, and 59 percent of staff stated they never met either. Given the nearly complete lack of contact, it is difficult to see how staff was able to answer the questions targeting each of these individuals. In order to answer most of

the questions, some contact with these individuals is required. Clearly this is not the case, but staff responded to the questions anyway and the author of the report carelessly reported the bogus data. If respondents state they never or seldom had contact with the two target individuals, and responses to the questions require contact with these individuals, then it is incumbent on the author of the report to note this and interpret the results very cautiously, if at all.

Direct Link to Enforcement of Productivity Standard. The survey results are for all intents and purposes a vendetta against Mental Health Administration and select staff members. The survey and the results from the survey do little to improve the services delivered to clients. It is clear that the imposition of the productivity standard roughly a year ago and the ensuing counseling memos to staff who are not meeting the standard was one of the primary motives for conducting the survey. The enforcement of the productivity policy was seen as "autocratic, unilateral, unreasonable, arbitrary, inflexible, and punitive." These points are arguable given:

- 1) The productivity policy was written and approved over 10 years ago in consultation with Local 1;
- 2) It is reasonable in the sense that it carries the lowest expectation for direct line staff of all the counties in the Bay Area and most likely is among the lowest across the State;
- 3) There is considerable flexibility built into the policy whereby individual staff can be specially considered depending on their job role (e.g., staff who have many lockout situations); and
- 4) It is punitive only to those who fall below a very low direct service threshold of 55% direct billable services, which leaves 45% of the week unaccounted for. It is difficult to justify these conclusions.

Response to NAMI Report References

The MHD agrees with the points made in the NAMI report "Grading the States 2006: Standards for a Quality Mental Health System: A Vision of Recovery", which was included in the Local 1 evaluation. The Division has been working to implement all the cited components of an effective community mental health system as described below:

- The MHD in fact is already providing housing through utilization of MHSA funds. For FY 09-10 housing is budgeted for \$4,931,234. This includes not only reimbursements to Crestwood as referenced in the Local 1 report, but also subsidized housing, master lease housing and purchased housing units.

- The MHD has provided medications to uninsured mental health consumers unable to pay for their prescribed psychiatric medications in order to support their recovery in the community. They attempted to utilize pharmacy assistance program (PAPs) in the past to assist consumers in obtaining free medications from pharmaceutical companies, but previously there were concerns by Health Services about doing so. However, this year they received approval from Health Services to assist consumers with PAP enrollment and already have implemented this process.
- The MHD does not maintain an Assertive Community Treatment (ACT) program per se, but consumers enrolled in Full Service Partnerships are receiving services consistent with this model. Also, a mobile response team is available to children and adolescents in need of crisis intervention services in the community and at home. Mobile response teams for adults have been considered but determined to be very costly; however, if funding allowed, this service might be re-considered.
- Integrated dual diagnosis treatment (for mental health and alcohol/other substance co-occurring disorders) already is a documented goal of the Division. Part of their MHSA Workforce and Education approved plan includes training of staff (hopefully resulting in staff certification in this area) in the provision of dual diagnosis treatment.
- Family psycho education already is offered to families of children and adolescent but admittedly needs further development for families of adults.
- Crisis services are available during week day work hours at all of the Division's clinic sites. Additionally, they are available on a 24 hour/7 day basis at the Crisis Stabilization Unit at CCRMC. One of the key programs supported by the MHD is establishment of a free-standing urgent care center available to children, adults and older adults, but the planning for this has been postponed secondary to public planning processes. Hopefully, stakeholders will be supportive of the plan in the future. MHD managers agree that having County staff operate this service would be preferable if fiscally feasible.
- The MHD hired a new Coordinator for the Office of Consumer Empowerment (OCE), additional staff for OCE, additional peer support workers (Community Support Workers) and family partners to assist in efforts to move further in full implementation of the principles of illness management, wellness and recovery, and consumer driven treatment. Also, additional funding has been awarded for community based consumer-operated wellness and recovery centers to further support this effort.
- The MHD operates a highly recognized Vocational Services program that assists consumers in job preparedness and placement. This program received special recognition this year by the State Department of Rehabilitation.
- Very successful programs sponsored by the MHD to assist in diverting consumers from incarceration are mental health courts for both adults and adolescents.
- The MHD has successfully implemented the IMPACT program, a collaborative, evidence-based treatment model which incorporates integration of health and behavioral services. They anticipate additional collaborative projects between the MHD and Primary Care this year to further improve integration of care.

Response to Questions about Need for a Deputy Director and Program Managers:

Contra Costa is the 9th largest county in the state. Every mental health division of equal and many of lesser size have both a director and deputy director given the size, scope and complexity of operations. It might not be fully understood by Local 1 that the MHD provides community mental health services not only through its County owned and operated programs, but even to a larger degree through its contracts with community based organizations and state-wide private provider network.

The MHD became the Contra Costa Mental Health Plan in 1998 and as such, became responsible for managing all mental health care to all Contra Costa MediCal beneficiaries and uninsured consumers, regardless of provider site. Consequently, the director, deputy director, chiefs and program managers not only manage care in the County-operated clinics, but to over 65 contracted community based organizations (CBOs), 250+ private providers, all hospitals providing inpatient psychiatric care, IMDs, augmented board and care facilities, group homes and out-of-county care. Further, they have regulatory responsibility for administering a 24/7 Mental Health Access Line.

The programs which are staffed by Local 1 members actually only account for 37.5% of the outpatient mental health services provided annually by the MHD, and of these many are provided by psychiatrists and nurses who are not Local 1 members.

48.8 % of outpatient services are provided by CBOs and 13.7 % by the Private Provider Network. Further, MHD Senior Staff is responsible for all services and programs funded through the Mental Health Services Act (MHSA). For MHSA Prevention and Early Intervention alone, there are over 23 contracts for services; this number is not included in the total for contracted CBOs referenced above, nor is the Full Service partnership contracts.

It also should be noted that the MHD, operating as a managed care entity, has an enormous number of state and federal regulations which demand adherence. The senior staff of the Division is responsible for ensuring compliance with all these...many of which Local 1 would have no awareness.

While they greatly value the staff of the County-operated clinics (which includes Local 1 members) and strongly believe they provide unique services to consumers of the highest mental health needs, in actuality, the majority (62.5%) of mental health services are provided outside the County-operated clinics and must be managed by Senior Staff. The existence of a deputy director, two chiefs and the number of current program managers is not excessive given an organization of this size with such a wide scope of responsibility.

January 26, 2010

Despite our criticisms of the study we are open to a constructive dialogue with an emphasis on mutual problem solving.

Sincerely,



Bob Britton, Director
Field Services
Professional & Technical Engineers
Local 21, AFL-CIO
415-864-2100

c: David Twa, County Administrator
Ted Cwiek, HR Director
Donna Wigand, Deputy Director
Mental Health Commission
Peter Mantas, Chair
Theresa Pasquini, Vice Chair
Rollie Katz, Local 1